

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity - Intellectual Disability Services
Centre ID:	ORG-0003199
Centre county:	Limerick
Email address:	Mary.powell@lim-docservice.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity - Intellectual Disability Services
Provider Nominee:	Denis Cronin
Person in charge:	Breda Noonan
Lead inspector:	Mary Costelloe
Support inspector(s):	Julie Hennessy;
Type of inspection	Announced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
10 March 2014 09:30	10 March 2014 16:30
11 March 2014 08:30	11 March 2014 02:00

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

This monitoring inspection was the first inspection of this centre (Group A) carried out by the Authority, it was announced and took place over two days. As part of the inspection, the inspectors met with residents and staff members. The inspectors observed practices and reviewed documentation such as personal plans, medical records, policies and procedures.

The centre (Group A) was made up of three single storey houses. Each house could accommodate six residents in four single and one twin bedroom. The houses were warm, comfortable, appropriately furnished and well maintained.

Overall, inspectors found that residents received a good quality service in the centre. Residents had complex social and healthcare needs. Staff were very knowledgeable regarding each resident's assessed needs and inspectors were satisfied that individual needs were being met. Staff supported residents in making decisions and choices about their lives. Residents were supported to pursue their interests, hobbies and to attend activation workshops.

Staff and residents knew each other well, residents were observed to be relaxed and comfortable in the company of staff.

Areas of non-compliance related to risk management, fire safety, medication management, the person in charge not employed full time in the post and personal planning documentation which are discussed further in the report and included in the Action Plan at the end of this report.

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 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

Judgement:

Non Compliant - Moderate

Findings:

The inspectors found that each resident had opportunities to participate in activities, appropriate to their individual interests and capacities. Staff were very knowledgeable regarding each resident's assessed needs and inspectors were satisfied that these needs were being met. However, improvements were required to ensure that the assessed needs of residents were clearly set out in personal plans and that individual plans took account of other specific plans such as health plans, risk management plans and intimate support plans. Residents and families were involved in the development of their personal plans and staff provided a good quality of social support to residents.

The inspectors reviewed a sample of personal plans. Staff showed the inspectors the new personal planning documentation templates which had recently been introduced however these had not yet been fully implemented. The personal plans contained important information about the residents' backgrounds, including details of family members and other people who were important in their lives. They also contained information about residents' interests and hobbies and a weekly work/activities timetable was included. Each resident's unique qualities were documented which clearly outlined their likes/dislikes, what made them happy/unhappy, the names of people they like to be with and special events/dates in their lives. Details of each resident's preferred day and night time routines were also included.

Inspectors noted inconsistencies in the personal planning documentation. Risk assessments were completed for some residents but these were not always dated.

Specific health care plans such as percutaneous endoscopic gastrostomy (PEG), epilepsy, and wound care were not included. Staff spoken with were knowledgeable regarding the specific communication needs of each resident and inspectors observed staff communicating with residents in an appropriate manner however, these specific needs were not included in personal plans. Individualised intimate support plans were also not included.

While there was evidence that individual goals were discussed at the annual review meetings, the goals and the name of those responsible for pursuing objectives within agreed time frames were not updated in the personal plan.

Each resident had an accessible version of the personal plan that they kept in their bedrooms. Some plans used pictures, words and photographs to depict the information in the residents' folders.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Findings:

The inspectors noted that improvements were required in relation to some aspects of risk management and fire safety.

On the first day of the inspection the inspectors had serious concerns in relation to some fire safety issues. There were no systems in place to ensure that fire doors were kept closed or could automatically close if kept open in the event of fire. Staff informed inspectors that the fire doors located on the main corridors between units were wedged open to facilitate staff supporting one another at night time, this practice posed a high risk in the event of fire. The inspectors also had concerns that the gaps noted between the fire seals on some fire doors might not be in compliance with fire safety Regulations.

Staff spoken with told the inspectors that they had not received recent fire safety training and that it had been several years since they had attended formal fire safety training. Some staff spoken with were not confident in knowing what to do in the event of fire.

These issues of concern were brought to the attention of the person in charge and the provider who undertook to immediately address them. They undertook to remove all door wedges and advised staff of the importance of ensuring that fire doors were not wedged open. On the second day of inspection the provider confirmed that fire safety training had been scheduled for all staff on the 18 and 19 March 2014 and that she had arranged for remedial works to be carried out to fire doors as required. Inspectors

observed this work taking place during the inspection.

