

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	North County Cork 2
Centre ID:	OSV-0003707
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Lead inspector:	Carol Maricle
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	26
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
31 January 2018 09:55	31 January 2018 18:00
01 February 2018 09:55	01 February 2018 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 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 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This centre was a designated centre for adults with disabilities that offered a residential and respite service. This was the second inspection of this centre since it had been reconfigured as a standalone centre in 2016. The current inspection was scheduled to inform the registration renewal of the centre.

How we gathered our evidence:

The inspectors reviewed documentation such as the centre's statement of purpose, personal planning documents, healthcare records, staff training records, staff files,

policies and procedures and fire safety records. As part of the inspection, the inspectors met and spent time with all of the residents. The inspectors also met with care staff, assistant house parents and nurses across the three units. The person in charge was present during the inspection and the person representing the provider was also met with for feedback. The inspectors spent time observing staff interactions with residents. Where possible, the inspectors engaged in discussion with residents who expressed satisfaction with their day-to-day life at the centre. The inspectors also spoke with six family representatives who expressed a high level of satisfaction with the care their relatives received however most commented about how the closure dates of the units were of a concern (of various levels) to them.

Description of the service:

The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. During and immediately following this inspection, the person representing the provider made a number of changes to the statement of purpose to ensure that it accurately reflected the service that the centre provided. The statement of purpose identified that the centre catered for adults with a diagnosis of an intellectual disability. The maximum number of residents that the centre could cater for was 28 at any one time and, at the time of this inspection, the centre had two respite rooms vacant. The inspectors found that the service was being provided for as it was described in the document.

There was a mixture of residential and respite services provided at this centre. The centre comprised three separate units. In the first unit, there lived 12 residents and they received 24-hour nursing care. This unit also provided a respite service from a dedicated respite bedroom. At the time of the inspection eight individuals were eligible to receive respite at the centre. The remaining three residents lived in an apartment adjoined to this dwelling and they were described as independent and requiring a lower level of support from staff. The overall capacity of this unit was 16 when the respite bedroom was used.

In a separate geographic location there lived 10 residents in one unit (two houses that were connected internally) and one resident in a second unit. Both units were located side by side. The second unit provided a respite service from a dedicated bedroom; however, at the time of the inspection it was not open to current admissions.

All three units operated closure dates at different time periods throughout the year and this information was set out clearly in the revised statement of purpose and in the resident guides. Two of the units were not staffed when residents attended their day-service on week-days.

Overall judgments of our findings:

Overall, it was demonstrated that residents were supported appropriately on a day-to-day basis in their personal planning arrangements by staff, however, there were a significant number of regulations that were not being met pertaining in particular to the arrangements for respite recipients. While there was a defined management structure this required on-going review as the person in charge was actively managing a second designated centre across a broad geographical area.

Some areas of non-compliance were identified in relation to:

- aspects of rights and dignity (Outcome 1)
- personal planning arrangements (Outcome 5)
- fire safety (Outcome 7)
- notifications (Outcome 9)
- aspects of healthcare (Outcome 11)
- medicines management (Outcome 12)
- aspects of governance and management (Outcome 14)
- aspects of staffing (Outcome 17)
- records and documentation (Outcome 18).

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 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The rights of the residents were promoted and their dignity was upheld. Residents were consulted about the running of the centre. There were systems in place for advocacy and complaint making. The majority of the actions arising from the previous inspection had been addressed, however, there were two outstanding actions regarding furniture and the recording of complaints. The closing dates of each unit were a concern to most of the family representatives spoken with.

There were systems in place to ensure that residents were consulted about the running of the centre. The inspector viewed documentation that showed how staff members consulted with residents each month. An inspector met with a staff member who organised these meetings and they discussed how meaningful actions took place following the suggestions of residents and gave examples of same.

Each of the units that comprised this designated centre had their own arrangements as regards the opening and closing of the unit. This meant that residents had to leave their home at weekends, bank holidays and during certain weeks of the year. The person in charge informed the inspector that one of the units would open more frequently in 2018 as a direct response to the needs of residents and their family circumstances. This was reflected in the revised statement of purpose. Although the provider was observed to have responded to this need in one unit this arrangement was not in place for all of the units.

