

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ox View Community Houses
<b>Centre ID:</b>	OSV-0004431
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Joanna McMorrow
<b>Lead inspector:</b>	Catherine Glynn
<b>Support inspector(s):</b>	Thelma O'Neill
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	20
<b>Number of vacancies on the date of inspection:</b>	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 to inform a registration renewal decision. This monitoring inspection was announced and took place over 3 day(s).

**The inspection took place over the following dates and times**

From:	To:
14 September 2017 10:00	14 September 2017 19:00
15 September 2017 09:15	15 September 2017 18:00
18 September 2017 10:00	18 September 2017 19:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

Background to inspection:

The designated centre was part of the service provided by the Health Service Executive (HSE) in Sligo and provided full-time residential services up to 22 to adults with a disability.

This inspection was a registration renewal inspection, the centre was initially registered in 13/2/2015.

Due to significant failings identified by the inspectors during the inspection, inspectors were instructed by the Office of the Chief Inspector to abandon the registration inspection of this centre and to focus on safeguarding and safety in the centre in order to determine the risk posed to residents.

How we gathered our evidence:

The inspector observed practices at the centre and reviewed documentation such as

personal care plans, risk management plans, safeguarding plans, behaviour support plans and health and safety records. During the inspection, inspectors met with 20 residents and 31 staff, including the person participating in management, provider's representative, Senior management of the HSE, and the multidisciplinary team and maintenance staff as part of the inspection. Inspectors observed and met with residents engaging and participating in the activities within centres. The inspection took place over three days and during the course of the inspection, all five houses were visited. Residents communicated in their own preferred manner with inspectors.

#### Description of the service:

This designated centre is operated by the Health Service executive (HSE) and is based in Sligo. The provider had produced a document called the statement of purpose, as required by the regulations. The designated centre aimed to provide residential, respite and shared care service in some houses for both male and female adults with intellectual disabilities over the age of 18. The centre comprises of five houses throughout Sligo county. Residents had access to transport provided and in some areas access to public transport.

#### Overall judgment of our findings:

12 outcomes were inspected. one outcome was compliant, one substantially compliant, 2 moderately non-compliant, and eight outcomes were found to be majorly non-compliant.

#### Summary of regulatory compliance:

Inspectors found that the provider had failed to ensure that adequate measures were in place to protect residents from the risk of being harmed or abused in the centre. During the inspection, residents told inspectors that they did not feel safe living with some of their peers in the centre, due to experiencing frequent incidents of physical aggression and intimidation by some of their peers. Staff confirmed to the inspectors that residents' fears were real, and had justification for feeling fearful in the centre due to the safeguarding risks posed to some of the residents in the centre.

Inspectors reviewed the safeguarding risk and found that safeguarding concerns had occurred or were present for residents in all of the five houses in this centre. However, appropriate safeguarding procedures were not being implemented to ensure residents and staff in this centre were safe. While inspectors were told that all staff had received the mandatory safeguarding and safety training provided by the HSE, inspectors found that they did not demonstrate knowledge of the actual safeguarding issues in the centre or how to follow up on the management of reported risks or implement safeguarding plans in the centre. In addition, to the physical and psychological risks identified in the centre the environmental practices in one house were restrictive in nature, and had not been identified as restrictive practices. The effects of such restrictive practices on the residents' quality of lives were not assessed for each of the residents in the centre.

Due to the significant safeguarding concerns identified on this inspection, the provider was required to take immediate action under Regulation 8(2), of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children

and Adults) with Disabilities) Regulations 2013, to ensure that residents living in the centre are being protected from all forms of abuse.

In addition, to the above the registered provider (The HSE) and the person in charge were required to take immediate action under the regulations to ensure that as a condition of the continued registration that the above centre is being run and operated in compliance with the above regulations, specifically regulations 8(1) and 8(3).

The provider was required to provide a written response to HIQA setting out the immediate actions to be taken to safeguard residents living in the above centre before the end of the inspection. The provider gave written assurances to HIQA that they would immediately respond to the risks identified and reported to inspectors, and submitted a specific action plan response outlining the actions that would be taken to safeguard the residents in this centre.

