

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Grangebeg Camphill Community
Centre ID:	OSV-0003621
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Lead inspector:	Louise Renwick
Support inspector(s):	Thomas Hogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 22 June 2017 09:30 To: 22 June 2017 18:10

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the fourth inspection of this designated centre which was registered by HIQA in May 2017 to accommodate 10 residents. The purpose of this inspection was to inform a decision to vary the conditions of registration in order to increase the number of residents to 13. This inspection also looked at the actions from the inspection in October 2016 to monitor improvement and compliance with the Health Act 2007 (Care and support of persons (children and adults) with disabilities) Regulations 2013.

Description of the service:

This designated centre is located in a rural setting in County Kildare. It is described in the provider's statement of purpose as a land-based community for adults with disabilities to live and work together with the support of life-sharing co-workers in healthy social relationships based on a mutual care and respect. The centre is made up of two separate houses which offers each resident their own private bedroom. There are additional workshops and purpose built facilities on site for residents to avail of.

How we gathered our evidence:

Inspectors spent time in the two houses of the designated centre and met and spoke with some residents. Inspectors spoke with the person in charge, the administrator, employed staff members and voluntary co-workers. Documentation was also reviewed such as personal plans, risk assessments, records of incidents and accidents and staffing files.

Overall findings:

Since the previous inspection, the provider had appointed a new person in charge who had partially, or fully addressed the actions identified within the last action plan. Improvements were noted in relation to the documentation, the assessment of residents' needs, the skill mix and number of staff and staff training. This inspection noted the improvements made, but also identified further areas in need of address in order to be fully compliant with the regulations.

Of the nine outcomes inspected, six outcomes were found to be substantially or fully compliant. Three outcomes were found to be moderately non-compliant and in need of improvement. These outcomes were:

- Social care needs in respect of personal plans
- Medication management
- Safeguarding and safety regarding the monitoring of personal finances, and the oversight of behaviour support plans.

Some residents spent time speaking with the inspectors, and said that they loved living in the centre and being part of the community. Residents were aware of the new person in charge and their role within the centre. Residents were observed to be content in their daily activation contributing to the Camphill community. For example, social farming and gardening, maintenance of the grounds, preparing home-cooked meals or attending community based coffee shops.

The findings of the report are outlined below, with areas in need of address in the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors determined that the actions from the previous inspection had been addressed.

The person in charge informed inspectors that he had provided training for staff in the management of complaints. Staff confirmed this. There was a well maintained record of complaints raised on the complaint register. At the time of the inspection, inspectors were informed that there were no open complaints in need of follow up.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Since the previous inspection, the person in charge had ensured improvements were made to the assessment of residents' health, social and personal needs. There were validated tools in use to assess residents in relation to their needs and support requirements. Information was clearly recorded within the documentation on the different health professionals that residents' availed of.

While there were improvements to the assessments, personal plans did not always included the supports for the needs identified through the assessment process to ensure a clear holistic plan was in place. This was a work in progress, with some files reviewed containing clearer plans than others. Similarly, while some residents were linked with allied health professionals such as physiotherapist, the advise was not always included within the overall plans. Also, the person in charge was seeking input from a psychologist for the implementation and review of plans to support residents with needs relating to behaviour to ensure plans and their reviews were multidisciplinary.

While these improvements were required within the documentation, inspectors found that residents were content with their daily activation and occupation, and had ample opportunities to lead social lives. The manner in which the centre was operated was in line with the social ethic of Rudolf Steiner, with a focus on community and shared living as promoting a healthy social life. Residents contributed toward the running of the centre from growing organic vegetables, working on the farm and maintaining the grounds. As well as their social roles in the centre and community, inspectors found that residents had access to local community facilities and amenities. For example, some residents worked in a coffee shop in the local town and some residents assisted to run a local farmers market. Some residents had clearly identified aspirations and goals that they were actively working on with the support of staff. For example, making jewellery. Staff had recently received training from the person in charge on outcome based goals setting.

Inspectors found that residents who had been identified to transition into the centre had plans in place to support their move. Staff had been identified to support residents in their move to residential and the premises had been amended to reflect the needs and wishes of residents moving in. For example, the addition of an en-suite bathroom.

