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:	Kilbride House
Centre ID:	OSV-0003377
Centre county:	Laois
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Danika McCartney
Lead inspector:	Maureen Burns Rees
Support inspector(s):	Noelene Dowling
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
27 June 2017 09:30	27 June 2017 18:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was an eight outcome inspection carried out to monitor compliance with the regulations and standards and further to an application to vary conditions of registration. The previous inspection was undertaken on the 18 and 19 of March 2015 and the centre was registered in May 2015.

The provider submitted an application to vary conditions of registration. The proposed variance was to change the foot print of the centre to include a one bedroomed building located beside the centre. It was proposed that the building would be a self contained unit for one of the service users currently residing in the centre. The number of service users living in the centre was to remain unchanged. The purpose of this monitoring inspection was to assess the appropriateness of the new unit to be part of the designated centre. The inspection findings will be used to inform the registration panel's decision regarding the application to vary the conditions of registration for the centre.

How we gathered our evidence:

As part of the inspection, the inspectors met with the person in charge, regional manager, director of operations and two social care workers. The inspectors spoke with each of the six service users living in the centre. A number of whom outlined that they enjoyed living in the centre. All of the service users were in good spirits and were observed to have warm interactions with the person in charge and staff caring for them. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff supervision files. The physical premises were inspected against regulatory requirements, including the new building.

Description of the service:

The service provided was described in the providers statement of purpose. The centre provided residential care for six adults with a diagnosis of an intellectual disability

The centre was located in a large two storey house located on a spacious site in a rural setting. There was a self contained one bedroomed apartment to the rear of the building which accommodated one service user. The apartment had its own entrance, which could be accessed from the back of the building. Adjacent to the side of the building, there was a new stand alone unit, which the provider had recently submitted an application to include as part of the centre. This building contained a living room, ensuite bedroom and fully equipped kitchen come dining area.

Overall Judgement of our findings:

Overall, the inspectors found that service users were well cared for and that the provider had arrangements in place to promote their rights and safety. The inspectors were satisfied that the provider had put systems in place to ensure that the majority of regulations were being met. The person in charge had taken up the post in 2016 and demonstrated adequate knowledge and competence during the inspection. The inspectors were satisfied that she remained a fit person to participate in the management of the centre.

Good practice was identified in areas such as:
- Service user's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified (Outcome 5).
- The design and layout of the centre, including the new unit reflected the layout as described in the centres statement of purpose and was suitable to meet the needs of the service users. (Outcome 6)
- Arrangements were in place to support service users on an individual basis to achieve and enjoy the best possible health. (Outcome 11)
- There were systems in place to support staff in protecting service users in relation to medication management. (Outcome 12)

Areas for improvement were identified in areas such as:
- Some improvements were required in relation to the management of risk. (Outcome 7)
- Arrangements in place for monitoring of restrictive practices required some improvements. (Outcome 8)
- The regulatory requirements to review the quality and safety of care required improvement and the providers understanding of the registration process in terms of their application to vary was not adequate. (Outcome 14)
- There were recruitment procedures in place, which were managed centrally by the provider. However, some improvements were required to ensure that all of the information required by the regulations was attained for all staff. (Outcome 17)

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

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

Theme:
Effective Services

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

Findings:
Service user's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified.

A full assessment of service users needs was completed as part of the admission process and reviewed at regular intervals. These assessments informed personal plans put in place. There was evidence that service users and their families were involved in these assessments.

There were person centred plans for each of the service users which detailed their individual needs and choices. Personal goals, actions required to achieve same and timelines were also recorded for each of the service users. Task analysis sheets had been completed for some goals. Person centred plans had a multidisciplinary input were appropriate and service users and their family representatives were involved in the development of plans put in place. They were found to be in an accessible format.

Personal plans were formally reviewed on a minimum of a yearly basis. There was evidence that service users and their families were invited to review meetings, although on some occasions they chose not to attend.

