**Health Information and Quality Authority Regulation Directorate**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Hazelville Retirement Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001820</td>
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<td>Centre county:</td>
<td>Limerick</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>St Joseph's Foundation</td>
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<tr>
<td>Provider Nominee:</td>
<td>Catherine O'Connell</td>
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<tr>
<td>Lead inspector:</td>
<td>Carol Maricle</td>
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<tr>
<td>Support inspector(s):</td>
<td>Conor Dennehy; Cora McCarthy</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>10</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 24 May 2017 10:45  
To: 24 May 2017 18:15  
From: 25 May 2017 09:00  
To: 25 May 2017 18:40

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

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Summary of findings from this inspection
Background to the inspection:
The purpose of this inspection was to inform a decision in relation to the renewal of this centre's registration.

How we gathered our evidence:
As part of this inspection, the inspectors met with 10 residents who lived at the centre, a number of staff, including care assistants, nurses and the person in charge; reviewed a sample of files and a range of other documentation such as medicines management records and incident and accident logs. Three questionnaires
completed by representatives of the resident and one questionnaire completed by a resident were reviewed. The inspectors also met in person with two family members who gave their feedback on their level of satisfaction with the service provided to their family member.

The residents with whom the inspectors met with were mostly unable to tell the inspectors of the extent of their experience of care but they presented as content and some enjoyed showing the inspectors their items of interest and their bedrooms. The inspectors observed a positive rapport between staff and the residents. The hallways of the centre had displays of recent photographs of the residents on various outings and participating in activities.

Description of the service:
The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. The inspector found that the service matched what was described in that document. There were 10 residents in receipt of services at the time of the inspection and the capacity of the centre was 10. The centre was described as a residential service to both female and male residents who may require a retirement or a pre-retirement type service. Services were described as providing care to residents who have a diagnosis of intellectual disability with additional health needs (physical and or mental), the management of which requires fulltime support and care. The residents were further described as unable to attend external day services due to their additional needs. During this inspection, the staff presented as busy but were observed attending to the needs of the residents in a warm and respectful manner.

The centre was located in a detached building on the outskirts of a village. The centre comprised ten residents' bedrooms, two staff offices, a kitchen, a dining area, two sitting rooms, a prayer room and a number of shared bathrooms and en-suites. Parking facilities were available to the front of the house to which the residents generally did not access. Residents could access an enclosed outdoor space to the rear of the house and had access to local villages as transportation was provided. During this inspection, there were plans for renovations to commence in one of the bedrooms to allow for a more timely egress to the outside in the event of an evacuation.

Overall judgment of our findings:
Overall, compliances were identified across a number of outcomes. Staff and residents knew who was in charge and were familiar with the person in charge. The residents had personal planning systems in place and their healthcare needs were being met. The centre was clean and a pleasant space to live in. The inspectors met with a number of family representatives who were very positive about the care that the residents received, their experience of visiting the centre and their interactions with the staff team and the person in charge.

However, significant improvement was required to ensure adequate oversight of actions that had been identified in the provider's annual review of the centre. Other non compliances related to the need to evidence how residents' goals were being achieved, assessment of residents' personal development needs, submission of
notifications in line with the regulations and the review of the resident's personal plan was not multidisciplinary.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end of the report.
Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over their life in accordance with their preferences and to maximise their 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:
There were systems in place to ensure that the rights of residents were promoted. Residents were involved in the running of the centre, had access to persons who advocated for them and they were aware of how to make a complaint.

Residents were consulted about the running of the centre. Each week a staff member organised a meeting with residents and during these meetings residents discussed issues such as menu options and outings. Minutes were kept of these meetings. The person in charge also showed an inspector records of 'open clinics' for family members and 'coffee evenings' for residents and their family that she organised each year. The open clinic was organised to offer families the opportunity to ask any questions that they had. The coffee evenings were for both the resident and their family members and this was more of a social evening where again, any views or feedback from the residents and their family members were listened to. The provider also issued family representatives feedback questionnaires annually; a sample of which were viewed by an inspector and the feedback was found to be overall positive about the service.