In response to the action plan, an inspector completed further follow-up inspection, after the weekend, to verify the actions that the provider had said they would take and that residents were protected and safe in the centre. During this follow up inspection the inspector interviewed all of the residents present in the centre, spoke with the eight staff on duty and the senior management and members of the multidisciplinary team. The inspector was given assurances that the residents were now safeguarded from the risk of harm. The residents spoken with confirmed to the inspector that they now felt safe. The inspector found that appropriate actions had been taken over the weekend to safeguard residents and additional actions were put in place on the day of inspection following a strategy meeting by members of the senior management team and multidisciplinary team.

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.

**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):**

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

**Findings:**

Residents' social care needs were not effectively managed through personal planning systems in the centre. The previous inspection found similar non-compliance regarding formalising residents social care goals as part of each resident's overall assessment of need. Inspectors found that the activities in some houses were task orientated and did not focus on individual choices, goals or aspirations.

Although residents' personal plans were being reviewed, these reviews did not evaluate the effectiveness of the plan or the progress made in achieving residents' personal goals. Person centred planning also required improvement to ensure residents identified goals were up-to-date and actions to support residents achieving them were outlined and implemented. Furthermore, on review of the annual plans completed, there was no review of the previous actions or the residents' satisfaction with the plan. Inspectors found that residents were not supported or informed regarding their personal plans or engaged in the reviews that had occurred. There was also limited information regarding participation and consultation with residents' representative's or family in their personal plans. Furthermore, Inspectors found that the staff were unclear about the document systems in place and had not identified that residents did not have a comprehensive assessment in place.

On review of residents' personal plans, residents had identified enjoying activities such as outings to the pub and swimming. However, on reading the daily activity logs inspectors found that these activities were not happening on a regular basis. For example, inspectors observed one resident sitting in an armchair in the living room of

the centre for the entire period inspectors spent in the centre. In addition, inspectors noted that in some residents' daily records that staff were focused on task orientated activities. Personal plans were not provided in an accessible format for residents' or their representatives where required in the centre.

Inspectors found that a discharge completed in the centre in February 2017, had not been completed in a transparent manner, in line with the statement of purpose. In addition, no records were maintained in the personal plan reviewed which detailed the rationale for the discharge or the consultation with the resident or their representative. While inspectors were informed of support that had been provided, there was no documentation to support this. Inspectors were told how this discharge was discussed with the resident and they had accepted the reason for the move. However, this information was not maintained in the person plan, as required by the regulations.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

On the day of inspection, inspectors found that the health and safety of staff, visitors and residents was not promoted and protected within the centre. The provider had not ensured that fire precautions were in place in the centre and that risk management activities were supported by policy and procedure. The provider had not ensured that fire precautions were in place throughout the centre. Therefore, inspectors found that significant improvement was required in risk management and fire safety in the centre.

The provider had put arrangements in place to guide staff in the practice of monitoring fire safety. However, inspectors found that records were not being maintained regarding fire drills in one house. Inspectors discussed this with staff on duty and were informed that a drill would be completed that evening and records would be provided.

Fire safety equipment including the fire alarm, extinguishers and smoke detectors were provided throughout the centre. There were records of regular servicing of this equipment. In addition, staff completed checks on these fire safety measures; however, these were not being documented in each house in the centre. Inspectors noted that improvement to the fire safety measures was required in some of the houses as they did not have emergency lighting internally or externally. Inspectors also noted that fire panels were not located in accessible areas of the houses which meant that staff may

not be unable to access the panel in the event of a fire.

Fire doors were not installed in all houses in the centre. Inspectors found that three doors were scheduled for installation after the inspection. Where fire doors were installed, these did not have not all have self-closing mechanisms. Inspectors found that the provider had not ensured that all fire measures were provided in all houses, at the time of inspection, and had not sought guidance from a competent person, to ensure that all appropriate fire safety measures were in place.

All staff had completed training in fire safety evacuation procedures.

Personal evacuation plans were in place; however, the information contained did not clearly outline all support residents required or any specific needs that they may require during an evacuation.