There was a health and safety statement dated 2013. Inspectors reviewed the risk management policy dated 2012. Systems were in place to assess risks and identified risks had been included in the risk register. Risks specifically required by the Regulations such as the unexpected absence of a resident, accidental injury to residents, visitors or staff, aggression and violence and self harm were not included.

There was a major emergency plan policy dated 2012 in place but it did not provide guidance for staff as to their roles and responsibilities in the event of various types of emergencies including arrangements for evacuation of the centre.

Inspectors reviewed the fire policies and procedures. Service records reviewed indicated that all fire fighting equipment had been serviced in February 2014 and the fire alarm was serviced on a quarterly basis. Systems were in place for daily checks on the means of escape and these checks were being recorded. Fire drills took place every six months, the inspector reviewed the records of the last fire drill which took place in February 2014. The procedure to be followed in the event of fire was displayed in a prominent place.

The inspectors were satisfied that infection control procedures were robust. Staff informed the inspectors that they had adopted the HSE community infection, prevention and control manual which they used to guide practice in the centre. Hand hygiene training was scheduled for all staff in March 2014. Household staff had attended training on infection prevention and control in January 2014. Regular environmental hygiene audits were carried out by the person in charge, issues identified at the the last audit had been addressed.

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

Judgement:

Non Compliant - Moderate

Findings:

The inspectors found that measures were in place to protect residents from being harmed or abused but noted that policies guiding practice had not been recently updated. Improvements were required in relation to reviewing/updating of policies, to some aspects of restrictive practice documentation and training of staff.

The inspectors reviewed the policies dated 2009 relating to protection and prevention of abuse and procedures for dealing with allegations of abuse. The policy outlined clear guidance for staff as to what their role would be if they suspected any form of abuse and outlined clear guidelines for managing allegations or suspicions of abuse. It also included the name and contact details of the designated contact person. Staff spoken with confirmed that this policy was in the process of being reviewed and updated. Staff spoken to were knowledgeable regarding their responsibilities in this area. Some staff confirmed that they had not received recent training on the subject while other staff had not received any training.

Inspectors reviewed the comprehensive policy on positive behavioural support, guidelines to support persons with behaviour that challenged and restrictive practices guidance documents. The policy included clear directions on the use of restrictive procedures including ensuring that the least restrictive intervention was used for the shortest period possible. The inspectors noted that some restrictive practices were in place such as locking of bedroom and bathroom doors but clear rationales regarding these practices were documented in residents' personal plans. Restrictive procedures were reviewed regularly by a multidisciplinary team to ensure that least restrictive options were in use. Bed rails were in use for some residents. Risk assessments were carried out but they did not contain all of the required information such as the alternatives measures that had been tried or considered prior to using bed rails. Consent was not always clearly documented.

Residents spoken with told inspectors that they felt safe in the centre. The inspectors observed staff interacting with residents in a respectful and friendly manner. Residents observed appeared to be relaxed, happy and content.

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Judgement:

Compliant

Findings:

The inspectors found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services.

All residents had access to GP services. There was an out-of-hours GP service available. The inspector reviewed residents' files and found that GPs reviewed residents on a regular basis.

Residents had access to a range of allied health professionals. Records of referrals and appointments were observed in residents' files and recommendations were reflected in resident's personal plans.

The inspectors were satisfied that residents' nutritional needs were well monitored. Residents who required specialised diets were catered for. Advice was sought from the dietician as required and residents were weighed regularly.

Residents were supported to have access to the kitchen at all times and could choose a time that suited them to have their meals. Residents had access to drinks and snacks throughout the day.

The main meals were prepared in the central kitchen and transported in heated trolleys to the centre. There was a weekly menu plan which included a choice of two main dishes each day. Pictorial menus which included coloured photographs of different foods were available to support some residents in making food choices. Breakfasts and evening meals were prepared and cooked in the individual houses. Staff told inspectors that all residents individual likes and dislikes were considered and that alternative foods were always available.

The inspectors observed the mealtime experience and found it to be a pleasant one. Staff offered appropriate support to residents. Suitable assistive dining aids were provided to some residents in order to promote greater independence.

Outcome 12. Medication Management

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

Theme:

Health and Development

Judgement:

Non Compliant - Moderate

Findings:

The inspectors noted that medications were generally safely managed, some improvements were required in relation to storage of some medications.

There was a comprehensive centre specific medication policy in place and staff spoken with were knowledgeable regarding medication management policies and practices.