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:

Inspectors reviewed the two houses of the centre to ensure appropriate accommodation and living space was available to facilitate an increase in the number of residents living in the centre.

Inspectors found that some internal works had been completed to the centre, based on the needs and knowledge of the two residents identified to move in. For example, an en-suite bathroom had been installed and a separate kitchen area.

Residents personal bedrooms had their photographs on the door, and the residents' identified to move into the centre had the opportunity to visit the centre on numerous occasions to support their transition.

The overall premises were found to be well maintained and clean and appropriate to residents' needs.

Judgment:

Compliant

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:

Inspectors found that the actions from the previous inspection had been addressed.

Staff had received training in Children First national guidance, and records of this training were maintained on their staff file. A safeguarding and protection plan had been drawn up in consultation with a young person and their family member who lived in the community to ensure any potential risks or concerns had been identified and supported.

Measures were in place to protect residents' from harm or abuse. For example, all co-workers and staff members had received training on safeguarding and the protection of vulnerable adults. Staff and co-workers had completed questionnaires following training, and periodically afterwards to ensure knowledge and skills were maintained. A recent audit had been carried out on by the person in charge and provider of previous incidents, complaints and adverse event to identify any potential safeguarding issues that may not have been identified at the time of reporting. From this, the person in charge had retrospectively submitted one notification to HIQA. The audit identified that the incident should have been managed in line with National policy and a preliminary screening should have been completed. On retrospective review, this incident was unfounded which the initial review back in December also identified. The person in charge endeavoured to complete a self-audit as requested by the National Safeguarding office, and would submit the findings and learning of this to HIQA post inspection.

One area identified on inspection that needed improvement was the monitoring and oversight of residents' finances to ensure protection of potential vulnerabilities. While there were structures and systems in place to monitor spending, these were not always utilised. For example, the absence of monthly reviews of balance sheets and the cross-checking against bank accounts. This was discussed with the person in charge.

Since the previous inspection, the person in charge had provided training for all staff and co-workers on a positive behaviour support model. In general, residents living in the centre did not present with very challenging support needs in relation to behaviour, with any inputs required of a proactive nature in order to further enhance residents' quality of life. That being said, behaviour support plans reviewed on inspection were not sufficiently guiding practice, and contained no input from a psychologist or a behavioural therapist. This was actively being worked on by the person in charge with dates set for training in a new approach to behavioural support in July 2017. Along with the training package for staff, the centre would be able to avail of psychology input with monthly reviews of any supports or interventions in use for residents.

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):

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

Findings:

Inspectors determined that the action from the previous inspection was addressed.

Residents had access to allied health professionals. Residents had their own General Practitioner (GP) and information was recorded in their files of all health professionals that provided support to them. Such as, neurologists or physiotherapists.

Improvements had been found in the assessment of residents' healthcare needs, with a new document being used to capture areas of need or risk. Healthcare plans were in place, but some additional improvements were required to ensure they were fully inclusive of all supports. This was mentioned under outcome 5 social care needs. Clarity had been sought from family members and improved communication to ensure the centre had information on residents' healthcare needs, and who would support the resident to attend health appointments.

Residents were encouraged to lead healthy lifestyles in the designated centre. For example, eating own-grown organic produce and limited processed foods. Inspectors observed residents preparing and cooking fresh meals on the day of inspection.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors determined that improvements had been made in relation to providing safe medicine practices in the designated centre, with some areas still in need of address.

Since the previous inspection, a staff member had been appointed to work in the centre for a number of hours a week with a specific focus on medicine management. Inspectors could see improvements from routine audits and reviews of practice, and measures taken by the person in charge to address any gaps identified through this system. For example, ensuring pain relief medicine was included on the prescription sheets.

Risk assessments had been completed on the self-administration of medicine for residents. These were found to be very thorough and identified additional supports required to encourage independence. However, the assessment did not include a capacity focus to ensure residents had the capacity and dexterity to complete the practical task of administering medicine. This was discussed with the person in charge.

Medicine was securely stored in a separate office area. There was a fridge available to store medicine that required refrigeration. All staff had received training from an external person on the safe administration of medicine which included a competency based assessment.