On this inspection, inspectors found an overall absence of any documentation in relation to risk identification, assessment, analysis and identification of control measures. Accidents and incidents in the centre, falls risk management and residents' actual or potential risks had not been adequately assessed. Inspectors found that individual risks did not reflect recent multidisciplinary reviews. For example, falls risk assessments were not completed to ensure appropriate control measures were put in place following an assessment where a resident was identified as being a high risk of falls. This was particularly important due to the fact that the residents' bedroom was located upstairs.

There was a failure by the person in charge to identify these risks and escalate the risk appropriately. For example, staff had identified that the fire doors were closing too fast on some residents' bedroom doors posing them a risk in June 2017. This was brought to the attention of the maintenance department. However, action was not taken by the provider during the inspection to introduce sufficient controls to manage this risk. On the third day of the inspection inspectors were told that one resident had caught their finger in their bedroom door and had to receive medical attention following this accident. The inadequate response to risks in this centre was brought to the attention of the staff nurse on duty and assurances were given to the inspector that the accident risks would be addressed immediately. Confirmation was received from the manager that that door closures were installed on all of the fire doors in this house two days post inspection.

The centre had a policy and procedure regarding incident reporting and incident review meetings were in place. However, Inspectors found that incidents were not being reported as required. On review of the daily notes in a sample of residents files, inspectors found numerous incidents that had not been recorded appropriately and as a result had not been reviewed by the incident review group, in-line with their national policy. The provider had failed to ensure that all incidents were identified and addressed appropriately and had not identified this failing following their own internal audit completed in the centre.

All staff were trained in manual handling at the time of the inspection.

Inspectors found that staff were trained in hand hygiene in line with the infection control

policy of the centre.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

Inspectors found that national and local policies were in place to safeguard residents from being harmed or from suffering abuse in this centre. However, safeguarding practice in this centre was poor and policies and procedures were not implemented as required. During the inspection, two residents told the inspectors that they did not feel safe in the centre, due to frequent incidents of peer to peer abuse. Furthermore, inspectors found that nine staff interviewed did not have the knowledge required to ensure safeguarding concerns were reported. In addition, safeguarding plans were not being implemented as required. Furthermore, the management of behavior's that challenge were not adequately addressed and staff did not have the required training in the management of behavior's that challenge.

Overall, Inspectors found that the provider had failed to investigate or put appropriate safeguarding, behaviour support plans, and restrictive practice measures in place for residents, in line with their own organisational policies and procedures.

Due to the significant safeguarding concerns identified on this inspection, the provider was required to take immediate action to safeguard residents under regulation 8(1) 8(2) and 8(3).the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The provider was required to submit a written response to HIQA before the end of day two of the inspection, setting out the immediate actions it would be taking to safeguard residents living in the centre. The provider gave assurances to HIQA that they would immediately respond to the risks identified, and submitted a specific action plan response outlining time specific actions that would be taken to safeguard the residents in this centre. An inspector reviewed this plan on day three of the inspection and found

that the provider was now taking measures to implement their immediate safeguarding plan.

During the inspection, Inspectors met with all of the residents, two residents told inspectors that they did not feel safe living in the centre, and when receiving services in their day service. Residents told inspectors that although staff were kind to them they were afraid of some individuals they were living with. One resident told the inspectors that they had been assaulted on several occasions by their peers and that their personal property had been damaged and stolen. Staff interviewed told inspectors that they were aware of the concerns reported by some residents, but had failed to recognise the residents' concerns as formal complaints and did not report the complaints, so they were not investigated.

In addition, inspectors found several incidents in residents notes that should have been reported to the person in charge and the safeguarding team; however, staff had failed to report the incidents or risks identified. For example, residents that presented with unexplained bruising were not properly investigated and an explanation of the cause of the bruising was not recorded in the incident report.

Inspectors found from speaking with nine staff members, that they had not seen a safeguarding plan or the recommendations contained in one residents safeguarding plan. In response, the provider agreed to conduct an immediate review of all residents care notes since January 2017 to identify if any safeguarding concerns not previously referred to the safeguarding team, needed to be referred. They also confirmed that retrospective notifications would be submitted to HIQA for any notification not previously submitted.

Training records showed that 11 staff in the centre did not have up-to-date training in behaviour management, as required by the organisations and the regulations. In addition, some behaviour support plans did not accurately reflect the behaviors of concern displayed by some residents, and some staff spoken with on the day of inspection were not familiar with individual residents' behaviour support plans.

