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 The Irish Society for Autism
Centre ID:	OSV-0003427
Centre county:	Meath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Irish Society for Autism
Provider Nominee:	Tara Matthews
Lead inspector:	Ciara McShane
Support inspector(s):	Philip Daughen
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
10 January 2015 11:20	10 January 2015 14:30
23 January 2015 10:00	23 January 2015 17:00
28 January 2015 10:30	28 January 2015 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Inspectors undertook five inspections in this centre throughout 2015 and 2016. These inspections found evidence of poor outcomes for residents and areas of risk relating to health and safety, risk management, social care needs, safeguarding and safety, governance and management, use of resources and workforce. Poor managerial oversight and governance arrangements were also a recurrent finding in this designated centres. Due to the seriousness of the concerns, HIQA issued immediate actions and warning letters. Regulatory and escalation meetings were also held with the provider.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to cancel and refuse the registration of the centre was issued to the provider on 13 January 2016.

The provider subsequently appealed the decision of the Chief Inspector to the district court and a court hearing was set to commence on the 9 May 2016. On this date, the provider applied to withdraw their appeal. In accordance with Section 64 of the Health Act the chief inspector made alternative arrangements with the Health Service Executive (HSE) to take over the running of the centre.

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

Findings from this inspection:
The Authority completed three unannounced inspection days of the designated centre over a period of three weeks. The inspections were triggered as a result of unsolicited information received by the Authority in relation to the premises, health and safety and the care, welfare and support of residents. Aspects of the unsolicited information were, at the time of the inspections, found to be unsubstantiated. However, some elements in relation to risk management, care planning and the premises were substantiated and found to have an impact on the care, welfare and support of the residents living at the designated centre.

Overall, the inspectors found the current management systems in the centre were poor. Effective management systems were not in place to oversee the day to day running of the centre including but not limited to; health and safety, maintenance of premises, information governance and equipment or to oversee staff performance and development. The management systems in place did not ensure that residents' needs were appropriate, consistent and effectively monitored, this is further detailed under outcome 5 and 11.

The inspectors found that the person in charge, due to the extent of her remit, did not have the capacity to have oversight for three designated centres as outlined in Outcome 14.

The inspectors reviewed residents' activation levels and staffing levels at weekends. The inspectors found that residents attended outings such as going for walks, going out for dinner and shopping. However, it was not evidenced that these activities took place frequently or that residents' preferences for activities as documented in their personal plans were met.

Inspectors found there were some adequate health and safety practices such as emergency lighting provision, firefighting equipment, which was within its service period, and staff spoken with were knowledgeable of what to do in the event of a fire. The centre recently had a fire; on review of the incident form, the inspectors found that staff responded appropriately and the kitchen, where the fire was isolated to, was temporarily out of use and being redeveloped at the time of inspection.

However, further improvements regarding health and safety practices, in particular risk management, were required. The inspectors reviewed the risk register and found that all hazards were not adequately outlined. For example, the inspectors saw that the risk of fire had not been outlined within it and also found there was no evidence that a risk assessment subsequent to the fire had been completed. The inspectors were not assured that learning subsequent to the fire had taken place and there was no evidence available to demonstrate that a discussion, identifying learning, had taken place amongst the provider and the persons participating in management. Other areas for improvement regarding health and safety included the absence of specific risk assessments, deficits in fire doors and the emergency units also required

a review. This is further outlined in Outcome 7.

The inspectors reviewed a number of personal plans. The centre was in the process of implementing a new personal planning system however, improvements were required. The inspectors reviewed the personal plan of a resident who recently had a significant incident. The inspector was not assured that all elements of their care were consistently being met. Subsequent to the incident there was no care plan developed for the resident and staff failed to administer pain medication for the resident over a two day period. This is further outlined in Outcome 5 and 17. The inspectors also reviewed a sample of personal plans for a number of additional residents and found that improvements were required. For example, there was an epilepsy care plan in place for one resident but it did not adequately detail the support staff should provide to the resident post seizure.

These actions along with other findings are outlined in the body of the report and the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The inspectors reviewed residents' preferences, access to and participation in recreational activities. The inspectors spoke with staff and residents in addition to making observations regarding residents' activation levels on the Saturday inspection in addition to reviewing the residents' progress notes. The inspectors found that residents had some level of activation however, improvements were required to ensure that the activities were meaningful, frequent and in line with residents' preferences.