PRN (as required) medicine such as pain relief medicine or anti-inflammatory medicine was now included on the prescription records. However, there was an absence of clearly written protocols for all PRN medicine to outline the maximum dosage to be used, how the resident presents when needed, the reasons for use and the desired effect. This was captured through the audit system and was in the process of being addressed.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Inspectors found that there was a full time person in charge in the designated centre who met the requirements of the regulations and was suitably skilled and experienced. Each of the two house in the centre had a house co-ordinator who reported to the person in charge. A new management role was in the process of being filled which would act as a bridge between the person in charge and the provider nominee. This post was to be filled in August 2017. Inspectors determined the structure in place was more stable than the previous inspection, and the person in charge had oversight of practice across the two houses in the centre.

Inspectors found there was now a supervision structure in place. While some

supervision records contained elements of performance appraisal and focused on discussing the personal and professional development of staff. Other records reviewed did not include this focus. This was something that needed further development by the person in charge to ensure all staff were supported to exercise their responsibility for the quality and safety of their work.

Since the previous inspection the induction process had been reviewed. The same induction training was given to co-workers and paid staff members alike and a formalised structure of induction was in place.

Since the previous inspection, the person in charge had met with all staff and co-workers and carried out a competency review. From these meetings some staff had been enrolled in courses to obtain qualifications in relevant areas such as social care practice, and others had decided to focus on other areas of strength outside of the designated centre.

Inspectors found that a 2016 annual report had been completed by the provider. Some actions in this report were parallel to the findings of this inspection. For example, to improve on the outcome based approach to goal setting and to improve upon personal plans.

Inspectors reviewed quality enhancement plans which had been updated regularly to work on areas identified in previous HIQA action plans, and the provider's unannounced visits. While it was a positive finding that the provider and person in charge were actively addressing issues, improvements could be made to the proactive auditing and review of the quality and safety of care outside of areas in known need of address. For example, routine audits of areas of care and support to identify potential gaps emerging.

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):

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

Findings:

Inspectors noted significant improvement in relation to the numbers of staff employed,

the training available to staff and co-workers and the supervision of those working in the designated centre.

Since the previous inspection, a number of new staff had been employed to work in the designated centre who held relevant qualifications or had previous experience in social care settings. There was now a balance of paid social care trained staff and voluntary co-workers. The person in charge aimed to have a mix of both on shift in the centre at any one time.

Since the previous inspection, training had been delivered to staff in line with the previous action plan. Such as:

- outcome based goal setting
- positive behaviour support
- report writing
- appraisal and supervision
- medicine management
- Children First
- needs assessments.

Inspectors noted improvements in relation to the supervision of staff and co-workers with a formal structure and schedule now in place and training in supervision delivered to staff who supervise others. Inspectors reviewed documentation and found there to be regularly recorded supervision meetings with staff and co-workers.

A large number of staff worked on the Camphill community where the designated centre was located. For example, in the day services or on the farm. Inspectors found that rosters did not clearly reflect who was employed to work specifically in the designated centre providing direct residential care to residents, their full name and their hours of work. This was discussed with the person in charge during the inspection.

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):

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

Findings:

Inspectors found that the previous action had been addressed.

There was a directory of residents maintained in the designated centre which contained the information as required by Schedule 3 of the regulations.

Improvements were noted to the overall quality of the documentation maintained in relation to residents' care and support on this inspection.

Judgment:

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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003621
Date of Inspection:	22 June 2017
Date of response:	03 August 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 05: Social Care Needs

Theme: Effective Services

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

Assessments and plans did not always include the relevant allied healthcare professional or multidisciplinary team member input or review. For example, behaviour support plans and advise from physiotherapy.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:

The Person in Charge will review the allied healthcare professional/MDT input tool to ensure staff reviewing the form are prompted to capture such input. These forms will be reviewed on an ongoing basis at Welfare Team Meetings. The Person in Charge will oversee the signing off of all annual Assessments and Personal Plans to ensure MDT inputs are captured

Proposed Timescale: 15/09/2017

Theme: Effective Services

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

While comprehensive assessments had been completed, there was a lack of appropriate plans to outline the supports in relation to aspects of health, personal and social care.

2. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:

The Person in Charge will conduct a review of the Personal Planning tool to arrange the goals into a format that better accepts and categorises the actions identified through the comprehensive needs assessment, i.e. into health and social care categories while being mindful to ensure the personal plan is person centred for each resident in accordance with his or her wishes.

