Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	The Glade
Centre ID:	OSV-0005398
Centre county:	Louth
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Lead inspector:	Maureen Burns Rees
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 November 2017 09:30	08 November 2017 17:30
10 November 2017 14:00	10 November 2017 16:30

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was an inspection carried out to monitor compliance with the regulations and standards. The previous inspection was undertaken on the 21 of September 2016 and the centre was registered in January 2017.

How we gathered our evidence:
As part of the inspection, the inspector met with the newly appointed person in charge, regional manager, the behavioural specialist and two social care workers. The inspector spoke with one of the three residents living in the centre. This resident outlined how they enjoyed living in the centre, spending time with the staff and engaging in a number of activities outside of the centre. The resident was observed to have warm interactions with the staff caring for them. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures, staff files and supervision files.

Description of the service:
The service provided was as described in the providers statement of purpose. The centre provided residential care for up to six adults with a diagnosis of an intellectual disability, mental health illness and/or acquired brain injury. At the time of inspection, there were only three residents living in the centre. There were three

vacancies in the centre which there were no imminent plans to fill.

The centre consisted of a large detached seven bedroomed house which was located in a rural setting. Each resident had their own bedroom and bathroom facility. There was ample communal accommodation with a large kitchen and three separate living areas. There was also a large well maintained garden surrounding the centre for residents use.

Overall Judgment of our findings:
Overall, the inspector found that residents were well cared for and that the provider had arrangements in place to promote their rights and safety. However, in the preceding three month period, the centre had been through a difficult period with an escalated number of peer to peer incidents and property damage. The provider subsequently reviewed the compatibility of residents and moved one resident inn response to their assessed needs. This had resulted in a significant decrease in adverse incident in the centre. The previous person in charge had resigned in August 2017 and a new person in charge had been appointed in October 2017. She demonstrated knowledge and competence during the inspection. However, her management experience did not meet the requirements of the regulations.

Good practice was identified in areas such as:

- Residents' individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified (Outcome 5).
- Arrangements were in place to support residents on an individual basis to achieve and enjoy the best possible health. (Outcome 11)

Areas for improvement were identified in areas such as:

- Improvements were required in monitoring progress regarding the implementation of personal plans. (Outcome 5)
- Some improvements were required in relation to the reporting of incidents, risk management and fire safety arrangements. (Outcome 7)
- There had been a number of serious allegations and whilst appropriate safeguarding measure had been put in place to ensure that residents were safe, the investigation into these allegations had not yet been completed. (Outcome 8)
- Some improvements were required in relation to arrangements to review and monitor safe medication management practices. (Outcome 12)
- The appointed person in charge in the centre did not meet the requirements of the regulations in terms of her management experience. (Outcome 14)
- Some improvements were required in relation to staff supervision and staff training arrangements. (Outcome 17)

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Resident's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified. However, improvements were required in monitoring progress regarding the implementation of personal plans.

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

There were person centred plans for each of the residents which detailed their individual needs and choices. These plans were found to have a multidisciplinary input, with the involvement of the individual resident and their family representatives. They were found to be in an accessible format. Short, medium and long term personal goals, actions required to achieve same and timelines were also recorded for each of the residents. Monthly outcome reports with progress in achieving goals were available in some instances. However, in one of the files reviewed the inspector found limited evidence of monitoring of progress in achieving goals set. It was noted that some key working sessions were completed but these were not focussed on specific goals set.

The inspector reviewed daily activity lists on file which showed that residents were engaged in a good range of activities in the local community and inside the centre. There had been a marked increase in the number and range of community outings for the residents in the preceding three week period since the discharge of one of the former residents.

All of the residents had only been admitted to the centre in the preceding nine month period. It was proposed that all personal plans would be formally reviewed on a minimum of a yearly basis with the involvement of residents and their families.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
There were arrangements in place to promote and protect the health and safety of residents and staff. However, some improvements were required in relation to the reporting of incidents, risk management and fire safety arrangements.