There was a transition plan in place for the move of one of the service users into the new unit which the provider had submitted an application to HIQA to include as part of the designated centre. The service user identified to move to the unit told inspectors how he had been spoken with regarding paint colours and soft furnishings for the unit. He indicated that he was looking forward to the move.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The design and layout of the centre reflected the layout as described in the centres statement of purpose and was suitable to meet the needs of the service users.

The centre was located in a large two storey five bedroomed house located on a spacious site in a rural setting. There was a self contained one bedroomed apartment to the rear of the building which accommodated one service user. The apartment had its own entrance, which could be accessed from the back of the building. Adjacent to the side of the building, there was a new stand alone unit, which the provider had recently submitted an application to include as part of the centre. This building contained a living room, ensuite bedroom, fully equipped kitchen come dining area and a room used for the storage of records.

The centre was observed to be spacious, homely, clean and tidy. Each of the other service users had their own spacious bedrooms. There were adequate communal bathrooms and space for social activities. The kitchen was found to have sufficient cooking facilities. There were facilities in place for service users to launder their own cloths if they so wished. There were sufficient furnishings, fixtures and fittings in all rooms. There was suitable lighting and ventilation in place. The inspectors found that the centre and new proposed unit promoted service user's safety, dignity and independence. There were adequate communal bathrooms and space for social activities. The kitchen was found to have sufficient cooking facilities. There were facilities in place for potential service users to launder their own cloths if they so wished. There were sufficient furnishings, fixtures and fittings in all rooms.

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:
There were arrangements in place to promote and protect the health and safety of service users and staff. However some improvements were required in relation to the management of risk.

There was a health and safety policy and procedure, dated June 2016, which was specific to the centre. There was a safety statement, dated March 2017. Site specific risk assessments had been undertaken and appropriately recorded. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a quality team which was accessible as a resource for the centre. There was a risk management policy, dated June 2016 which met the requirements of Regulation 26. Individual risk assessments for service users had been undertaken. However, the level of detail provided in relation to controls to manage risks identified were not always adequate or appropriate. A risk register was not in place in the centre.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving service users. This meant that opportunities for learning to improve services and prevent incidents were promoted. The person in charge provided the regional manager with a weekly written report on the numbers of incidents in the centre. There was some evidence that incident trends were considered, but further work in this area was required. There was a computer based system for incident and near miss reporting which included a section to record action taken and further actions required. A procedure for completing incident forms was in place to guide staff. There was evidence that individual incidents were reviewed and discussed at staff team meetings.

There were procedures in place for the prevention and control of infection. There was an infection control policy and procedure, dated June 2016. There were cleaning schedules in place and sign off sheets. Colour coded cleaning equipment were in place and appropriately stored. The inspector observed that there were facilities for hand hygiene available. All areas were observed to be clean and in a good state of repair.

There were precautions in place against the risk of fire. There was a fire safety certificate in place from a suitable expert. A procedure for the safe evacuation of service users and staff, in the event of fire, was prominently displayed. Each of the service users had a personal emergency evacuation assessment completed and plan in place. The mobility and cognitive understanding of each of the service users was accounted for in personal evacuation plans. The inspectors found that there were adequate means of

escape in both units and that all fire exits were unobstructed. The fire assembly point was identified with appropriate signage in an area to the front of the building. A fire risk assessment had been undertaken. There was documentary evidence to show that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Fire doors with self closing hinges had been installed in the centre. All staff had received appropriate training. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals. Fire drills involving all service users were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered.

The centre had four vehicles for use to bring service users to day services and social outings.

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):
No actions were required from the previous inspection.

Findings:
There were measures in place to safeguard service users and appropriate actions had been taken in response to allegations or suspicions of abuse. However, arrangements in place for monitoring of restrictive practices required some improvements.

There was a policy and procedure on protection of vulnerable persons, dated June 2016, which was in line with the national guidance. The inspector noted that the responsibilities and contact details for the designated officer and a deputy, were detailed in the policy. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. Records showed that staff had received appropriate training. There had been a number of allegations in the previous 12 month period and these were found to have been appropriately responded to. There was a policy and procedure on service users finances, dated January 2017.