There was a complaints system in place. There was a designated complaints officer and his name, contact details and photograph was displayed around the centre. There was an organisational policy on complaints and how to make a complaint and a service user friendly version of the complaint policy. The inspectors reviewed the complaints log book. There had been a number of complaints made in the 12 months prior to the inspection and these complaints were processed informally by the person in charge. The log book stated the nature of the complaint and whether or not the complaint remained open. The record written did not always explicitly state whether or not the complainant
was always satisfied following the outcome of the complaint although the record suggested that satisfaction was achieved. The person in charge agreed to write going forward a specific note on the record stating the satisfaction level of the complainant following the outcome.

All residents had family members that acted as their advocates. Each resident was also assigned a staff member who acted as their advocate. The inspector read questionnaires returned to the Health Information and Quality Authority (HIQA) by family members and these confirmed that family members knew who to contact if they had any concerns about their family member.

Each resident had their own bedroom and there was sufficient space for them to receive visitors, both in their own bedroom and in the communal rooms available to them.

Each resident had their own money management system and the inspector reviewed a sample of the arrangements. There were arrangements in place whereby a sum of money was withdrawn from the residents’ bank account periodically rather than on a day-to-day basis. The person in charge described how she received copies of bank statements and could see the withdrawals made by staff members. Balances were checked twice a day by two staff. Residents had running balances and the records clearly showed lodgements and withdrawals from their balance. Should a resident receive money from relatives or friends then this was appropriately recorded as a lodgement. When staff members assisted residents to spend their money or made purchases on their behalf, receipts were maintained and these corresponded to the details kept in the ledger books. There was evidence that residents had money management support plans developed for them. Staff maintained an inventory of possessions for residents which was added to when the need arose.

A representative of the provider completed a financial audit of the money arrangements at the centre in 2016 and 2017 and no adverse findings were found.

There was evidence of residents being supported by staff to attend activities in the community. Some of the residents were described by staff as choosing to not engage with the community on a regular basis. This was evidenced in the documents viewed by the inspectors. Staff and family members told the inspectors that they respected the wishes and decisions of the residents in this regard.

**Judgment:**
Compliant

**Outcome 02: Communication**

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

**Theme:**
Individualised Supports and Care
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were systems in place to promote the communication abilities of each resident.

All residents had varying levels of abilities in the area of speech and language. The inspectors viewed a sample of residents' files and the records kept clearly demonstrated that the needs of each resident in this area were assessed as part of the assessment of need and set out in the personal planning arrangements. Each resident whose file an inspector viewed had a communication profile. There was evidence that residents had access to speech and language therapists who in turn issued reports with recommendations for staff to follow. These reports were all filed in the residents’ personal file and they cross-referenced with the communication profile.

There were visual displays around the centre giving information to residents on areas such as making a complaint and fire evacuation. Improvements were required to ensure that communication aids were available to support residents with dietary needs and this is addressed under outcome 11.

The residents had access to radio, television and information about activities in the community.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
There were systems in place to ensure that all residents were supported to maintain family and personal relationships and links with the community.

Each resident had a personal plan in place and the information in this plan contained clearly the details of the circle of family and friends around each resident. The statement of purpose set out the arrangements for visitors and the resident guide also confirmed these arrangements. The organisation maintained a policy on visitors.
The person in charge had a very good understanding of each resident and their family members and could describe to the inspector the level of contact each resident had with their family. Family members confirmed to inspectors that they were made to feel welcome when they visited the centre and they spoke of the nice atmosphere at the centre. They also confirmed that they were kept up to date on any pertinent issues. The inspectors observed a number of residents receiving visits from family members during the inspection. There was evidence viewed by inspectors that showed how information received from the family members was taken note of, such as their own availability and travel plans.

Residents were supported to be involved in their local community. Inspectors observed residents being asked if they would like to leave their home and depart for an activity in the community. The views of the residents were respected in this regard. There were pictures displayed in the centre of the residents enjoying day trips further afield.

**Judgment:**
Compliant

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

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

**Theme:**
Effective Services

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

**Findings:**
There were suitable systems in place regarding admission and contracts of service.

The provider maintained a policy on admissions and discharges from the service. There had been an admission of a resident to the centre in the 12 months prior to the inspection. An inspector reviewed the admission process involved and found that the resident was supported appropriately in their move to the centre.

Some family members gave feedback in HIQA questionnaires stating that their family member was supported by staff when they first moved to the centre.