There were systems in place regarding complaint making. The previous inspection had

found that verbal complaints were being made but such complaints were not recorded. During this inspection, a complaints log was in place which outlined the nature of the complaint, any action taken and if the complainant was satisfied with the outcome. However, when reviewing the complaints log in one unit of the centre it was noted that there was no entry between March 2015 and February 2017. This was brought to the attention of the person in charge who acknowledged that verbal complaints had been received during this time period but had not been recorded. A second complaints log was viewed by an inspector and it was noted that the satisfaction level of a complainant was not recorded following the resolve of one complaint. This was resolved immediately by the person in charge.

During this inspection, staff were observed treating residents well and upholding their dignity. A member of staff was observed comforting residents where they required verbal reassurance. During interview, staff spoke positively about the residents. Staff were clear about the needs of each resident, their strengths, their goals, their likes and dislikes.

Some of the residents were observed to have their own interests outside of the centre and were facilitated by staff to enjoy these. An inspector spoke with a group of residents who confirmed their plans for the evening of the inspection. A resident spoke with an inspector and stated that they were happy to stay in that night of their own choice having been out already that morning.

Residents were supported to manage their finances and records of any transactions were kept within the centre along with corresponding receipts. Inspectors reviewed a sample of such records and it was noted that receipts and transactions were appropriately signed for while balances recorded matched up. Arrangements were also in place for resident finances to be audited on a monthly basis and inspectors saw records of such audits. A policy in this area was also in place which had been reviewed during the previous three years.

Most bedrooms across the centre were single rooms with the exception of two shared double rooms in one unit. In the November 2014 inspection it was found that screening arrangements were not in place to safeguard the privacy of residents who were sharing these bedrooms and that residents had to share wardrobes. While privacy screens were available in the centre during this inspection, it was observed that the shared bedrooms continued to have only one wardrobe and one locker in each meaning residents had to share this furniture.

Respite services were offered at this unit to eight individual service users of the organisation. Since the previous inspection, respite was now provided from dedicated bedrooms. This meant that no resident had to share their room with a respite recipient which was an improvement since the previous inspection.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

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

Findings:

There were systems in place to ensure that communication supports were in place for residents. The action that arose from the previous inspection had since been implemented in the centre.

The provider maintained a policy on supporting residents in their communication. There was a speech and language therapist service available to residents as part of the suite of services provided by the organisation.

Each resident had their own personal planning arrangements set out and these arrangements included a written record of the abilities of each resident to communicate in addition to the needs of the residents in this area. This section of the plan was generally written by care staff as they had a close relationship with the resident. The records viewed by the inspectors showed how staff wrote a detailed record of how each resident liked to communicate including their use, if any, of established communication methods. Some residents had developed their own communication style using gestures, pointing, body language and their own adaptations of established forms of communication. The inspectors observed a communication board in the units which contained a picture rota of which staff were on duty and a menu plan for breakfast and tea.

Television was provided in the main living room and a number of residents had televisions and stereos in their own room.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain relationships in the community.

There was evidence confirming that residents were supported, as appropriate, to maintain relationships with their friends and family. This was confirmed by the family members who the inspectors spoke with. There was a policy on visiting, maintained by the organisation. There was a high level of satisfaction expressed by the representatives of residents in this area and they appreciated the open door policy of the centre while stating that they were always made to feel welcome by staff.

Residents told inspectors how they liked to attend events that took place in the community, for example, weekly dance classes. Family members confirmed these arrangements which were also set out in residents' personal plans.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There was a policy on admission which described the admission process including assessment, access and the transition period that would be agreed with the resident. The person in charge described the transition plan in place for a recent new admission which was appropriate; however, an accompanying written document to support this plan was not on file. This has been commented upon in outcome 18.

The inspector reviewed a sample of written contracts for those living at the centre and found each been agreed and signed by the resident and or their families. The contracts included details of the services to be provided and there was additional information for the resident on fees to be charged for services provided. Contracts for residents in receipt of respite services only were not kept on-site and this has been commented upon in outcome 18.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The provider had systems to ensure that personal planning arrangements were in place. However, significant improvements were needed in the application of these arrangements for respite recipients. At the previous inspection there were a number of actions identified, some of which had been implemented. Two actions remained outstanding and these were in relation to healthcare plans. These are also commented on in outcome 11.