On the first day of inspection, the inspectors found that residents were enjoying a leisurely Saturday. At the time of inspection a number of residents were having a lie in, while other residents were making a cooked breakfast and planning their day. Staff spoken with told the inspectors that activities such as walking and completing the food shop were planned for the day. Some residents had plans to attend mass that evening. Staff also stated that residents would occasionally go out on a Saturday afternoon for dinner to a local restaurant.

The inspectors reviewed a sample of residents' preferences for activities and recreational activities in their personal plan. The inspectors reviewed their corresponding progress notes and activity logs to identify their level of activation in line with their preferences. The inspectors found that over a period of seven months, one resident was out 16 times, nine of which were supported by their family therefore only seven outings over a period of seven months, averaging one a month, were supported by staff. For another resident the inspectors saw, documented in their progress notes, that for the same seven month period the resident had been out seven times. The team leader spoken with stated that the residents had possibly been out more but staff had possibly not

documented it. From this review of residents' personal plans and progress notes the inspectors saw that these two residents had not participated in their preferred activities as outlined in their personal plan over the previous seven months. For example, one resident had a preference for bowling but had not been bowling in the previous seven months. From a review of the resident's activation levels and the type of activation residents were involved in, the inspectors were not assured their preferences were being met or that they were participating in sufficient meaningful activities. In addition, the inspectors also found that outings were mostly group based activities; one to one activities and outings were infrequent.

On the initial day of inspection, 10 January 2015, a staff member was unavailable to attend for duties in one of the units for that day. As a result, two residents had to be moved to another unit. The inspectors found the staffing contingency plans were inadequate. The team leader informed the inspectors they were unable to get a replacement staff after trying a number of relief staff. However, the staff member on the night shift was available to come on duty earlier at 16.00. This resulted in two residents having to leave their home for a duration of six hours due to lack of available staff.

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

Findings:
On the first inspection to the designated centre in July 2014, the provider was found to be introducing a new personal planning system, which resulted in the personal plans at that time being incomplete. This personal planning system was subsequently made redundant. On this inspection, the centre was in a process of introducing a revised personal planning system which was at its infancy stages. Significant improvements were required to ensure the assessed needs of residents continued to be met.

The inspectors reviewed a sample of residents' personal plans. The inspectors found that residents' needs were not sufficiently assessed and documented to ensure staff were providing safe and effective care in line with their assessed needs. Inspectors found where care plans were in place, they were not comprehensive or sufficiently detailed to guide staff in providing consistent care. Care plans were also found not to be

in place to meet the needs of some residents.

Accidents and incidents documented at the centre and a recent notification received by the Authority was reviewed by inspectors. The inspectors found that appropriate care had not been provided. The inspectors reviewed a file of a resident who was recently admitted to hospital for surgery on foot of an accident and who had returned to the designated centre for postoperative care. The following was found; there was no discharge letter within their personal plan although the team leader told the inspector this was in her office. There was no post operative care plan to guide staff to support the resident ensuring their needs were met. The inspectors did review a file note that had be entered into the residents personal plan but it was vague, insufficiently detailed and therefore compromised the safety of the resident. The file note did not outline the resident's full post operative care including but not limited to pain management, intimate care and moving and handling requirements. The risk of not having a care plan in place was evident as the inspectors found on review of the residents' medication administration record that staff had failed to administer the resident's pain medication for two days post discharge from hospital. This is further outlined in Outcome 17. The inspectors found gaps in the personal plan for this resident with their 'current physical health' and 'emotional well being' was not populated. Both areas would be compromised post surgery and therefore vital that such information was documented ensuring consistent care was provided in line with their physical and emotional well being.

The inspectors also found that although this resident was at risk of falls, there had been no falls risk assessment completed. The need for assistive equipment such as the use of a wheelchair and a walking aid were not clearly outlined. Their mobility level was also unclear. The inspectors found the procedures followed for this resident, subsequent to a serious fall, were inadequate and compromised their well being. The resident, whose fall was unwitnessed, received a laceration to their eye which resulted in swelling. The staff contacted the on-call team. The on-call person returned to duty and assessed the resident. However, the resident was not subsequently referred to medical services. On the following morning post incident, the resident was noted as being unable to walk and at that point was transferred to the accident and emergency department.