The inspectors sampled a number of resident’s files and these were found to have their contacts of care in place. The contracts all contained reference to the fees that each resident incurred. They also contained reference to costs associated with outings and holidays and other information such as arrangements for visitors, medicines and sickness, complaint process and other services provided.
Judgment: Compliant

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

Theme: Effective Services

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

Findings:
The wellbeing and welfare of residents was promoted by the personal planning system in place. Improvements were required to the tracking of residents' goals. In addition, the review of the residents' personal plan was not multidisciplinary.

There was a suite of policies, procedures and processes in place to promote the wellbeing and welfare needs of each resident in line with the regulations. The provider had put in place documentation that prompted staff to record an assessment of the needs of each resident, the outcome of this needs assessment and the support plans put in place to address needs identified. Each resident also had their own file entitled 'my life, my story, my plan'. This contained photographs and information on the resident such as their communication profile.

There was a key worker system in place and these staff members had responsibilities for the maintenance of the residents' files. There was evidence of the person in charge maintaining oversight of records contained within these files.

Each resident had an assessment of their needs completed by a nursing staff member which was then reviewed by the person in charge. The assessment considered a range of healthcare and social needs such as education, mental health, mobility, personal and intimate care and communication. The assessment was informed by reports and assessments conducted by the relevant health care professional such as a speech and language therapist and occupational therapist. Although the assessment of need was informed mostly by the reports of healthcare professionals, the inspector identified that the information contained in the section entitled 'education' was not sufficient and this has been further commented upon in Outcome 10.

There were appropriate systems in place for personal planning, however, some
improvements were required. Each resident had a personal plan which was reviewed annually by the key worker and this plan also was signed off by the resident and or their family member. The review of the personal plan was informed by a team of multidisciplinary professionals as the resident had engaged with these professionals throughout the year and records of their appointments were kept. However, the review of the personal plan was not multidisciplinary, as required by the regulations. The person representing the provider told the inspectors at the close of the inspection that the need for personal plans to be conducted in a multidisciplinary manner was an improvement area that the organisation was looking at across the entire service.

The individual goals for each resident were outlined and there was consideration given to the tasks that were required to take place in order to achieve these goals. However, despite these arrangements, the evidence presented in the files did not show sufficient progression against these goals over the course of the 12 months from when the goals were first set.

At the time of this inspection, there was no resident who was due to be discharged from the centre. Where required, consideration had been made to the choices of the residents as they approached their end of life.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The premises provided a homely environment for residents that was suited to meet their needs.

The designated centre was a purpose built one storey building, located on the outskirts of a village and provided a home to ten residents. Parking facilities were available at the front of the building while to the rear there was a courtyard area with facilities provided for residents to sit outside. A small garden area was also available to the rear of the building.

Each resident had their own bedroom within the designated centre. Some residents
showed inspectors their bedrooms which were well furnished, brightly coloured and personalised with photographs and posters. The bedrooms seen by inspectors were noted to have sufficient facilities available for residents to store their belongings such as wardrobes and presses.

Also present in the centre was a sitting room, visitors’ room, a prayer room, a kitchen, a dining area, utility room, two staff offices, two bathrooms and laundry room. The designated centre was presented in a homely manner and photographs of residents were on display throughout the centre.

The designated centre was presented in a clean manner and was in a good state of repair during the course of the inspection. Hoists within the centre were noted to have been serviced at the required intervals.

**Judgment:**
Compliant

### Outcome 07: Health and Safety and Risk Management

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

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

**Findings:**
While the health and safety of residents was promoted within the designated centre, an external fire safety review had highlighted some areas for improvement and the need to carry out some remedial works. In addition, risk assessments were required in relation to use of a restrictive practice in the centre.

A fire alarm system, emergency lighting, fire doors and fire fighting equipment, including fire extinguishers, were present in the centre. Inspectors saw certificates of maintenance which had been carried out at the required intervals by external bodies for the fire alarm, emergency lighting and the fire extinguishers. In addition, records of daily and weekly internal staff checks were also seen by inspectors.

Fire drills were carried out at regular intervals and appropriately recorded. The provider had also taken proactive steps to ensure the safety of residents with regard to fire safety. For example, a night time fire drill had been simulated during 2017 and the local fire brigade had visited the centre, by invitation, to become familiar with the nature of the designated centre. All residents had personal evacuation plans in place which were noted to have been reviewed the day before inspection.