**Judgment:**

Non Compliant - Major

**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:**

Notifications as required by the regulations had not been notified to HIQA by the provider, within the timeframes as specified in the regulations.

Safeguarding concerns were not notified and unexplained bruising had not been recognised as a notifiable incident. Subsequent to the inspection and at the request of the Chief Inspector, retrospective notifications were submitted. In addition, inspectors found restrictive practices used in the centre which had not been notified to HIQA in the provider's quarterly returns.

**Judgment:**

Non Compliant - Major

**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:**

Inspectors found that efforts were not being made for some residents to access opportunities for skill development. Inspectors found there was an absence of appropriate assessment to identify opportunities for residents to engage in training, education and employment. Although there had been an increase in day trips for residents the majority of residents' lives remained passive and they continued to have limited opportunities for meaningful engagement and personal growth.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

Residents were not being adequately supported to achieve their best possible health at all times. Significant improvements were required in relation to healthcare supporting planning to safely and accurately guide staff practices in the support of residents' healthcare needs. Not all aspects of this outcome were reviewed during this inspection.

Inspectors found two examples where healthcare needs were not supported in line with the General Practitioners' (GP) recommendations. For example, one resident had been supported by staff to attend a GP complaining of foot pain, the GP advised that an x-ray was required. The x-ray was not completed as required and staff failed to alert the GP to seek further guidance regarding the discomfort the resident was experiencing.

Another resident had attended a review with a specialist. The specialist had made recommendations about investigations that were required as part of the residents overall healthcare assessment. The investigations included blood tests and an Magnetic Resource Imaging (MRI) scan. Inspectors found that this recommendations had not been completed.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Overall, inspectors found that medication management was not in line with the organisation policy in the centre. Inspectors found that the action from the previous inspection was not satisfactorily implemented. Inspectors did not review all aspects of this outcome.

During the previous inspection it was identified that residents had not been assessed for the self-administration of medication. Inspectors found during this inspection that while assessment had been completed, these were not comprehensive as risks including the residents' swallowing ability had not been considered. This resulted in a poor assessment of the residents' capacity to self-administer their own medication and the support they may required to do this.

In addition, inspectors found that the medication records reviewed also contained numerous errors and were not legible. In addition, this person in charge had failed to identify this during their own audits.

**Judgment:**

Non Compliant - Moderate

**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 found that the statement of purpose reflected the services and facilities provided. However, improvement was required.

The centre's statement of purpose did not contain all information required under schedule 1 of the regulations; for example, the information set out in the registration details of the centre, and the age range of the residents who could live in the centre.

Inspectors found that the statement of purpose was not in an accessible format for residents or their representatives where required.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

On this inspection, inspectors found the provider and person in charge had failed to ensure the service provided was safe, appropriate to residents' needs and that the service was consistently and effectively monitored. Provider-led systems, that were in place to assess for compliance and quality, were not resulting in any effective changes in the centre and residents, as a result were experiencing a poor quality service and experiencing ongoing incidents of peer-to-peer assault.

Despite the numerous and sometimes daily incidents relating to peer-to-peer abuse that had occurred in the centre it was not evident that this escalated risk to residents had elicited a timely or comprehensive response from the provider or a review of the risk management systems in the centre.

The person in charge was not ensuring that the governance, operational management and the administration of the designated centre was being effectively overseen . In addition, inspectors found that the person in charge had failed to ensure they were present or attended each house in the centre. There were no records which reflected their attendance to all houses and this was not clearly outlined in the planned or actual rosters in place in the centre. Staff informed the inspectors that they did not see the person in charge on a planned basis and that they were always based in one part of the centre.

Inspectors reviewed the provider led audit completed in May 2017, inspectors found that 13 actions were identified, but the provider had failed to identify any concerns with safeguarding practice and fire safety in the centre. In addition, where actions were identified, there was no timeframe in place for completion of the work required. There was also no evidence of consultation with residents or their representative and inspectors during the audit visit. Inspectors found as a result the audit was task orientated rather than focusing on the quality of the service provided.