The inspectors found, for another resident, they too did not receive appropriate care post incident. The inspectors reviewed an incident of self injurious behaviour where a resident suffered a head injury. The inspectors found, on review of the incident report form appropriate medical attention had not been received. The head injury was unwitnessed and lacerations were received to their forehead in addition to swelling. However, neurological observations were not completed by the care staff nor was the resident immediately or subsequently referred for medical attention. The inspectors also saw in the residents' behavioural support plan guidelines in place for staff to follow subsequent to such an incident. The protocol was unclear, vague and insufficient to direct care staff in the absence of medical expertise.

From a review of additional care plans the inspectors found they too were unclear. For example, the inspectors reviewed an epilepsy care plan and found that the care to be provided post seizure was not outlined, it was therefore unclear how staff were to support the resident. There was a descriptive record of seizure activity present in addition to a seizure record sheet. The inspectors were told that staff had training in

epilepsy management. Other areas within the personal plan required improvement; discrepancies in care plans were found which could lead to confusion for the care staff reviewing the information. For example, information regarding a resident's eyesight stated the resident 'could see' and also 'they can't see'.

Significant improvements were required to ensure that care plans were in place to meet all the assessed needs of residents ensuring safe and effective care was provided. From a review of sample care plans, the inspectors were not assured that all residents' assessed needs were being consistently and comprehensively met. The inspectors were not assured that staff had sufficient knowledge on how to complete a personal plan and subsequent care plans. The inspectors were not assured staff had the appropriate skill set to meet the needs for all residents as further outlined in Outcome 17.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors reviewed the premises having regard to the suitability of the premises to meet resident's needs and the suitability of the premises post fire.

The inspectors reviewed the living accommodation for two residents who had recently changed rooms to meet the need of a resident post surgery. The inspectors found that both bedrooms met the needs of both residents and they were safe and content. The inspectors saw that the premises was equipped with the necessary aids for the specific needs of a resident. However, due to the bathroom being located upstairs, interim measures had been arranged for showering facilities. The inspectors found these to be appropriate in the short term. The resident was able to mobilise safely around the ground floor of the unit.

In relation to the incident, where a recent fire occurred as a result of the stove going on fire, the inspectors found the premises to be of adequate condition. The smoke damage was limited to the kitchen. On the day of inspection, the inspectors saw that contractors were on-site and repair works were in process. The works were been overseen by the maintenance person, there was no schedule of works available for review. The inspectors saw as part of the works a chimney, which had been erected post build, had been removed as a precaution. The solid fuel stove was being replaced by an electric cooker. Interim arrangements had been put in place for mealtimes. The inspectors

found these to be adequate in the short term. The maintenance person told the inspectors, as a result of the stove fire, the remaining three stoves in neighbouring units were serviced. The inspectors were told the stoves were cleaned out but staff could not confirm if they had been serviced. The inspectors reviewed the service docket outlining checks were carried out. However the docket did not sufficiently detail the works which were carried out and it was also not dated. It was therefore unclear if the stoves were cleaned out or serviced and when the actual servicing was completed.

The inspectors were told that family members had recently made a complaint regarding the heating in the designated centre. The inspectors found for this time of year the unit was unnecessarily cold. This was conveyed to the team leader on duty. As a result the timer switch was changed. Although residents were at the training centre on site, they came and went to the unit throughout the day.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Findings:
While inspectors found some satisfactory practices in place regarding health, safety and risk management, significant improvements were required to comply with the Regulations.

Inspectors walked through a number of the residential units at the centre. It was found that the units were provided with largely comprehensive fire alarm systems for detecting and giving warning of fires. The layouts of the units were compliant with respect to providing adequate means of escape in the event of fire and there was emergency lighting provided throughout. Fire procedures were displayed in the main circulation spaces of all units inspected. A number of staff questioned on the procedure to follow in the event of fire were familiar with the procedure. Staff questioned confirmed they had received training in fire safety management and the use of fire extinguishers. The centre was able to provide records to show the fire alarm, emergency lighting, fire extinguishers were regularly serviced. The centre was also able to provide records of regular fire drills.