However, a fire safety review had been carried out by an external competent person in
the month before inspection. While this review did note areas of good practice, it also made recommendations in a number of areas. For example, the report highlighted that cabling of the fire alarm required improvement, the coverage of emergency lighting required improvement, there a lack of fire stopping in certain areas of the building, some fire doors required replacement due to old age while the partition between two residents bedrooms also require review. The review recommended that these issues be resolved immediately and a representative of the provider confirmed following completion of the inspection that external contractors had been commissioned to address the issues identified in this fire safety review.

Training records for staff working in the centre were reviewed and it was noted that while the majority of staff had undergone fire safety training within the previous 12 months, two members of staff had not. The training records also indicated that these two staff members were due to complete this training the week following this inspection. Staff members spoken to were aware of the steps to be taken should an evacuation of the centre be required. However, the external fire safety review had noted that, at the time of that review, a number of fire doors within the centre were held open and had recommended that fire safety training should include more on the correct use of fire doors and the potential consequences of interfering with them.

A safety statement and risk management policy were in place in the designated centre along with a risk register; which was reviewed by inspectors. The risk register contained risks covering the centre as a whole along with risks relating to individual residents. All risk assessments where observed to have been recently reviewed. It also noted that accidents and incidents occurring in the centre resulted in a risk assessment being generated with control measures put in place as required.

However, during the course of the inspection, it was noted that there was a half door in use in the kitchen and this prevented residents from accessing all of the kitchen and its cooking facilities. The inspectors were told that this was in use for health and safety reasons and to keep residents safe while food was being prepared. On review of the centre’s risk register and from discussion with staff it was noted that a risk assessment had not been completed relating to the use of this gate.

There was one vehicle assigned to the designated centre. Inspectors saw service records for this vehicle and confirmation that the vehicle has passed a recent roadworthy test.

Personal protective equipment such as gloves and aprons along with hand gels were also available throughout the designated centre.

Judgment:
Non Compliant - Moderate

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

**Theme:**
Safe Services

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

**Findings:**
Overall, it was not demonstrated that restrictive practices were in line with national guidance. Also, improvement was required to ensure safeguarding procedures were fully adhered to in terms of reporting timelines. Finally, improvements were required to a behavioural support plan viewed.

Inspectors were informed that the restrictive practices policy was currently being reviewed and a restrictive practices committee was in place. However, inspectors found no evidence of a care plan to support individual resident's positional changes or mat-time for residents who were non-ambulant. This had also been highlighted in the annual review and the associated action plan for the service in 2016.

The previous inspection had found that risk assessments for the use of bed rails had not been carried out in line with national policy and evidenced based best practice. At this inspection it was found that these risk assessments had taken place and inspectors were provided with copies with these. However, as previously mentioned under Outcome 7, there was a half door in use in the kitchen and this prevented residents from accessing all of the kitchen and its cooking facilities. There was insufficient documentation in place to demonstrate that the restriction was used as a last resort, for the shortest duration of time and that all other methods had been exhausted before this restriction was in place.

Plans were in place to respond to the behaviours of residents while in the centre. However, on review of a resident’s personal plan, it was noted that their support plan did not wholly correspond with a plan written by a psychologist. In addition, it was not clear on both plans the pro-active strategy measures to be used coupled with the reactive strategies. Finally, the plan did not provide sufficient guidance in relation to the use of chemical restraint.

The safeguarding procedures within the designated centre were reviewed and it was noted that that appropriate actions had been taken in response to any safeguarding issues which arose. However, it noted for two issues, that the timeframes required by national policy to carry out preliminary investigations had not been adhered to. In addition, as will be discussed under Outcome 9, one incident of a safeguarding nature had not been notified to HIQA in the timelines set out in the regulations; this was forwarded to HIQA following the inspection.

Inspectors reviewed training records and noted that all staff members had undergone
training in relation to safeguarding. Staff members spoken to were aware of the steps to be taken in the event that they became aware that a resident was at risk of abuse. While reviewing training records it was noted that some staff members were overdue refresher training in de-escalation. This is addressed under Outcome 17.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Not all notifiable events had been submitted as required to HIQA.