Proposed Timescale: 06/10/2017

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:

Behaviour support plans were not sufficiently guiding practice, and had no input from psychology / behavioural therapist.

Staff required training and up-skilling in the management and support of behaviour and the writing of support plans.

3. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date

knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:

Behaviour support plans are being updated with psychology / behavioural therapist input

A new behavioural support approach (Studio 3) has been adopted by the Service, The programme which will be integrated into care practice includes:

1. Full Staff Training in the approach held on 10-12th July, 17-19th July and 24-26th July
2. Monthly Clinical Support Days by a psychologist and other professionals will provide clinical guidance and sign off of behaviour support plans
3. A staff member will be trained as a trainer in the approach to ensure consistency moving forward.

Initial Staff Training will be completed by 15/09/2017.

The first full clinic day will be completed by 06/09/ 2017 and thereafter monthly.

The Trainer will be trained by the 15/12/2017.

Proposed Timescale: 15/12/2017

Theme: Safe Services

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

The measures in place to review and monitor residents' finances required improvement.

4. 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:

For each resident in receipt of finance management support the bank statements will be checked monthly against receipted expenditure by house coordinators. The finance administration officer will exercise oversight by monthly audit that will ensure that

- o All receipts are kept
- o All money is accounted for
- o All bank transactions reconcile with bank statements

Monthly reconciled ledgers will be in place for all service users to reflect all transactions and be signed off by the finance administration officer.

Random audits of residents' managed finances will be conducted on a 6 weekly cycle with oversight of these by the Person in Charge

Proposed Timescale: 31/08/2017

Outcome 12. Medication Management

Theme: Health and Development

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

Assessments used did not include an assessment of capacity.

5. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:

An assessment of capacity for the safe Self Administration of Medication will be added to the existing Risk Assessment.

A review of the medication management self-administration will be undertaken for all residents using the new form.

Proposed Timescale: 30/09/2017

Theme: Health and Development

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

PRN (as required) medicine did not have clear, written protocols in place to guide staff on their use for individual residents.

6. Action Required:

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

Please state the actions you have taken or are planning to take:

The protocols for the administration of PRN medications will be reviewed for each service user by house co-ordinators and GP's to ensure that protocols and the prescriptions correlate.

PRN Medication Administration Recording will have clear, written protocols in place to guide staff on their use for individual residents e.g. The presentation of the resident that initiates the need to administer; the maximum dose in 24 hours; identifying the expected outcome and how to monitor for it; what to do if the outcome is not achieved; any expected side effects

Proposed Timescale: 15/08/2017

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:

While improvements were noted in relation to the supervision of staff, further work was needed to ensure all staff were consistently reviewed regarding their professional development and responsibility for the quality and safety of care.

7. Action Required:

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

Please state the actions you have taken or are planning to take:

The Person in Charge will:

Introduce a new Staff Supervision Template that will be used as a guide for regular staff supervision which will more adequately initiate the generation of both performance related goals and the skills capacity assessment that identifies the skills that exist or that are needed, Should skills be identified as needed appropriate coaching, mentoring or training approaches will then be identified

Proposed Timescale: 31/07/2017

Theme: Leadership, Governance and Management

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

There was a lack of audit and review across all areas of care and support on a continuous basis to ensure areas in need of address were captured.

8. Action Required:

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

Please state the actions you have taken or are planning to take:

The schedule of audits to be undertaken will be reviewed to ensure cover of all eight themes of quality and care and these audits will inform the Service's Quality Improvement Plan.

The Person in Charge will:

- Add the review of our Quality Improvement Plan to our existing Audit Schedule for review on a quarterly basis.

Proposed Timescale: 01/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Rosters did not clearly reflect who was employed to work in the designated centre, their full name and their hours of work.

9. Action Required:

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

Please state the actions you have taken or are planning to take:

The Person in Charge has:

Introduced new weekly rosters specific to the designated centre that clearly identify:

- The name of the designated centre
- The specific residence within the designated centre
- The staff on duty and whether qualified employed, regular/relief or volunteering
- The hours of their work
- The W/C date and the payroll week to which the roster relates
- Hours related to Annual Leave, Sick Leave, Training etc

Proposed Timescale: 21/07/2017