Improvements were required regarding the procedure to manually raise the alarm in the event of fire in the group units. The arrangement observed on inspection required the use of a key that had to be inserted in to the manual call point. These keys were not held by all staff members but were held in a cupboard in the kitchen of each group unit or by the lead staff member on duty. This potentially introduces an unnecessary delay in the raising of the alarm in the event of fire as the staff member will have to travel to the

kitchen to obtain the key or as observed on inspection the lead staff may not be present in the unit. This could also potentially cause an unnecessary delay in giving warning of fires as well as delay the potential use of fire fighting equipment and/or the evacuation of the premises. There was no evidence of why these key operated manual call points were provided. The inspectors found that conventional break glass units were provided within the apartment type units inspected. However, the main units were equipped with the key operated units. One of the conventional break glass units, in an apartment, had tape over the cover preventing operation of same.

Inspection of a selection of units at the centre also showed that fire doors had been provided throughout where required. However, there were multiple incidences of fire doors where the self closers had been disabled or removed therefore preventing their operation as fire doors. There was a fire door provided to a storage room containing combustibles that had been left ajar within a stair enclosure. There was also a fire door provided to a bedroom that would not close as it was sagging on its hinges. These doors would be unable to fulfil their function of containing a fire and preventing the movement of smoke through the building and protecting the escape routes for occupants of the building.

Inspectors reviewed the centres' safety statement/health and safety policy document in addition to the risk management policy and risk register. The safety statement and health and safety policy were centre specific and named staff in key roles but were not dated or signed so there was no indication as to how old the document was or when it would require review. The risk management policy contained some information on the assessment of risk but was not clear on the methodology to follow in the risk assessment process. The inspectors found there was insufficient detail on hazard identification as part of the risk assessment process. The risk management policy was not dated. The risk management policy also failed to adequately address the measures and actions in place to control; the unexpected absence of any resident; accidental injury to residents, visitors or staff; aggression and violence, and self harm as outlined in Regulation 26. The most up to date risk register was dated 13 January 2015. There were a number of relevant risks and associated control measures identified in the register. The recorded risks were found to be generic and not entirely centre specific. For example, inspectors found one general entry for 'environmental, building and health and safety risks'. There was no specific risk assessment process followed for individual hazards and associated risks contained within this such as fire, slip or hot surfaces. For example there was no entry in the risk register to reflect hazards identified as a result the stove and chimney fire that occurred on the 12 December 2014. At the time of inspection, there was a selection of building work being carried out on site. This included the construction and fit out of a new apartment. It also included the removal of an external chimney from one of the group units. There was no entry in the risk register to take in to account the additional hazards present on site as a result of this building work being carried out at the centre. This would indicate that any learning from past adverse events was not being recorded. There were also examples of risks recorded in the previous risk register as high being carried over to the current risk register, also defined as high, with no additional control measures identified to reduce the risk.

A sample of residents' personal evacuation plans were reviewed by inspectors. It was found that generally they provided an adequate level of information on the evacuation needs of individual residents. However, inspectors found a residents' personal evacuation plan had not been updated to reflect the current needs of the resident which had recently changed.

Infection control procedures required a review. For example, a memo was circulated to staff in relation to procedures to follow in the wake of an outbreak of a communicable infection at the centre. However, the memo contained no information as to the importance of hand hygiene in containing the outbreak.

Overall, while there was documentation present outlining the systems in place for assessment, management and the ongoing review of risk, this documentation lacked detail and did not appear to be implemented consistently in practice at the centre. As outlined in Outcome 14, the management system for health and safety and risk management was found to be poor and required a review.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

Findings:
The inspectors reviewed a sample of personal plans and although there were some satisfactory practices regarding residents' health-care; improvements were required.

Upon review of residents' care plan, the inspectors found that residents were linked to allied health professionals including physiotherapy and the general practitioner. Records of these appointments had been made. However, all follow up details had not been documented. For example, one resident was to be scheduled for additional treatment but this need had not been documented. For this same resident, as outlined in Outcome 5, clear guidelines outlining the support required to meet their physical and emotional needs at this time of recovery were not outlined.

As outlined in outcome 5, the inspectors observed a resident with lacerations on their forehead and subsequent swelling. On speaking with staff, and from a review of an incident report form, it was evident that this was as a result of self injurious behaviour (SIB) causing the injuries. The inspectors found that the resident had not been referred to a general practitioner to seek medical attention for the unwitnessed head injury. The inspectors also reviewed an additional incident report form for a resident who had an unwitnessed fall. This resulted in a significant injury however, the centre's referral to

medical services was not timely.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors found the organisational structure in place required significant improvements regarding management systems to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs.