There was a safety statement, dated February 2017. Site specific risk assessments had been undertaken and appropriately recorded. However, a number of environmental risk assessments in place required revision. There was a health and safety policy and procedure, dated June 2017, which was specific to the centre. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a quality team which was accessible as a resource for the centre. There was a risk management policy, dated June 2017 which met the requirements of Regulation 26. Individual risk assessments for residents had been undertaken with plans put in place to address risk identified.

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

Arrangements were in place for investigating and learning from serious incidents and adverse events involving residents. However, some improvements were required. A new on line reporting system had been introduced to the centre in July 2017. It was proposed that it would be implemented fully in the centre in the coming months. The system included a section to record action taken and further actions required. There was evidence that individual incidents were reviewed at staff team meetings. The person in charge provided the regional manager with a weekly written report on the numbers of

incidents in the centre. There was some evidence that incident trends were considered. However, since July staff were required to complete a paper based report in addition to the online incident report form. It was reported that for a period this had not always happened, with some staff only completing the paper based form and others, only the computer based system. This meant that analysis of trends of incidents in the centre may not have included all of the incidents depending on which system was looked at. Hence opportunities for learning to improve services and prevent incidents may have been missed. It was noted at the time of inspection, that the person in charge was in the process of collating all incident report forms for the identified period.

Overall, there were adequate precautions in place against the risk of fire. However, fire evacuation drills and arrangements required some improvements. A procedure for the safe evacuation of residents and staff, in the event of fire, was prominently displayed. There were adequate means of escape. The fire assembly point was identified with appropriate signage in an area to the front of the building. A fire risk assessment had been undertaken. Records showed that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals. Generally fire drills involving residents were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered. However, a fire drill had not been undertaken since the admission of a resident in June 2017. A personal emergency evacuation plan was not available for one of the residents. It was observed that a key for an external door, which could act as an escape route for a resident with mobility issues, was not readily available on the day of inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There were measures in place to safeguard service users and appropriate actions had been taken in response to allegations or suspicions of abuse. However, there had been a

number of serious allegations and whilst appropriate safeguarding measure had been put in place to ensure that residents were safe, the investigation into these allegations had not yet been completed.

There was a policy and procedure on protection of vulnerable persons, dated June 2017, which was in line with the national guidance. The inspector noted that the responsibilities and contact details for the designated officer and a deputy, were detailed in the policy. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff had attended appropriate training. There had been a number of serious suspicions of abuse in the centre in the previous 12 month period. The inspector found that appropriate safeguarding measures had been put in place in light of these allegations to keep residents safe. Investigations had commenced but at the time of inspection these had not yet been completed.

The centre had an intimate care policy in place, dated June 2017. Intimate care assessments and plans were in place for residents identified to require same.

Arrangements were in place to provide residents with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. The centre had a policy and procedure on behaviour support, dated June 2016. Incidents of challenging behaviour were reported for a number of residents in the preceding period but had significantly reduced in the preceding three week period with the discharge of one of the residents. Risk assessments and safeguarding plans had been put in place. The centre had access to the providers behaviour support team which included expertise in psychology, psychiatry and psychotherapist. There was evidence that the providers behaviour specialist attended the centre at regular intervals to provide support for residents and staff. He also reviewed all incident report forms. Training records showed that staff had received appropriate training in a recognised behaviour management approach. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques.

There was a policy and procedure on restrictive practices, dated June 2016. Restrictive practices in place were approved and regularly reviewed by the providers behaviour support team. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place. There was evidence that restraints used were discussed at the providers clinical meetings on a two weekly basis.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

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

Residents healthcare needs were met by the care provided. Overall service users had low healthcare needs. There was a policy on health and wellbeing, dated June 2016. Comprehensive health assessment and action plans had been completed for residents. Personal plans included a section on personal health. A hospital passport was in place which included pertinent information. Records were maintained of all contact with GP's (general practitioner) and other health professionals. Each of the residents had their own GP. In the preceding period a number of residents had to travel some distance to attend their GP as they had been unsuccessful in registering with a local GP. However, each of the residents had recently registered with a local GP. An out of hours doctors service was also located nearby. The provider employed and or had access to a number of therapeutic supports which where available to residents. These included: speech and language therapy, dietician, occupational therapy, physiotherapy, behaviour specialist, psychology, psychiatry and counselling therapist.