An inspector reviewed a sample of files representing both residential and respite recipients. Overall, where the inspector viewed the file of a resident who lived full-time at the centre, personal plans had either been updated and were now aligned to the organisational personal planning arrangements or were scheduled to be updated and aligned. The updated files showed evidence of an assessment of need in areas such as; healthcare, eating and drinking, speech and language requirements, positive behavioural support and mobility requirements. Each resident had personal planning arrangements (separate to their person-centred plan) and this set out a range of information about each resident, such as important information for staff to know, important dates in their year, their likes and dislikes, their abilities in the area of communication, hospital passports and individualised risk assessments. Not all residents had a person-centred plan; however meetings to create such a plan were all scheduled for the coming months. There was evidence of a formal multidisciplinary review. This was an annual event. The person in charge demonstrated appropriate awareness of the outcome of these meetings. The inspector found that achievements in goal setting were not recorded in a consistent manner across personal planning arrangements. However, new documentation had been introduced at the centre and the person in charge was confident that the new methods of recording would ensure greater consistency.

There were eight individuals who availed of respite at one of the units. Their files did not demonstrate how the requirements of the regulations were met as there were gaps in

the assessment of their need and a lack of evidence to show how the individual was involved in the creation of their own personal plan.

Where there had been a new admission of a resident (who had moved from respite), an inspector viewed the documentation on file and the personal planning arrangements did not meet the requirements of the regulations. There was no evidence of a formal assessment of need conducted either before or following their admission and there was no significant up-dating of their file since their admission. Some information was inaccurate, for example, risk assessments on file pertained to a different unit and not the unit that they lived in. The person in charge showed the inspector how a date had been arranged for the review of this file but it was not suitable as it was scheduled to take place a number of months following the inspection.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the premises provided was designed and laid out to meet the needs of the residents living in this designated centre.

The designated centre comprised three units located within a town setting a short distance from each other. All three were close to local shops and amenities. The first unit was a purpose-built detached bungalow, while the second and third units were both two-storey houses located beside one another. All three units had access to a garden area.

Having reviewed all three units, inspectors were satisfied that the relevant requirements of the regulations had been met. For example, there were sufficient bathroom and toilet facilities, communal space and separate kitchen areas in all three units. The designated centre was presented in a clean manner during the inspection and was observed to be in a good state of repair. One carpet in one unit required replacing but this was in progress at the time of the inspection.

Efforts had been made to give all three units of the centre a homely feel, for example,

various photographs of residents were on display throughout. Inspectors observed some bedrooms used by residents which were well maintained and personalised. Residents were provided with ample storage through large wardrobes in the bedrooms. However, as discussed under Outcome 1, some residents in shared bedrooms had to share wardrobes.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

While efforts were being made to promote the health and safety of residents, improvement was required in relation to the provision and use of fire doors.

Prior to the inspection, the representative of the provider had informed inspectors that a recent fire safety assessment had been carried out in all three units which had determined that fire doors were required in one unit of the centre. In addition the previous inspection had found that fire doors were being wedged open. On day one of this inspection fire doors were observed being held open by furniture in one unit of the centre. Such action would reduce their effectiveness in the event of a fire.

A fire alarm system, emergency lighting and fire fighting equipment including fire extinguishers were present in the centre. Emergency lighting was seen to be operational on the day of inspection while fire exits were also observed to be unobstructed. The fire evacuation procedures were also on display throughout the three units that made up the centre. Internal staff fire safety checks were being carried out and documented while training records reviewed indicated that all staff members had received fire safety training. Inspectors saw records of certificates of quarterly maintenance checks carried out by external bodies for the fire alarm, emergency lighting and fire extinguishers.

Residents had personal evacuation plans (PEPs) in place which were noted to have been reviewed within the previous 12 months. Fire drills were being carried out at regular intervals and were recorded. Inspectors reviewed a sample of these records which included the names of staff, the number of residents who took part and the duration of the evacuation. Any issues arising in drills were documented with residents' PEPs.