While reviewing a record of accidents and incidents in the centre, inspectors saw a record of one abusive incident. While this incident had been reviewed by the provider in line with their own processes, at the time of this inspection this incident had not been notified to HIQA as required. This was raised with the representative of the provider who submitted the required notification following the completion of the inspection.

In addition, during the course of inspection some forms of restraint, such as the use of a gate in the food preparation area, had not been notified to HIQA at quarterly intervals as required.

The provider sought and received clarification on the notification of chemical restrictive practices to HIQA and confirmed to the inspectors that going forward all 'as required' medicines administered as a chemical restraint (not including those prescribed for the management of anxiety, depression or psychosis) would be notified going forward.

**Judgment:**
Non Compliant - Moderate

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**Outcome 10. General Welfare and Development**

*Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*
**Theme:**
Health and Development

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

**Findings:**
Significant improvement was required in order to ensure that an appropriate assessment of each resident's abilities in relation education, training and employment was completed.

During this inspection, the residents were observed to be comfortable and content and some were observed being brought to appointments and for social drives. None of the residents were found to participate in education, training or employment. The person in charge explained to the inspectors that the residents were retired from training and employment on account of their age and for other reasons such as their healthcare. This was set out in the revised statement of purpose submitted to HIQA following the inspection.

There was evidence of in-house activities completed with the residents such as occasional baking. There was also evidence that residents were spoken with occasionally about topics of interest to them and an in-house certificate was created for them and placed in an easy to read personal plan.

The personal planning system in place at the centre prompted the staff member to complete a section on education for each resident. The inspectors viewed a sample of these records. The information provided was not sufficient and did not address the resident's full capabilities in this area, as evidenced by a relevant professional. The section did not adequately set out the information pertaining to the retirement or early retirement of each resident and how their health or age prevented them from accessing employment, training or education.

**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):**
No actions were required from the previous inspection.
Findings:
The inspector found that residents’ overall healthcare needs were met and they had access to appropriate medical and allied healthcare services. However, residents did not have access to the mobility equipment that they required and not all information relating to special diets was readily accessible to residents.

Residents’ healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical practitioner was available to each resident and an "out of hours" service was available if required. Access to a medical practitioner was facilitated regularly. There was evidence that where treatment was recommended and agreed by residents, this treatment was facilitated.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, access to allied healthcare professionals was facilitated including psychiatry, psychology, audiology, dental, dietetics, optical and chiropody.

Each resident's personal plan included specific support plans to guide staff in supporting residents to manage individual healthcare needs. Healthcare assessments were in place. Staff with whom inspectors spoke were knowledgeable in relation to each resident’s healthcare needs. Some residents experienced seizures and there was evidence of risk assessments in place for seizure activity. Falls prevention care plans were in place for residents, where required, residents were individually risk assessed for same.

Residents had received access to occupational therapy where required. However, where a new wheelchair had been recommended for a resident in May 2016, it had not been provided by the time of inspection. While this was progressed with the occupational therapist at the time of the inspection, it indicated a lack of follow through of required actions by the person in charge. This will be addressed under outcome 14.

An inspector reviewed the support provided to residents who received nutrition and hydration via percutaneous endoscopic gastrostomy (PEG). The support was broadly in line with a regulatory notice issued to all providers by HIQA in relation to this matter. The person in charge was familiar with the regulatory notice. PEGs were managed by nursing staff in the centre who demonstrated their experience in relation to all aspects of PEGs. The PEG regime was written up by a dietician and reviewed as and when required. Nursing staff clearly articulated the information in the PEG regime. At the time of the inspection, inspectors noted that there was no observation sheet in place to guide staff and no risk assessment with regard to the use of PEG; this was introduced by the person in charge by the close of the inspection.

Healthy living choices were promoted. Fresh food was made daily. Residents had access to a dietician, in line with their needs. A process was in place to make referrals to a speech and language therapist, when appropriate for assessments to support the resident in their dietary intake and drinking. The inspectors were satisfied that residents' nutritional needs were well-monitored. Residents who required specialised diets were catered for. Advice was sought from the dietician and speech and language therapist as required and residents were weighed regularly. Daily records of all residents' fluid and food intake were maintained.
 Meals were prepared for the resident by an in-house caterer. The meals served each day offered choice and a visual was prepared of the choices available to residents on a standard diet. However, where residents required a specialised diet, visuals around choice options and information were not evident in the kitchen and dining area.