The annual review of the quality and safety of care was completed and three actions were identified in this document. No action related to the significant areas of concern identified in this report.

**Judgment:**

Non Compliant - Major

**Outcome 15: Absence of the person in charge**

*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.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found, there were arrangements in place to cover the absence of the person in charge both during planned absence and out-of-hours. This arrangement was reflected in the statement of purpose and the inspectors found that the staff were all familiar with the plan in place.

The centre had arrangements in place that ensured there was management available in the 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:**

Inspectors found that the provider and person in charge had not identified or addressed gaps that were evident in staffing knowledge, skill and training requirements in the centre. Inspectors found that the numbers and skill mix in the centre did not meet the assessed needs of residents and the provider had not completed a review of the workforce. In addition, inspectors found that there continued to be a lack of appropriate training, recruitment and allocation of resources and skill mix in line with the assessed needs of residents.

The person in charge had ensured that planned and actual rotas were in place throughout the centre. However, on review of the rotas, inspectors found that they did not clearly identify the hours worked by the person in charge in all five houses in the centre. There were no volunteers in place at the centre, on this inspection.

Inspectors found that the lack of sufficient staff in all areas in the centre, was having a

negative impact on the quality of life for residents in the centre. On review of the personal plans in place in two houses, it was evident that the centre did not have enough staff on duty to meet residents' needs. In addition, the person in charge and the provider had not completed a thorough review of the staffing required and the allocation of resources or skill mix required to support residents.

The inspectors reviewed 11 staff files and found that they did not meet the requirements of schedule two of the regulations. For example:

- Garda vetting was not available in all staff files
- unexplained gaps in employment history were noted
- the dates that employment commenced was not recorded
- photo identification was not available on some files.

**Judgment:**

Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were significantly concerned in the manner in which documentation pertaining to the care and welfare of residents was managed in this centre. The provider failed to ensure that residents were protected against risks of unsafe or inappropriate care by failing to maintain complete and accurate documentation.

Not all documents, as required under Schedule 3 of the regulations, were available on the day of inspection. Records in all areas reviewed by inspectors relating to schedule 3 were either absent, incomplete or inaccurate and could not provide guidance to staff on appropriate care, safeguarding and risk management.

Not all documents as required under Schedule 4 of the regulations were available on the day of inspection. This included a record of each fire practice, drill or test of fire equipment (including fire alarm equipment) conducted in the designated centre and of

any action taken to remedy any defects found in the fire equipment.

**Judgment:**

Non Compliant - Major

**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:***

Catherine Glynn  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0004431
<b>Date of Inspection:</b>	14, 15 & 18 September 2017
<b>Date of response:</b>	18 October 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider had failed to ensure that suitable resources were in place to meet the needs of residents' assessed needs.

**1. Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the

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

assessed needs of each resident.

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

The provider is currently reviewing staff rosters in three of the facilities under the Oxview designated centre to ensure that suitable resources are in place to meet the needs of residents' assessed needs.

**Proposed Timescale:** 06/11/2017

**Theme:** Effective Services

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

Personal plans were not provided in an accessible format to all residents.

**2. Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The Person in Charge has ensured that all residents' person centred plans have now been made available in accessible format

**Proposed Timescale:** 16/10/2017

**Theme:** Effective Services

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

The person in charge had failed to ensure that all personal plans were reviewed regarding their effectiveness in line with the residents' assessment.

**3. 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 full review of all Persons Centred Plans has been completed for all residents residing within Oxview Designated Centre regarding their effectiveness in line with the residents' assessment

**Proposed Timescale:** 18/10/2017

**Theme:** Effective Services

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

The person in charge had not ensured that a discharge was conducted in a transparent manner, in line with the statement of purpose.

**4. Action Required:**

Under Regulation 25 (4) (a) you are required to: Discharge residents from the designated centre on the basis of transparent criteria in accordance with the statement of purpose.

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

Regarding the discharge completed in the centre in February 2017 records have now been updated detailing rationale for the discharge and consultation with the resident.

The Registered Provider and Person in Charge will ensure that any future discharge of residents from the designated centre is on the basis of transparent criteria in accordance with the centres statement of purpose. Regarding any future discharge there will be a clear record maintained in the personal plan detailing the rationale for the discharge and or the consultation with the resident or their representative. The centres statement of purpose has been reviewed and updated in relation to discharge.