A comprehensive risk register was in place which had been reviewed in the months

leading up to this inspection. This risk register included potential risks which affected the centre as a whole such as medicines errors, slips trips and falls, food hygiene, the use of oxygen and fire safety.

Risk assessments relating to individual residents were maintained in their personal plans. While these were noted to have been reviewed, it was observed that one resident did not have a risk assessment in place relating to choking despite having a near miss of this type during 2017. It was also noted that some hazards pertaining to individual residents had not been identified as same and risk assessed. In addition, individualised risk assessments in place relating to a new admission required updating.

A process for recording accidents and incidents occurring in the centre was in place. Appropriate policies relating to health and safety and risk management were in place, while audits in areas such as hand hygiene and fire safety were also conducted.

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):

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

Findings:

There were systems in place to protect residents. The previous inspection found that not all staff had received training in dealing with behaviour that challenges. This action had not been satisfactorily addressed.

The provider maintained policies on the safeguarding of vulnerable adults and a separate policy on responding to behaviours. In 2017, the organisation had introduced an updated policy on the rights of residents and this addressed the use of restrictive practices. There was a separate policy on intimate care.

However, as on the last inspection, not all staff had received training on dealing with positive approaches to behaviour that challenges. At this inspection, one staff member was found to require refresher training in de-escalation and intervention while evidence

was not provided that agency staff working in the centre had undergone such training.

Each resident had an assessment of their ability to self-care and arising from this, an intimate care plan was then created.

Part of the multidisciplinary team available to residents included access to a behavioural support team. This discipline was also represented at the annual multidisciplinary review meeting of the resident. At the time of this inspection, there was evidence that residents had an individualised behavioural support plan in place where required.

During interview, staff confirmed their knowledge of safeguarding matters and the correct procedure should they have a safeguarding concern about a resident. Previous allegations of abuse had either been or were in the process of being investigated and dealt with appropriately.

The inspectors reviewed the use of restrictive interventions and found that there was minimal use of restrictive practices and these were limited to window restrictors in some communal rooms.

Judgment:

Substantially Compliant

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:

A system was in place within the centre for recording accidents and incidents.

A log of such events was reviewed during the course of the inspection. While doing so inspectors came across one incident of a safeguarding nature which had not been notified to HIQA as required.

Judgment:

Non Compliant - Moderate

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:

Residents were supported to access education and training.

All residents living at this centre had a day service available to them. At the time of the inspection, some residents chose not to attend a day service and where this was the case they were supported to be involved in aspects of the running of the centre. An inspector met with a number of these residents who said that they enjoyed doing errands with staff, relaxing at home and getting involved in their own home-based pursuits such as crafts. A number of residents had undertaken training and took on roles in areas such as advocacy.

Judgment:

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):

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

Findings:

There were systems in place to ensure that residents had their healthcare needs supported and staff were knowledgeable of these needs. However, the documentary evidence to support these arrangements did not meet the requirements of the regulations. The majority of the actions arising from the previous inspection were met; however, an action regarding healthcare plans was still outstanding.

Residents had access to general practitioners (GPs). They also had access to a multidisciplinary team including disciplines such as psychology, physiotherapy, behavioural support and occupational therapy. There was evidence of access to specialist care in psychiatry as required. There were systems in place to establish end-

of-life care plans where necessary. There were written records kept of the residents' appointments with various professionals. During discussions, staff members could articulate the healthcare regimes of each resident.

The inspector reviewed a sample of healthcare information in the files of residents that lived and received respite in the centre. Overall, the residents' files demonstrated a formal assessment of need had been completed. However, a newly admitted resident was yet to have their healthcare needs assessed since their admission. An inspector found guidance given by a healthcare professional in a separate file relating to a new regime around drinking was documented but not acted upon by staff.

Key information pertaining to the healthcare of respite recipients was not on file. During discussions, staff could articulate to inspectors the healthcare regimes of respite recipients and it was clear that they were very familiar with their needs. However, this was not set out sufficiently in writing. The information contained in their files did not show in all cases that a formal assessment of need was conducted. In addition, some respite recipients did not have written protocols in place for staff to follow in relation to their healthcare needs. For example, guidance regarding diabetes, epilepsy and asthma was not found in the file of all respite recipients with needs in this area. The person in charge attended to this issue immediately and confirmed both during and following the inspection that healthcare plans had been devised for all respite recipients who required same.