The inspectors reviewed the system in place to manage risk. The inspectors found the systems in place to manage risk insufficient, unclear and adhoc. The inspectors were told by the person in charge she had the responsibility for maintaining and completing the risk register. The risk register, as outlined in Outcome 7 was vague, not centre specific and failed to highlight all hazards within the centre. There was no multidisciplinary approach to completing and managing the risk register. The centre had a day service trainer employed who also had the added responsibility of fulfilling the health and safety officer role within the designated centre. Upon speaking with this employee it was evident their role was also ill-defined and unclear. This employee was also not given protected time to carry out the duties. The inspectors requested a job specification for this employee however, they were not furnished with same.

The systems to manage maintenance required improvement. The maintenance team, consisting of two persons, carried out maintenance work on the properties. There was no system in place to outline the checks and balances relating to maintaining and servicing equipment.

As outlined in Outcome 7, the centre did not adhere to their risk management policy. The inspectors saw, outlined in their policy, that the person in charge along with the provider nominee should hold a review meeting post a serious incident, identify the learning and record same. The centre had two recent significant incidents. There was no documentary evidence that a formal meeting had taken place between the person in charge and the provider nominee. It was also evident that no learning regarding these

two incidents had taken place. For example, the hazards relating to both incidents were not highlighted on the risk register and no guidelines had been developed i.e. there were no guidelines developed relating to the safe management of stoves in the units.

There was no formal system in place to supervise staff on a daily basis. There were two team leaders, both persons participating in management, who had responsibility for a number of units each in the designated centre. In addition, they had obligations to another designated centre. The inspectors reviewed a daily checklist which team leaders used to supervise the unit. On speaking with the team leaders it was evident that the items were not checked daily and it depended on 'how the day went'. The inspectors found the checklist was not robust and failed to identify significant supervisory areas such as following up on personal plans. Staff, as outlined in Outcome 17, were also found to be inappropriately supervised. Medication errors, incomplete care plans and documentation errors in care plans were not followed up with individual staff members from a supervisory perspective. The inspectors saw a memo sent to staff regarding a medication error however this was found to be unsatisfactory.

Information governance required significant improvement. The inspectors found that the person in charge had access to a computer. However, the team leaders or staff had no access to a computer for administration purposes. The team leaders told the inspectors that personal plans were sent to head office for typing. The inspectors found that writing at times, within personal plans, was illegible and posed a risk if read incorrectly. This had been identified on a previous inspection. As confirmed, by the persons participating in management, the lack of information technology equipment posed a difficulty in the day to day managing and updating of personal plans. The inspectors were not assured that posting or faxing documentation to head office regarding resident's specific and personal needs was appropriate. The inspectors also found that the centres policies did not have an implementation or review date identified on each policy. It was therefore unclear to the inspectors if the polices were up-to-date. The inspectors were aware this information was held at head office by the registered provider however this was unsatisfactory. The inspectors were told an architect and fire consultant had visited the centre and as a result had three reports. All three reports were not available for the inspectors to retrieve at the designated centre. The person in charge retrieved one report, on the day of inspection, however two reports remained outstanding.

As with the previous inspections, the centre continued to not have an audit schedule and staff did not receive formal supervision or performance management. Over the three inspections, completed by the Authority over a period of 6 months, the designated centre had a total of 84 actions. For this inspection there are 27 breaches in the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with Disabilities) Regulation 2013. Twenty four of these actions are the responsibility of the provider and three are the responsibility of the person in charge.

Given the cumulative findings, inspectors concluded the current management and governance arrangements did not ensure the safe delivery of service.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors found that improvements were required regarding the workforce as there was insufficient provision of suitable qualified staff to meet the needs of the residents.

Inspectors were not assured the contingency plans for staff were robust as outlined in Outcome 1. Inspectors were not assured, as outlined in Outcome 5 and 11, that the skill mix of staff was appropriate to meet the needs of residents. From a review of recent incidents the inspectors found that staff did not have the appropriate clinical knowledge or understanding to complete assessments. For example, neurological observations post head injury and/or the knowledge and understanding to make a judgment as to when residents should be referred for medical treatment.