The inspectors reviewed a sample of prescription/administration charts and noted that they contained all the information required to enable staff to safely administer medications. All medications were individually prescribed including medications that were required to be crushed. The inspectors noted that the maximum dosage of PRN medications were also prescribed and all medications were regularly reviewed by the GP. There were no residents prescribed controlled medications at the time of inspection.

Regular PRN medication audits were carried out, these in turn were reviewed by the drugs and therapeutic committee. Staff informed inspectors that there were two qualified nurse prescribers and that they were currently developing audit tools in order to complete more detailed medication management audits.

The inspectors noted that improvements were required to the storage of some medications. Medications requiring strict temperature control were stored in an unlocked refrigerator in an accessible area, this posed a risk to residents and visitors. The temperature of the refrigerator was not monitored/ recorded on a daily basis in line with best practice.

Systems were in place to record medication errors and staff were familiar with them. Staff confirmed that they had attended recent medication management training.

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

Judgement:

Non Compliant - Moderate

Findings:

The person in charge while not working full time in the post had the required qualifications and experience for the post. She was a qualified nurse and worked full time in the organisation. She informed inspectors that she also worked six months of the year as a night sister. She had been appointed as the person in charge for group A the week prior to the inspection but had worked as Clinical Nurse Manager 2 (CNM2) for over 20 years. The person in charge worked as a nurse on the floor supporting residents with their daily assessed needs, there were no working hours specifically allocated to her to engage in the governance, operational management and administration of the centre.

The person in charge was knowledgeable regarding the general requirements of the Regulations and Standards, and had very clear knowledge about the support needs and personal plans of each resident. She was in regular contact with staff and residents as she worked day, weekend and night time shifts. The inspectors observed that she was well known to staff and residents. Arrangements were in place that a CNM deputised in her absence.

The provider had established a clear management structure, and the roles of managers and staff were clearly set out and understood. The structure included supports for the person in charge to assist her to deliver a good quality service. These supports included a full multidisciplinary team including occupational therapy, speech and language therapy, dietician, physiotherapist and psychiatrist. Clinical nurse specialists in health promotion, infection control, feeding and nutrition and tissue viability were also available to support the person in charge. There were established monthly management meetings where the managers of services could meet to discuss common areas of interest and share their learning. The person in charge told the inspector that she felt well supported in her role and could contact any member of the management team at any time should she have a concern or issue in relation to any aspect of the service.

The provider had not yet established a formal annual review of the quality and safety of care in the centre, however, some audits had been completed including environmental hygiene, personal planning files, finance and management of PRN medications. Staff told the inspectors that additional audit tools were being developed locally to ensure review of quality and safety of service.

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

Judgement:

Compliant

Findings:

The inspectors noted adequate staffing levels to meet the needs of residents at the time of inspection. There were normally three staff members on duty during the day time, two staff in the evening and one staff member on duty at night time in each house. There were normally two CNM's on duty between the three houses four days a week. Housekeeping staff were rostered three days a week. Staff told the inspector that staffing arrangements were flexible in order to meet the needs of residents and that staff supported one another between houses. The inspector noted that while there was a staffing roster showing staff on duty it did not include the times that all staff were on duty. Staff told inspectors that residents needs were always prioritised but that they found it difficult at times to keep up with additional cleaning/laundry duties and administration work such as updating personal plans.

The management team were committed to providing ongoing training to staff. There was a training plan in place for 2014. Staff spoken with confirmed that they had attended training and that records of training were maintained in staff files. Recent

training included risk management, infection prevention and control, nutritional assessments, medication management, care planning and water hygiene awareness/legionnaires disease. Hand hygiene training was scheduled for all staff.

The person in charge told inspectors that staff appraisals were completed on an annual basis, these were also used to identify areas for training and development. Records of staff appraisal were maintained on staff files.

The inspectors were informed that staff were recruited centrally and that the recruitment policy and staffing files were held centrally in the Dublin office. These files were not reviewed at this inspection.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity - Intellectual Disability Services
Centre ID:	ORG-0003199
Date of Inspection:	10 March 2014
Date of response:	17 April 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Theme: Effective Services

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

Specific health care plans such as percutaneous endoscopic gastrostomy (PEG), epilepsy, and wound care were not included in the personal plans. Residents specific communication needs were not included in personal plans. Individualised intimate support plans were also not included.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

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

Whilst these documents are in place in separate folders, not in the individuals care plan, staff are currently amalgamating the documents together into one care plan.

Proposed Timescale: 31/05/2014

Theme: Effective Services

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

While there was evidence that individual goals were discussed at the annual review meetings, the goals and the name of those responsible for pursuing objectives within agreed time frames were not updated in the personal plan.

Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

As part of the person centred planning document, the goals and persons responsible for pursuing the objective within agreed time frames will be documented and reviewed.

Proposed Timescale: 31/05/2014

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 emergency plan did not provide guidance for staff as to their roles and responsibilities in the event of various types of emergencies including arrangements for evacuation of the centre.

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:

Local designate area risk assessments regarding responding to emergencies are complete and attached to this response.

Designate area safety statement amended to include this risk.

Organisational Risk management policy DOC052 in place copy of same in all designate centres.

Proposed Timescale: 17/04/2014

Theme: Effective Services

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

Risks specifically mentioned in the Regulations such as the unexpected absence of a resident were not included in the risk management policy.

Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

Risk assessment complete in the designate area regarding the actions in place to control the unexplained absence of a resident.

Designate area safety statement amended to include this risk.

Also organisational policy re missing person DOC 049 is in place.

Proposed Timescale: 17/04/2014

Theme: Effective Services

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

Risks specifically mentioned in the Regulations such as accidental injury to residents, visitors or staff were not included in the risk management policy.

Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Risk assessment complete in the designate area regarding the actions in place to control the accidental injury to resident's visitors and staff.

Designate area safety statement amended to include this risk.

DOC 010 Incident reporting policy in place in all designate centres.

Proposed Timescale: 17/04/2014

Theme: Effective Services

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

Risks specifically mentioned in the Regulations such as aggression and violence were not included in the risk management policy.

Action Required:

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

Risk assessment complete in the designate area regarding the actions in place to control aggression and violence.

Organisational guidelines DOC011 to support persons with behaviours that challenge this is currently being reviewed and will be circulated as a policy by the last week of May 2014. This is available in the designate centre.

Designate area safety statement amended to include this risk.

All above complete, with exception of challenging behaviour policy which will be complete and ready for circulation by the last week in May 2014.

Proposed Timescale: 31/05/2014

Theme: Effective Services

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

Risks specifically mentioned in the Regulations such as self harm were not included in the risk management policy.

Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

There is a risk assessment in place to reflect this area, where risk has been identified individualised risk assessment and management plans will be developed to support the service user and staff to manage this risk.

Proposed Timescale: 17/04/2014

Theme: Effective Services

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

All staff had not received up to date fire safety training.

Action Required:

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

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

Fire training complete for staff in the area, evidence of certificates of completion attached to the feedback report.

Proposed Timescale: 17/04/2014

Theme: Effective Services

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

There were no systems in place to review all fire precautions, for example ensuring that fire doors were kept closed or could automatically close in the event of fire and regular review of gaps in fire doors to ensure compliance with fire safety Regulations.

Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

All precautions reviewed including the fire doors kept closed, magnetised holds put on doors where required which are currently having the alarm and electricity connected to same, training in place for staff, fire marshal training complete

Proposed Timescale: 17/04/2014

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:

Risk assessments for use of bed rails did not contain sufficient information such as the alternatives measures that had been tried or considered prior to using bed rails.

Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are

considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

All risk assessment are currently under review and will be complete by 12th May 2014.

Proposed Timescale: 12/05/2014

Theme: Safe Services

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

All staff had not received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Review of Policy for protection and welfare of vulnerable adults and the management of allegations of abuse near completion, will be complete by end of April 2014, training will commence with immediate effect from this date.

Proposed Timescale: 31/05/2014

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:

Medications requiring strict temperature control were stored in a unlocked refrigerator in an accessible area, this posed a risk to residents and visitors. The temperature of the refrigerator was not monitored/ recorded on a daily basis in line with best practice.

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:

Fridge from date of monitoring inspection is at all times locked.
Daily checklist/recording of fridge completed by staff.

Proposed Timescale: 17/04/2014

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 person in charge did not work full time in the post, she also worked six months of the year as a night sister. There were no working hours specifically allocated to her to engage in the governance, operational management and administration of the centre.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

There are two person in charges to the designate centre, both work a 39hr week rotating from the designate centre to night duty on a three month rotation. This ensures that both day and night there is a person in charge with the knowledge qualifications skills and experience to oversee care delivery on the 24 hour basis to the designate centre.

The person in charge is reviewing how the roster can be managed so as to allocate management and administration time to herself for designate centre operation.

Proposed Timescale: 17/04/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staffing roster did not include the times that all staff were on duty.

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:

Roster indicating hours with immediate effect from the date of registration.

Proposed Timescale: 17/04/2014