The meals prepared on the day appeared nutritious and appetising and were home-cooked meals. A resident was observed being offered an alternative choice to the two meals already cooked. Staff members kept a record of fluid and nutritional intake. During interview, staff had an understanding of the dietary requirements of each resident and knew that some residents required certain foods of a particular texture while other residents required food in accordance with their taste and preferences. The personal planning documentation also set out the food preferences and like and dislikes of residents.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
There were systems in place to promote the safety of the residents in the management of their medicines.

The inspector reviewed the updated medication policy which included guidance on areas such as prescribing, administration, safe keeping and disposal of medications. The nurse on duty told the inspector that there was always a nurse on duty and that only nurses administered medications. Nursing staff spoken with were knowledgeable regarding medication management policies and practices.

The inspector reviewed a sample of administration charts and noted that they contained all the information required to enable staff to safely administer medications. All medications were individually prescribed. Crushed medications were individually prescribed as such. All medications were regularly reviewed by the general practitioner (GP). There was evidence that a psychiatrist had assessed the residents' capacity to self-medicate and found that the residents lacked the capacity to self-administer.

All medications including medications requiring refrigeration were stored securely. The
Temperature of the refrigerator was monitored and recorded daily. There was one resident prescribed a medicine that required stricter controls at the time of inspection and there was a bound register in place to track the receipt, administration and count of these medicines. These medicines were stored separately.

Systems were in place for checking medications on receipt from the pharmacy and recording medications on return to the pharmacy. Systems were in place to record medication errors and staff were familiar with them.

Regular medication audits were carried out by the person in charge. The annual review of 2016 contained a comprehensive list of all medicine errors made in 2016. The person in charge showed written evidence to the inspectors of training in medicines management specifically designed for nurses; all nurses on the staff team were due to attend in 2017 following her review of medicines errors at the centre in 2016/2017. An audit of medicines took place in 2017 by an external pharmacist and the person in charge was familiar with the findings.

**Judgment:**
Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Inspectors reviewed a copy of the statement of purpose which included most of the details required by the regulations.

However, it was noted that some of the required information in the document required review. For example, the fire precautions and associated emergency procedures in the designated centre required further detail while the resident profile also required additional clarification. Following the completion of the inspection, an amended statement of purpose was provided to inspectors which addressed these issues.

**Judgment:**
Compliant
Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, while there was a clear management structure in place and a comprehensive review of the service had taken place in 2016, significant improvement was required to ensure that the gaps identified in that report had been adequately addressed.

The provider had completed a detailed annual review of the service for 2016. Inspectors identified failings during the inspection that related that had also been identified in the provider’s annual review report. As previously mentioned under Outcome 8, a care plan had not been developed for positional changes and mat time for non-ambulant residents. In addition, the action plan developed to address gaps relating to medication errors, behaviour support plans or the management of restrictive practices was inadequate as it did not contain sufficient detail to outline how the systems in place were now robust.

The annual review report also acknowledged what while a six monthly unannounced inspections had taken place in 2016, the format of same was not in line with the regulations.

There was a clear management structure in place. Care assistants reported to nurses who in turn reported to a person in charge. There was a nurse involved in the day to day management of the centre and during periods of absence of the person in charge she assumed managerial responsibilities.

The person in charge also facilitated and carried out internal audits on the centre to complement those organised by the provider. Aspects of medicines management were audited, finances were audited and aspects of health and safety were audited.

The person in charge had the required managerial experience. She was committed to her own professional development, as evidenced by her completing at the time of the inspection a masters in a relevant area to her work. Staff, residents and family knew who was in charge. She was supernumerary to the roster for a portion of her working week. At the feedback meeting of the inspection, the person in charge and person representing the provider stated that they would continuously monitor the amount of time that the person in charge had to govern the centre given that her role was not fully
supernumerary to the roster.

**Judgment:**  
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 15: Absence of the person in charge</strong></th>
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</thead>
<tbody>
<tr>
<td><em>The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.</em></td>
</tr>
</tbody>
</table>

**Theme:**  
Leadership, Governance and Management

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

**Findings:**  
The provider was aware of their responsibility to notify the chief inspector of the absence of the person in charge where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days of more, whether planned or unplanned. To date there had been no such absence requiring notification. Arrangements were in place to cover such an absence should it arise and a person involved in the management of the centre would cover this absence.