The inspectors, through conversations with staff and persons participating in management, learned that although staff received manual handling training this did not include the moving of patients; considering the nature of human services this was found to be wholly inadequate. The inspectors also learned that only 16 staff, out of approximately 50 staff, received training, in the recently revised personal planning process. From a review of personal plans it was evident that all care staff, regardless of their employment status, required training on personal planning. This required an immediate review to ensure that all staff received appropriate training to safely and effectively support residents and to ensure the correct skill mix was employed.

Improvements were required regarding the supervision of staff. From a review of the progress notes for a resident, the inspectors found the notes were not reflective of their progress. This had not been identified by supervisors. In addition, newly completed personal plans were insufficiently detailed and did not adequately described resident's needs. For example, the communication plan reviewed for one resident was minimal in content and not wholly reflective of their communication style. As detailed in Outcome 5, staff failed to administer pain medication to a resident on multiple occasions. The staff members were not formally spoken with; a memo was sent to the staff team.

As outlined in Outcome 14, a structured management system was required to ensure staff were effectively supervised and their performance managed. In addition, a robust audit schedule for persons participating in management to review progress and

developments within the designated centre was also required. In light of the continued non compliances and breaches in Regulations across the designated centre, there was a requirement to review the current governance and management arrangements.

The inspectors reviewed the roster, as with the previous inspection, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night. The centre also had waking night staff this was also not clearly denoted on the roster.

Judgment:
Non Compliant - Major

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

Findings:
Although the inspectors saw some improvements had occurred regarding documentation within personal plans, further significant improvements were required to ensure compliance with the Regulations.

The inspectors found:
- Records for residents were not kept up to date or accurate.
- All care provided to the resident, including a record of the resident's condition and any treatment or other intervention, were suitably documented in the progress notes reviewed.
- Documentation was not maintained in the resident's plans such as follow up information post appointments.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Irish Society for Autism
Centre ID:	OSV-0003427
Date of Inspection:	10 January 2015
Date of response:	6 March 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The availability of staffing levels dictated the routine of residents. For example a staff member was unable to attend for duty and two residents had to spend six hours in another unit.

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

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
The team leaders will maintain the appropriate staffing levels to ensure that planned activities can occur in line with the resident's choices. The Person in Charge has sent a memo to the Team leads to this effect and has spoken to the team leads to this effect. 6th March 2015.

The Person in Charge will monitor the rosters on regular basis. An external review has been commissioned of staffing requirements and this will be completed by 30th March 2015. Residents will not spend time in another unit due to staffing difficulties from this point on. The Person in Charge and the team leads will monitor this on a continuous basis.

Proposed Timescale: 30/03/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As found on the initial day of inspection that residents access to recreational activities were minimal. For example, as seen documented in the care plan for one resident they had on average one outing per month.

2. Action Required:
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
A memo has been distributed to staff with immediate effect regarding completion of documentation to record all activities - 17th February 2015 by Person in Charge. Participation in activities will be reviewed at the 6 weekly activities planning meeting. The Person in Charge will monitor this to ensure that residents have access to a range of activities in line with their needs and preferences.

Proposed Timescale: 17/02/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' were not always afforded the opportunity to be involved in activities of their preference.

Residents' activities were predominantly group based therefore not taking into account resident's interests.

3. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
A recreation/activity meeting will take place every six weeks to discuss resident's activities in accordance with their interests, capacities, developmental needs and individual plans. These will be conducted by activities co-ordinators and attended by the resident where appropriate, the relevant staff and overseen by the Person in Charge. The individual care planning process will identify resident's preferences, needs and interests with regard to activities including one to one activities. The Person in Charge will continuously monitor this. The first meeting will take place by 21st March 2015.

Proposed Timescale: 21/03/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors found that the arrangements to meet the needs of residents were insufficient:
- Care plans were not comprehensive or appropriately detailed.
- The staffing arrangements in place to meet the needs of residents required review.

4. 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:
The new template of the care plans will be comprehensive and meet the needs of the residents. A review of care plans was completed on the week commencing 2nd March 2015. Gaps have been identified and are currently being rectified.

An external consultant is currently reviewing the needs of the residents in line with staffing arrangements, this report will be provided to the provider nominee and Person in Charge, who will then put in place arrangements for each resident. This report will be available from 30th March 2015.