The centre had an intimate care policy in place, dated June 2016. Intimate care

assessments and plans were in place for service users identified to require same.

Arrangements were in place to provide service users with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. The centre had a policy and procedure on behaviour support, dated June 2016. Incidents of challenging behaviour were reported for a small number of the service users. Risk assessments and safeguarding plans had been put in place. Reactive strategies and anxiety plans were on file for service users who were identified to require same. Training records should that staff had received appropriate training in a recognised behaviour management approach. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques. The centre had access to the providers behaviour support team which included expertise in psychology, psychiatry and psychotherapist. There was a facility for a drop in clinic for behavioural support and the inspectors reviewed the minutes of a recent meeting where a number of the service users behaviours were discussed.

There was a policy and procedure on restrictive practices, dated June 2016. There were minimal restrictive practices in place but ones in place were approved and regularly reviewed by the providers behaviour support team. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place. However, the inspectors identified a small number of incidences where chemical restraints prescribed on an as required, or PRN basis, had been given to alter the behaviour of a service user. This had not been identified or monitored as a restraint or reported to HIQA.

Judgment:
Substantially Compliant

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:
Arrangements were in place to support service users on an individual basis to achieve and enjoy the best possible health.

Service users healthcare needs were met by the care provided. Overall service users had low healthcare needs. There was a policy on health and wellbeing, dated June 2016. Comprehensive health assessment and action plans had been completed for service users. Personal plans included a section on personal health. A hospital passport was in

place which included pertinent information. Pre and post consultation notes were maintained of all contact with GP's and other health professionals. Each of the service users had their own GP (general practitioner). The provider employed and or had access to a number of therapeutic supports which where available to service users. These included: speech and language therapy, occupational therapy, physiotherapy, behaviour specialist, psychology, psychiatry and counselling therapist.

There were arrangements in place for service users to be involved in choosing and assisting to prepare meals in the centre. There was a fully equipped kitchen come dining area with adequate seating to allow meal times to be a social occasion. A weekly menu planner was agreed at the weekly service user forum meeting which were generally attended by all of the service users. There was a policy on diet and nutrition, dated June 2016. The inspector observed that a healthy diet and lifestyle was promoted in the centre. There was evidence that service users, identified to require such support, had access to a dietician. Recommendations from dieticians for some service users were being implemented in the centre. Nutritional intake records were maintained for service users identified to require same.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There were systems in place to support staff in protecting service users in relation to medication management.

There was a policy and procedure on the safe administration of medication, dated June 2016. A secure storage press was in place for medications. All staff identified had completed appropriate training in the safe administration and management of medications. The inspectors reviewed a sample of medication prescription and administration records and found that they had been appropriately completed. Records showed that medications had been administered as prescribed. Individual medication management plans were in place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained. A seven day supply of all medications including PRN or as required medications was maintained in the centre.

There were arrangements in place to review and monitor safe medication management practices in the centre. Medication audits were undertaken by the providers quality assurance department on a regular basis. There was evidence that the output from these audits, with any learning identified was discussed at staff team meetings. be reviewed by the senior management team with any learning identified shared across the wider service.

There were procedures for the handling and disposal of unused and out of date drugs with a record maintained of all unused and out of date drugs medication returned to pharmacy. There was a separate secure area for the storage of out of date medications.

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:
There were proposed arrangements in place to monitor the quality and safety of care and support once the centre opened. However, the regulatory requirements to review the quality and safety of care required improvement and the providers understanding of the registration process in terms of their application to vary was not adequate.

There was a management structure in place which had recently been reconfigured. The person in charge reported to the regional manager who in turn reported to the director of operation who reported to the chief operating officer. Staff interviewed had a clear understanding of their role and responsibility, and of the reporting structure.

The person in charge held a full time position and was not responsible for any other centre. She had been working in the centre as the person in charge for the past nine months and had previously worked for a year in the centre as the team leader. She held a degree in social care. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a good understanding of the individual care needs of each of the service users. She was

supported by a deputy team leader.