**Judgment:**  
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 16: Use of Resources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</em></td>
</tr>
</tbody>
</table>

**Theme:**  
Use of Resources

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

**Findings:**  
Inspectors were satisfied that the centre was appropriately resourced to meet the needs of residents.

With the resources available to this centre, the registered provider was able to provide the service as described in the statement of purpose to meet the needs of residents on
an ongoing basis. Resources available included the provision of sufficient staffing and a vehicle which was assigned to the designated centre.

Judgment: Compliant

### Outcome 17: Workforce

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

There was evidence of adequate staffing levels at the centre and supervision arrangements were in place. However, some staff members were overdue refresher training in relation to de-escalation and not all staff.

In preparation for this inspection the lead inspector spoke to the representative of the provider who confirmed that the provider had been unable to obtain evidence of an Garda Siochana vetting for some agency staff members who worked in the centre. Upon commencement of this inspection it was confirmed that an Garda Siochana vetting for these staff members had been received and inspectors saw evidence of this. It was also confirmed that a new process had been enacted to ensure that all agency staff working in the centre would provide proof of an Garda Siochana vetting to the person in charge before commencing in the centre.

Inspectors also reviewed a sample of staff files, including agency staff, and noted that all of the required information including evidence of an Garda Siochana vetting, two written references and photo identification were contained within these files. Inspectors were informed that there were no volunteers involved in the centre at the time of inspection.

Throughout the inspection, warm and positive interactions were observed between staff members and residents. Inspectors reviewed staff rosters and were satisfied that there were appropriate numbers of staff to meet the needs of residents. A continuity of staffing was available in the designated centre and the person in charge had access to regular relief staff if required. Nursing care was provided for within the designated centre.
The staffing arrangements within the centre had been reviewed in the months before this inspection in response to the changing needs of resident(s). This review had resulted in an increased allocation of staffing at a particular time which had resulted in positive outcomes in the centre.

Training records were reviewed. As mentioned under Outcome 7, not all staff had undergone fire safety training within the previous 12 months but these were scheduled to receive this training the week following inspection. It was also noted that some staff members were overdue refresher training in relation to de-escalation. Inspectors were informed by the person in charge that there had been issues in accessing this training, but that it was due to recommence.

Arrangements were in place for the supervision of staff members. Inspectors saw records of supervision meetings and staff member spoken to stated that they found the supervision processes to be beneficial in raising issues if required. Staff team meetings took place at regular intervals.

**Judgment:**
Substantially Compliant

### Outcome 18: Records and documentation

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**
Use of Information

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

**Findings:**
Overall, inspectors were satisfied that there was a good level of documentation was maintained within the designated centre.

Inspectors reviewed a copy of the directory of residents. While most of the required information was present it was noted that some admission dates were not the actual date of admission of the resident to the centre but were dates when the resident first engaged with the centre. To concur with regulatory requirements, the person in charge undertook to make this change immediately following the inspection.
A copy of the residents’ guide was reviewed and was found to meet the requirements of the regulations.

The policies and procedures required by the regulations had been reviewed on recent inspections of other designated centres under the auspices of this provider and so were not reviewed during this inspection.

All other documents requested by inspectors were available to view on the day of inspection.

**Judgment:**
Substantially Compliant

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**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:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Joseph's Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001820</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>24 May 2017 and 25 May 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>17 July 2017</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of the personal plan was not multidisciplinary.

1. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
• There is presently a referral system in place for accessing multidisciplinary support as required.
• Relevant multidisciplinary members will be invited to the remaining annual reviews which are already scheduled.
• A review has commenced whereby a system will be developed to ensure that annual reviews have input from multidisciplinary supports.

Proposed Timescale: 30/09/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to show that goals agreed with the residents were tracked on a regular basis to show progression.

2. 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 documented review of each individuals goals will take place every 3 months or more often if there is a change in circumstances recording the progression of the goals or any changes necessary.

Proposed Timescale: 31/10/2017

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 register required review and updating to reflect all risks, for example, the use of a half door in the kitchen and consideration of all risks associated with enteral feeding.