Proposed Timescale: 17.10.2017 Complete and on going

**Proposed Timescale:** 17/10/2017

**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 provider had failed to ensure that procedures were in place to review, update and guide staff in their practice;

- incidents had not been identified and no review of documentation was evident
- escalation of risks identified were not managed appropriate as a result
- there was limited awareness, understanding or risks identified, therefore staff were not adequately guided in their practice.

**5. 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 Registered Provider has put systems in place in the designated centre for the assessment, management and on going review of risk, including a system for

responding to emergencies.

A full review of all documentation has been completed across the Oxview designated centre. This entailed a comprehensive review of all documentation from January 2017 to date. As part of the review the Behaviour Support Therapist completed a site visit to the five houses under Oxview Designated Centre.

An incident review group has been established to review all incidents on a monthly basis and ensure appropriate measures are put in place pertaining to each incident. The person in charge will ensure that measures are clearly reflected in residents risk assessments where appropriate.

A number of training sessions has been provided for frontline staff to in relation to understanding of incidents, risk and risk management. Three further workshops are scheduled over the next 3 week period to ensure all staff completes this training.

Proposed Timescale: 6th November 2017 on-going

**Proposed Timescale:**

**Theme:** Effective Services

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

The provider had failed to ensure that fire safety arrangements were in place in all houses, in the centre.

- fire panels were located in inaccessible areas
- appropriate fire doors in line with assessed needs of residents were not in place.
- self closing devices in line with all residents assessed needs were not in place.

**6. 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:**

A comprehensive site review has been completed across Oxview designated centre.

Identified fire works for completion as follows;

- Replacement of existing doors with appropriate fire doors in line with assessed needs of residents – completed on 30.09.17
- Fire panels relocated to accessible low risk area in the facility – completed 16.10.17
- Self-closing devices in line with residents assessed needs are in place – due for completion 31.10.17

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

**Theme:** Effective Services

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

The provider had failed to ensure that emergency lighting was provided in all houses internally and externally, in the centre.

**7. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

A comprehensive site review has been completed across the designated centre. Adequate emergency internal and external lighting will be in place on the below date.

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

**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:**

The provider and person in charge had not ensured that all staff working in the centre, had the necessary skills and knowledge to implement specific strategies recommended for the management of safeguarding concerns.

**8. 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:**

Bespoke safeguarding training has been provided for all staff working across Oxview designated centre to educate and support staff to fully understand safeguarding, safeguarding plans and processes. Completed

A Designated Officer now conducts a site visit once per week to each house under the Designated Centre. All staff is familiar with the designated officers and have been advised to contact the designated officer with any safeguarding queries or concerns. Complete and on going

The CHO 1 Safeguarding Team has provided additional support with the allocation of a Safe Guarding Team Social Worker to complete a site visit across the designated centre. Additional safeguarding information support sessions will be provided by the Learning

Disability Services assigned Social Worker and A/Assistant Director of Nursing over the next six weeks.

Proposed Timescale: 17.10.17 Complete and on-going

**Proposed Timescale:** 17/10/2017

**Theme:** Safe Services

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

The provider had not completed a comprehensive functional analysis to ascertain why residents engaged in particular behaviours that challenge. In addition, the provider had failed to develop strategies which would support residents, lessen the likelihood of the behaviours occurring and direct staff in what to do if they occur.

**9. 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:**

Comprehensive functional analysis to ascertain why residents engage in particular behaviours that challenge have now been complete. Where appropriate strategies have been developed to support residents.

Proposed Timescale: 13.10.17 Complete and on-going

**Proposed Timescale:** 13/10/2017

**Theme:** Safe Services

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

The provider had failed to ensure that all residents were supported and empowered to maintain their safety in the centre.

**10. Action Required:**

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed

for self-care and protection.

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

The provider and person in charge has ensured that all residents are supported and empowered to maintain their safety in the centre. This action has been supported by the assigned social worker who is facilitating support sessions with all residents to discuss strategies on keeping safe, to date this has been completed in Rusheen House. Complete.