The providers quality department had undertaken a range of audits in the centre. These included audits of personal plans, medication management and cleaning schedules.They had also undertaken an unannounced visit of the quality and safety of care in the centre on a six monthly basis. There was evidence that issues identified were reported to the regional manager along with an action plan with timelines to address issues identified. The person in charge submitted a weekly report to the regional manager which included information such as incidents, maintenance concerns and any clinical concerns. An annual review of the quality and safety of care in the centre had been undertaken. However, the detail in the report was generic in some areas and the quality of detail provided was poor.

The provider submitted an application to vary conditions of registration so as to include a one bedroomed building located beside the centre. It was proposed that the building would be a self contained unit for one of the service users currently residing in the centre. However, on the day of inspection there was evidence that the service user identified to live in the new unit had been informed that the move would occur within a few days of the inspection. This timeline had not been discussed with HIQA and was not appropriate. It was evident that the provider did not have a clear understanding of the registration process for applications to vary. This was discussed with staff on the day and assurances were given that the centre exiting conditions of registration would be adhered to.

Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
There were recruitment procedures in place, which were managed centrally by the provider. However, some improvements were required to ensure that all of the information required by the regulations was attained for all staff.

There was a recruitment and selection policy and procedure in place, dated June 2016.

The inspector reviewed a sample of four staff files. In the majority of these, the information as required in Schedule 2 of the regulations was available in the files reviewed. However, on one of the staff files reviewed, two satisfactory references from a previous employer were not available on file.

There was an actual and planned staff roster in place which showed that there were adequate numbers and skill mix of staff on each shift to meet the needs of the service users. The full whole time equivalent staff complement identified for the centre was in place.

There was a training and development procedure in place, dated June 2016. There was a training programme in place which was coordinated centrally by the provider. Records showed that all staff had attended mandatory training within required timelines. The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and the regulatory requirements.

There were formal supervision arrangements for staff in place. The inspectors reviewed a sample of supervision records and found that they were of a good quality and that they had been undertaken in line with the frequency proposed in the providers policy. A local induction and staffing policy, dated June 2016 was also in place.

There were no volunteers working in the centre at the time of inspection.

Judgment:
Substantially Compliant

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0003377
Date of Inspection:	27 June 2017
Date of response:	18 July 2017

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 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 level of detail provided in individual risk assessments for service users regarding the controls to manage risks identified were not always adequate or appropriate.

A risk register was not in place in the centre.

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

There was some evidence that incident trends were considered, but further work in this area was required.

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

Please state the actions you have taken or are planning to take:
1.As per the risk management policy [PL-OPS-003], all Risk Assessments in the Centre will be reviewed, to ensure that all control measures are implemented into practice, while ensuring staff are fully briefed with all risks.

2.Key risks for the resident and for the staff will be compiled in the risk register. Risks shall be risk rated and controls shall be reviewed to ensure all potential controls are in place. The risk register document shall be reviewed on a weekly basis by the PIC to ensure it is fully up to date and reflective of the needs of the residents and staff.

3.The risk register document shall be communicated to all staff on a weekly basis and shall be displayed prominently in the staff area

Proposed Timescale: 18/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors identified a small number of incidences where chemical restraints prescribed on an as required, or PRN basis, had been given to alter the behaviour of a service user. This had not been identified as a potential form of restraint or reported to HIQA.

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

Please state the actions you have taken or are planning to take:
PIC will complete a review of chemical restraint within the centre to ensure that it is being completed in line with HIQA guidance on the chemical restraint.

Proposed Timescale: 18/08/2017

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:** An annual review of the quality and safety of care in the centre had been undertaken. However, the detail in the report was generic in areas and the quality of detail provided was poor. **3. 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:** Moving forward the annual review of the quality and safety of care and support in the Centre will be completed in accordance with standards
Proposed Timescale: 18/08/2017

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** On one of four staff files reviewed, two satisfactory references from a previous employer were not available on file as required by schedule 2 of the regulations. **4. Action Required:** Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff. **Please state the actions you have taken or are planning to take:** A full review will be completed of staff files to ensure that they are line with Schedule 2
Proposed Timescale: 18/08/2017