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

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:

There were systems in place to support staff in protecting residents in relation to medication management. However, some improvements were required in relation to arrangements to review and monitor safe medication management practices.

There was a policy and procedure on the safe administration of medication, dated June 2017. A secure storage press was in place for medications. All staff had completed appropriate training in the safe administration and management of medications. The inspectors reviewed a sample of medication prescription and administration records and found that they had been appropriately completed. Records showed that medications had been administered as prescribed. Individual medication management plans were in place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained. A seven day supply of all medications including PRN or as required medications was maintained in the centre. Information sheets specific to individual residents medications were available on file. Self medication assessments had been completed for each of the residents to ascertain if it was appropriate for the residents to be responsible for the administration of their own medications.

PRN or as required medication protocols were in place for residents who were identified to require same. A PRN administration record was maintained of all administrations and included information on the reasons for administration, synopsis of all other techniques used prior to resorting to the PRN administration and the outcome as a result of the medication being given. There were no controlled drugs in use in the centre.

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

Arrangements in place to review and monitor safe medication management practices in the centre required some improvement. There was a named medication officer in the house whom it was proposed would undertake medication audits at regular intervals. It was noted that these were not being undertaken in line with the frequency proposed. There had been a relatively small number of medication errors in the centre.

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

Findings:
There were some arrangements in place to monitor the quality and safety of care and support in the centre. However, the appointed person in charge in the centre did not meet the requirements of the regulations in terms of her management experience.

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

The newly appointed person in charge held a full time position and was not responsible for any other centre. She had taken up the position at the start of October 2017. The person in charge held a degree in social care practice which she had attained in 2016 and which included a module on management. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a fair understanding of the individual care needs of each of the residents. An administrative support had recently been appointed to the centre to support the person in charge. However, the person in charge did not meet the regulatory requirement as she did not have three years management experience within the area of health and social care.

In the preceding four month period, the centre had been through a difficult period with an escalated number of peer to peer incidents and property damage. A residents had recently been temporarily discharged to another facility for treatment and remained absent from the centre at the time of inspection. This had resulted in a significant decrease in the numbers of incidents in the centre. It was reported that the resident would not be returning to the centre. The previous person in charge had resigned in August 2017 with the appointment of the new person in charge in October.

The regulatory requirements for the provider to undertake six monthly unannounced visits to the centre and produce a report of the quality and safety of care had been undertaken. An annual review of the quality and safety of care in the centre had not yet been completed as the centre was only open nine months. There was evidence that a governance matrix report was submitted on a weekly basis to the regional manager which included information on incidents, restrictive practices, complaints and other clinical and operational issues in the centre. In the preceding period there was limited evidence of other audits being undertaken in the centre.

The provider had implementing a new governance plan across the service which had been submitted to HIQA. The regional manager and person in charge were knowledgeable about the governance plan and requirements in the centre to adhere to the plan.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
There were recruitment procedures in place, which were managed centrally by the provider. However, some improvements were required in relation to staff supervision arrangements.

There was a recruitment and selection policy and procedure in place, dated June 2016. The inspector reviewed a sample of five staff files and found that the information as required in Schedule 2 of the regulations was available in the files reviewed.

There was an actual and planned staff roster in place which showed that there were adequate numbers and skill mix of staff on each shift to meet the needs of the residents. The full whole time equivalent staff complement identified for the centre was in place. On occasions a small number of relief staff were used to cover leave. The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and the regulatory requirements.

There was a training and development procedure in place, dated June 2016. There was a training programme in place which was coordinated centrally by the provider. Records for staff training were held off site but a summary record was provided by the training department on the day of inspection. This document showed that al staff had attended mandatory training.