Support session to be rolled out across the remaining part of the service over the next 6 weeks. 29/10/17

The social worker will attend weekly meetings at Rusheen House initially to discuss safeguarding. House meetings to follow a set template which will incorporate safeguarding, complaints and other issues that residents may wish to add to the agenda under any other business. Commenced and on-going

Proposed Timescale: 29.11.17 Complete and on-going

**Proposed Timescale:**

**Theme:** Safe Services

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

The provider had failed to ensure that all residents were protected from abuse in line with national policy.

**11. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

The provider will ensure that all residents are protected from abuse in line with national policy through effective governance of the designated centre.

Bespoke safeguarding training has been provided for all staff working across Oxview designated centre to educate and support staff to fully understand safeguarding, safeguarding plans and processes. Completed

A Designated Officer now conducts a site visit once per week to each house under Oxview Designated Centre. All staff is familiar with the designated officers and have been advised to contact the designated officer with any safeguarding queries or concerns. Complete and on going.

The registered provider and person in charge have investigated all incidents of peer on peer, unexplained bruising, and verbal abuse for all residents in the centre. Existing safeguarding plans have been reviewed and new plans developed were appropriate.

The Person in charge has a clear reporting relationship with the Assistant Director of Nursing on a weekly basis.

Proposed Timescale: 29.09.17 Complete and on going

**Proposed Timescale:**

**Theme:** Safe Services

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

The person in charge had failed to investigate all incidents of peer on peer, unexplained bruising, and verbal abuse for all residents in the centre.

**12. Action Required:**

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

The registered provider and person in charge have investigated all incidents of peer on peer, unexplained bruising, and verbal abuse for all residents in the centre. Existing safeguarding plans have been reviewed and new plans developed were appropriate.

Proposed Timescale: 29.09.17 Complete and on going

**Proposed Timescale:** 29/09/2017

**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:**

The person in charge had failed to identify and report all incidents of suspected, witnessed or reported incidents of abuse.

**13. 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:**

The provider and person in charge will ensure that all residents are protected from

abuse in line with national policy through effective governance of the designated centre.

Bespoke safeguarding training has been provided for all staff working across the designated centre to educate and support staff to fully understand safeguarding, safeguarding plans and processes. Completed

A Designated Officer now conducts a site visit once per week to each house under the Designated Centre. All staff are familiar with the designated officers and have been advised to contact the designated officer with any safeguarding queries or concerns. Complete and on going.

The registered provider and person in charge have investigated all incidents of peer on peer, unexplained bruising, and verbal abuse for all residents in the centre. Existing safeguarding plans have been reviewed and new plans developed were appropriate. Complete

Any future notifications will be reported as per the HSE safeguarding policy and process.

Proposed Timescale: Complete and on going.

**Proposed Timescale:**

**Theme:** Safe Services

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

The person in charge had failed to identify and report all restrictive practices in use in the centre.

**14. 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 provider and person in charge have identified all restrictive practices in use in the centre. Restrictive practices are now identified and a restrictive practice log has been set up and is maintained.

All restrictive practices in use through out the centre will be returned on the quarterly notification returns.

**Proposed Timescale:** 18/10/2017

### **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:**

Residents were not supported to access opportunities in learning, education or development.

**15. 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:**

The person in charge has commenced the process of referring all residents were appropriate to access opportunities in learning, education and development. The referral pathway to access this support is the through the Learning Disability Adult Referral Committee.

**Proposed Timescale:** 06/11/2017

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

The person in charge failed to ensure that residents medical treatment was followed up as directed by a medical practitioner and ensured that all residents medical care was reviewed.

**16. Action Required:**

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

The person in charge has reviewed all documentation concerning residents' medical treatment and follow up review. Complete

Actions as directed by a medical practitioner have been reviewed and are currently being followed through with identified resident and representative. Commenced

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

## 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:**

The person in charge had not ensured that appropriate practices were in place to ensure medication records were well maintained, legible and reviewed as required.

**17. Action Required:**

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

The person in charge is currently overseeing the introduction of a new drug karex template ,done in conjunction with general practioner. Going forward medication records will maintained, legible, reviewed as required. A monthly medication is currently being introduced across the designated centre.