Proposed Timescale: 30/03/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear to what extent the stoves were serviced previous and post fire.

5. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
All solid fuel stoves will be serviced on an annual basis by an external engineer. Stoves are cleaned on a regular basis and were last cleaned on 26th November 2014.
The solid fuel stoves were serviced in January 2015.

Proposed Timescale: 12/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises were found to be cold.

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

Please state the actions you have taken or are planning to take:
The heating has been adjusted. 28th January 2015. A memo was circulated to staff by the Person in Charge on the 4th March 2015 with regard to heating. A management team member will monitor this on a daily basis.

Proposed Timescale: 04/03/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy was unclear as to the procedure to follow in the identification of hazards and assessment of risk.

7. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on the procedure to follow on the identification of hazards and assessment of risk. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is insufficient detail in the risk management policy as to the implementation of measures and actions to control the risks identified.

8. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on measure and actions to control risk. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is insufficient detail in the risk management policy as to the measures and actions in place to control the risk of an unexpected absence of any resident.

9. Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on unexplained absence. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is insufficient detail in the risk management policy as to the measures and actions in place to control the risk of an accidental injury to residents, visitors and staff.

10. Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on accidental injury to resident, visitors and staff. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is insufficient detail in the risk management policy as to the measures and actions in place to control the risk of aggression and violence.

11. Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on aggression and violence. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is insufficient detail in the risk management policy as to the measures and actions in place to control the risk of self harm

12. Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to incorporate further detail on self harm. This will be conducted by the provider nominee in conjunction with the Person in Charge.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although the centre's risk management policy outlines the arrangements for learning from past events, this was not reflected in practice at the centre.

13. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The risk management policy will be amended to further include Regulation 26 (1) (d). This will be conducted by the provider nominee in conjunction with the Person in Charge. 15th May 2015.

The provider nominee met with the Person in Charge immediately to record and learn from recent past events. Completed 12th February 2015.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system for the assessment, management and on-going review of risk at the centre was ineffective. For example, all risks were not outlined in the risk register. It was unclear who was responsible for the management of risk at the centre on a day to day basis.

14. 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 risk management team has been developed to oversee the assessment, management and review of risk. Meetings will be recorded on quarterly basis. The Risk management team will consist of the Person in Charge, the Health and Safety Officer and an identified co-worker who has received Risk Management Training. The Person in Charge will monitor this. This team will commence on the 31st March 2015.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not assured that clear infection control procedures such as hand hygiene were being adhered to at the time of the outbreak.

15. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
All staff are trained in hand washing and increased levels of staff supervision will be provided by the Person in Charge and Team Leads in the event of an outbreak to ensure staff compliance with training with immediate effect.

Proposed Timescale: 11/02/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were multiple examples of fire doors which were not maintained to a satisfactory standard in order to fulfil their functional requirement to prevent the spread of fire and smoke throughout the building.

16. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
An audit of fire doors was carried out 26th January 2015. A specialist contractor was engaged to carry out any remedial works which were completed on 26th January 2015.

Proposed Timescale: 26/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The current arrangements in place for giving warning of fires potentially introduces an unnecessary delay in the raising of the alarm in the event of discovery of fire by a staff member or indeed anyone without a key on their person to operate the nearest manual call point.

17. Action Required:
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
The key activated alarms were replaced with break glass units on 19th and 20th February 2015.

Proposed Timescale: 20/02/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not in all instances provided with timely and appropriate health-care. For example a resident, as a result of self injurious behaviour, acquired trauma to their forehead. However, a review with a general practitioner was not sought.

18. 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:
The resident visited the GP and there is now regular programme of checkups in place. Where residents require health care this will be provided in accordance with the assessed needs and personal plan under Regulation 06 (1).

Proposed Timescale: 11/02/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As seen in the personal plan for a resident who was receiving post operative care, there were no guidelines completed on supporting their physical and emotional wellbeing.

19. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
Guidelines have been completed on supporting the resident's physical and emotional well being. This includes, discharge letter, guidelines for care from GP, information on assistive equipment, care plan from physiotherapist, blood test results, care plan for intimate care and also a guideline concerning his daily routine, the care of stitches, use of the toilet and use of slider cushion. There are also various GP visits documented. This was completed on 6th February 2015. This will be completed for residents at times of illness in accordance with Regulation 06 (3) and will be overseen by the Person in Charge.