There were formal supervision arrangements for staff in place. The inspectors reviewed a sample of supervision records and found that they were of a good quality. However, a small number showed that supervision had not been undertaken in line with the frequency proposed in the providers policy.

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

Judgment: Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Maureen Burns Rees
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[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0005398
Date of Inspection:	08 & 10 November 2017
Date of response:	08 December 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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
In one of the files reviewed the inspector found limited evidence of monitoring of progress in achieving goals set. It was noted that some key working sessions were completed but these were not focussed on specific goals set.

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

1. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Person in Charge has reviewed Personal Plans and goals set ensuring key working sessions are focused on goals and outcome.
.
Provide further training and development for the Person in Charge and staff team in personal planning. Day One of Personal Plan training was completed in Oct 2017, Day 2 will be completed on the 11th January this is a follow on session from previous training.

Proposed Timescale: 11/01/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A number of environmental risk assessments required revision.

Since July 2017, staff were required to complete a paper based report in addition to the online incident report form. It was reported that for a period this had not always happened, with some staff only completing the paper based form and others, only the computer based system.

2. 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:
Person in Charge has reviewed and updated all environmental risk assessments
.
All staff have been debriefed in daily handovers and in the team meeting in regards to all incidents being reported in line with Policy

AIRS System to go live in all Nua Healthcare Centres in December 2017

Proposed Timescale: 11/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A fire drill had not been undertaken since the admission of a resident in June 2017.

A personal emergency evacuation plan was not available for one of the residents.

It was observed that a key for an external door, which could act as an escape route for a resident with mobility issues, was not readily available on the day of inspection.

3. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
Person in Charge to ensure fire drills are completed in line with policy

All personal emergency evacuation plan has been updated in the Designated Centre

All staff have been debriefed in daily handovers and in the team meeting in regards to carrying the key for fire door on their persons while on shift.

New access control mechanism to be fitted to external door noted in report.

Proposed Timescale: 18/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There had been a number of serious allegations and whilst appropriate safeguarding measure had been put in place to ensure that residents were safe, the investigation into these allegations had not yet been completed.

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:
Human Resource Department are currently in the process of completing and closing out the investigations noted in report. These have commenced since Sept 2017 and will be closed out.

Proposed Timescale: 31/12/2017

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:
There was a named medication officer in the house whom it was proposed would undertake medication audits at regular intervals. It was noted that these were not being undertaken in line with the frequency proposed.

5. 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:
Person in Charge will ensure medication audits are completed in line with the Medication Policy.

Proposed Timescale: 11/12/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The person in charge did not meet the regulatory requirement as she did not have three years management experience within the area of health and social care.

She had only been working within the area of social care for a relatively short period.

6. Action Required:
Under Regulation 14 (3) (a) you are required to: Regulation 14 (3) (a) Ensure the person who is appointed as person in charge on or after the day which is 3 years after the day on which these regulations came into operation has a minimum of 3 years' experience in a management or supervisory role in the areas of health or social care.

Please state the actions you have taken or are planning to take:
Regional Manager will take up position of Person in Charge in the Designated Centre and will be placed in the Centre for 1 day each week. Person in Charge is suitably qualified and experienced as per Regulation 14 (3) (a). All relevant paperwork has been submitted to the Authority.

Person in Charge will be supported by a Team Leader (PPIM) and will be employed in the Designated Centre on a full-time basis. All relevant paperwork has been submitted to the Authority.
▪
Deputy Team Leader has been appointed to the Centre on a full- time basis and will support Person in Charge and Team Leader in the daily running of the Centre.

Proposed Timescale: 04/12/2017

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Supervision for a small number of staff had not been undertaken in line with the frequency proposed in the providers policy. **7. Action Required:** Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised. **Please state the actions you have taken or are planning to take:** The PIC to conduct a full review of the Supervision taking place in the Centre . Team Leader (PPIM) and Deputy Team Leader completed Supervision Training. The Management team of the Designated Centre will continue to support staff through supervision on a regular basis as per the Centre's Supervision Policy
Proposed Timescale: 11/12/2017