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

Please state the actions you have taken or are planning to take:
• The risk register will be reviewed to include the assessment and 3 monthly ongoing
review of risks associated with the half door in the kitchen and enteral feeding.

**Proposed Timescale: 30/06/2017**
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An external fire safety report made a number of recommendations including issues relating to the fire alarm cabling, emergency lighting, fire stopping, fire doors and the partition between two residents bedrooms.

4. **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:
- The fire door identified as needing replacing will be replaced with new fire door set and any door sets requiring cold smoke seals fitted will be fitted with same as recommended.
- The air vent in one of the rooms will be removed and sealed.
- The glazing and ventilation arrangements in the in the office area will be replaced with fire rated units.
- The fire rated glazing on three doors will be replaced with glazing units which are provided with the required intumescent gaskets.
- The Emergency Lighting system will be examined to ensure that adequate power can be supplied to the general lighting system in the case of emergency.
- A door closer unit will be fitted to the sluice room door.

**Proposed Timescale: 31/07/2017**
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An external fire safety review had made a recommendation that fire safety training should include measures to educate staff on the use of fire doors as a number of fire doors were held open

5. **Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
- Objectives of the fire safety training which takes place on site will be reviewed to
ensure that they are in line with Regulation 28 (4).

**Proposed Timescale:** 03/07/2017

### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

It was not demonstrated that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, was used.

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

**Please state the actions you have taken or are planning to take:**
All restrictive practices will be reviewed by a multidisciplinary team ensuring use of same as a last report following consideration of all other alternative measures.

**Proposed Timescale:** 31/07/2017

**Theme:** Safe Services

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

The procedures for responding to abusive incidents required review to comply with national policy.

**7. 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:**
• Review the procedures for responding to abuse incidents to ensure a correct response is in place to comply with national policy.

**Proposed Timescale:** 30/06/2017

### Outcome 09: Notification of Incidents

**Theme:** Safe Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At the time of the inspection an abusive incident had not been notified to HIQA.

8. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
• Incident reported to Chief Inspector on 26/05/2017.
• The person in change will ensure that any future incident will be reported as per regulatory framework.

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all forms of restrictive practices had been notified to HIQA.

9. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
• The person in change will ensure that all forms of restrictive practices will be reported at the end of each quarter as per Regulation 31 (3) (a).

Proposed Timescale: 30/07/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to demonstrate that residents were unable to access opportunities for training, education and employment as their assessment of need in this area was not sufficient.

10. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.
Please state the actions you have taken or are planning to take:
- An assessment will be completed for each individual with regard to support to access opportunities for education, training and employment with reference to their needs and wishes.

**Proposed Timescale:** 31/10/2017

### Outcome 11. Healthcare Needs
**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improvements were required to ensure that appropriate health care was provided for each resident, having regard to each resident’s personal plan. For example, where residents required a specialised diet, visuals around choice options and information were not evident in the kitchen and dining area.

11. **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:**
- Visual aids around choice options and information regarding specialised diets will be updated and made available to residents.

**Proposed Timescale:** 30/06/2017

### 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:**
While a comprehensive annual review of the quality and safety of care and support in the designated centre had been completed, the review did not clearly state the update to the action plan arising from that review.

12. **Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
- The action plan resulting from the annual review and the HIQA inspection will incorporate a 3 monthly review to be completed by the registered provider or nominee.
with the person in change.

**Proposed Timescale:** 11/07/2017  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The format of the biannual unannounced visit did not meet the requirements of the regulations.

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

**Please state the actions you have taken or are planning to take:**  
• The format of the biannual review will be reviewed and the registered provider or nominee will carry out an unannounced visit at least once every six months, prepare a written report and meet with the person in change to put a plan in place to address concerns. This plan will be reviewed 3 monthly.

**Proposed Timescale:** 30/07/2017

**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some staff members were overdue refresher training in relation to de-escalation.

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

**Please state the actions you have taken or are planning to take:**  
• 1 staff member completed training on 22/06/17.  
• Remaining outstanding staff member scheduled for training on 04/07/2017.

**Proposed Timescale:** 04/07/2017
Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Admission dates for some residents were not recorded in the directory of residents.

15. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Any residents admission dates to the residential services not currently recorded in the Directory of Residents will be documented as per Regulation 19 (3).

Proposed Timescale: 23/06/2017