Proposed Timescale: 06/02/2015

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:
Based on the cumulative findings the inspectors were not assured the person in charge could have complete oversight and responsibility for three designated centres.

20. 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:
A new management structure will be put in place to ensure that effective governance operation management and administration of the designated centre can be carried out. 8th May 2015.

An additional Person in Charge will be appointed for one of the designated centres to reduce the responsibilities of the current Person in Charge. The post was advertised in local media on 20th January 2015 and 10th February 2015 and again on 10th March 2015. A new post of Senior Manager Compliance and Quality has been approved and a recruitment process has begun immediately. Three large specialist recruitment agencies have been contacted to source the new Senior Manager Compliance and Quality post with immediate effect.

Proposed Timescale: 31/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure did not effectively identify lines of authority and accountability, specify roles or detail responsibilities for all areas of service provision. For example, significant improvements were required regarding the oversight of risk management, supervision of staff and maintenance of property and equipment.

21. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The management structure is being reviewed by the Executive Director, Deputy Executive and where necessary the Person in Charge in line with the regulations to provide clearer lines of authority and accountability to re-define roles and to give detailed responsibilities. 8th May 2015.

This will include a programme of formal recorded individual staff and management supervision meetings.

Proposed Timescale: 08/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective management systems were not in place to oversee the day to day running of the centre including but not limited to; health and safety, maintenance of premises and equipment or to oversee staff performance and development. The Management system in place did not ensure that residents' needs were appropriately met, consistent and effectively monitored.

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

Please state the actions you have taken or are planning to take:
The management system will be reviewed by the Executive Director, the Deputy Executive Director and the Person in Charge where appropriate and re-designed to ensure that the service provided is safe, appropriate to residents needs, consistent and effectively monitored.

Proposed Timescale: 08/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Significant improvements were required to ensure staff were being effectively supervised and their personal and professional responsibility for the quality and safety of services was overseen.

23. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
A schedule of formal management and support meetings has been developed and roll out of same will commence on week commencing 9th March 2015.

All staff will have completed one of these by 1st June 2015 in accordance with the previous plan. Informal arrangements are also in place including staff meetings, one to ones between management and other staff, one to ones between management and senior management.

Proposed Timescale: 01/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of staff skills, as outlined in the body of the report, was required to ensure they were appropriate in meeting the needs of residents.

A review of supervisory staff compliment was required to ensure there were sufficient supervisory staff on duty to oversee the service.

24. 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:
An external consultant is currently reviewing the needs of the residents in line with staffing arrangements and will include review of supervisory staff compliment. This report will be provided to the provider nominee and Person in Charge by the 30th March 2015.

Proposed Timescale: 30/03/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further maintenance of the roster was required to ensure that it reflected all shifts in the centre.

25. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
Copies of planned and actual staff rota will be maintained by the Person in Charge with immediate effect. 6th March 2015.

Proposed Timescale: 06/03/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As outlined in the body of the report, there was a significant amount of evidence to demonstrate that increased staffing supervision was required for example;
- Documentation was incomplete and inaccurate such as progress notes, assessments, communication plans and care plans.
- Significant medication errors were made in the absence of any follow up with the staff.

26. 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:
A schedule of formal management and support meetings has been developed and roll out of same will commence on week commencing 9th March 2015.

All staff will have completed one of these by 1st June 2015 in accordance with the previous plan. Informal arrangements are also in place including staff meetings, one to ones between management and other staff, one to ones between management and senior management.

A memo was circulated to all staff on the 9th Feb 2015 by the Provider with regard to medication management errors.

The Person in Charge and the Provider discussed medication errors in details on 12th February 2015. A medication management refresher training programme has been set for 13th March 2015. The Person in Charge will continue to review all medication errors and take corrective action where necessary. A formal audit of medication will take place by 30th March 2015 and a corrective action put in place. Management staff will monitor practice and supervise staff on a daily basis.

Proposed Timescale: 01/06/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All records as outlined in Schedule 3 were not maintained for each resident.

27. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
A review of care plans was completed on the week commencing 2nd march 2015. Gaps have been identified and are currently being rectified. 10th April 2015 and ongoing.

Proposed Timescale: 10/04/2015