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

**Theme:** Health and Development

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

The person in charge had failed to ensure that all self assessments reflected all residents risk concerns regarding self administration of medication.

**18. 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:**

The person in charge had ensured that all self assessments have been reviewed and appropriate measures put in place regarding any risk concerns identified.reflected all residents risk concerns regarding self administration of medication. Complete

The person in charge has contacted the designated pharmacist regarding the review of the self assessment tool currently utilised for self administration of medication.

In future the person in charge will ensure, in conjunction with the relevant members of the multi disciplinary support team .i.e SALT that the self administration assessment tool will take into account all individual eating guidelines in place.

**Proposed Timescale:** 16/11/2017

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The provider failed to ensure that the statement of purpose contained the information as required by schedule one.

**19. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:**

The provider has reviewed the statement of purpose which now contains the information as required by schedule one.

**Proposed Timescale:** 18/10/2017

**Theme:** Leadership, Governance and Management

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

The statement of purpose was not provided in an accessible format.

**20. Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

The provider and person in charge have reviewed the statement of purpose and it is now available and in an accessible format and provided to all residents across the service.

**Proposed Timescale:** 29/09/2017

**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:**

The provider had failed to ensure that timely and accurate incident recording in the

centre was completed

**21. 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 Registered Provider and person in charge has put systems in place in the designated centre for the assessment, management and on going review of risk, including a system for responding to emergencies.

A full review of all documentation has been completed across the Oxview designated centre. This entailed a comprehensive review of all documentation from January 2017 to date. As part of the review the Behaviour Support Therapist completed a site visit to all houses under the Designated Centre.

An incident review group has been established to review all incidents on a monthly basis and ensure appropriate measures are put in place pertaining to each incident. The person in charge will ensure that measures are clearly reflected in residents risk assessments where appropriate.

A number of training sessions has been provided for frontline staff to in relation to understanding of incidents, risk and risk management. Three further workshops are scheduled over the next 3 week period to ensure all staff completes this training.

Proposed Timescale: 06.11.17 and on-going

**Proposed Timescale:**

**Theme:** Leadership, Governance and Management

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

The provider had failed to ensure that where the unannounced audit was completed, that it identified and addressed areas of concern in a timely manner.

**22. 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 provider has completed an unannounced visit to all five houses under the designated centre. The provider is currently completing the necessary report. This report on completion will be available to the Authority upon request.

**Proposed Timescale:** 08/11/2017

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The person in charge had not clearly outlined the days worked in all areas of the centre.

**23. 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 clearly outlined the days which she will work in all areas of the centre

**Proposed Timescale:** 18/10/2017

**Theme:** Responsive Workforce

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

The person in charge had failed to ensure that all staff files contained the information as set out in schedule two of the regulations.

**24. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

The provider and person in charge have completed a review of all files and awaiting outstanding information in regard to garda vetting only.

The provider has made a specific request to the Head of Human Resources for outstanding garda vetting information.

**Proposed Timescale:** 08/11/2017

**Theme:** Responsive Workforce

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

The person in charge had failed to ensure or identify all staff who required training and refresher training in line with local policy.

**25. 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:**

The person in charge has ensured that all staff have attended training and refresher training in line with local policy. Training has been provided and attended by all staff in the designated centre as follows:

- Safeguarding, Studio 3, Risk Management – complete.
- Open Disclosure – Due 16.10.17 – re-scheduled for 23.10.17

**Proposed Timescale:** 23/10/2017

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Not all records as required by schedule 3 were available on the day of inspection. Records in all areas reviewed by inspectors relating to schedule 3 were either absent, incomplete or inaccurate and could not provide guidance to staff on appropriate care, safeguarding and risk management.

**26. Action Required:**

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

The provider and person in charge have reviewed all documentation in line with schedule 3 and same is in place across the designated centre.

**Proposed Timescale:** 18/10/2017

**Theme:** Use of Information

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

Not all documents as required under schedule 4 of the regulations were available on the

day of inspection.

**27. Action Required:**

Under Regulation 21 (4) you are required to: Retain records set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 4 years from the date of their making.

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

The provider has reviewed all documents in line with schedule 4 of the regulations and same are now available.

**Proposed Timescale:** 18/10/2017