The needs of some residents were such that they required a wide range of level of support from staff in their eating and drinking. Where required, each resident had their own individualised eating and drinking regime (as prescribed by a speech and language therapist). This information was displayed in each unit for all staff to see. The organisation maintained a policy on nutrition and hydration. Each resident's person-centred planning folder contained details of the resident's particular food likes and dislikes. Residents had their main meal either in the day centre or in their home. Staff prepared meals for the residents and residents were also facilitated to go to restaurants and cafes in line with their preferences. The inspector found adequate quantities of food available for snacks and refreshments.

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):

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

Findings:

Procedures were in place for medicines management; however, improvements were required in the recording of medicine administration and the auditing of same. The actions arising from the previous inspection had been implemented.

The provider maintained a policy on medicines management. There were local protocols in place that helped staff to understand the medicines management processes in the centre. Medicines were dispensed from the pharmacy in a monitored dosage system. They were kept securely in a locked cabinet in all three units. At the time of this inspection, no resident was prescribed drugs that required stricter controls.

Samples of prescription and administration records were reviewed by an inspector. It was found that the required information such as the medicines' name, the dosage and the resident's date of birth was contained in these records. Prescription charts were dated within six months. The records viewed by an inspector indicated that medicines were not always signed as having been administered at the time indicated in the prescription sheets. This was identified in two files viewed. These errors had not previously been identified during regular medicines management audits that took place at this centre nor by staff members following each occurrence. This was brought to the attention of the person in charge during the inspection who commenced an immediate review of same. At the conclusion of the inspection the person in charge stated that this issue pertained to two files only and it was a recording issue rather than an administration issue. She informed inspectors that she would continue to investigate and implement a plan to address learnings. At the time of finalising this report, the person in charge confirmed to HIQA that she had since met with all relevant staff to share the learnings of these recording errors and had commenced a tailored monthly audit which would specifically audit this issue.

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):

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

Findings:

Inspectors reviewed a copy of the statement of purpose and found it was lacking detail in relation to the mixed nature of the service (residential and respite). Following

completion of this inspection, an amended statement of purpose was provided to inspectors which addressed these issues.

The statement set out the aims, objectives and ethos of the centre. It confirmed management and staffing arrangements and described the services and facilities to be provided. The statement had been reviewed within the previous 12 months and was available to residents and families

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

There was a clear management structure at the centre; however, some of the findings from this inspection show that improvements were required in the provider's oversight at a governance level. There was one action outstanding from the previous inspection regarding the appointment of the person in charge to more than one designated centre.

The management system at the centre was clear. Care assistants reported to nursing staff who in turn reported to the person in charge. During discussions, staff were clear about who was in charge and the management structure. On-call services were provided during out of hours. The residents confirmed to inspectors that they enjoyed good relations with the staff team and knew who was in charge.

There were systems in place for the completion of the annual review of the centre for 2017 and the representative of the provider was aware of the requirements of the regulations in this regard. The annual review of the centre encompassed residents' observations and the viewpoints of family representatives. The person in charge could account for all findings arising from this review and set out progress against same. The findings of this inspection in areas such as personal planning and healthcare planning were indicative of better oversight required by the provider in their six monthly inspections and annual reviews. There was no formal gap analysis conducted at provider

level of resources at the centre, particularly in relation to staffing and the impact of closure of the units to the residents.

The person in charge was employed full-time and was found to have the qualifications, skills and experience necessary to manage the centre. She was also appointed as person in charge for one other centre across a broad geographical area. The person in charge was committed to her own personal development, as evidenced by her continuing professional development. She was supernumerary to the roster. The annual review of the centre identified that she was not supported in her role by any persons involved in the day-to-day management of the centre. The representative of the provider stated to the inspectors at the feedback meeting that they were hoping to appoint a person to be involved in the management of a second centre to which the person in charge was also responsible. This would therefore give the person in charge additional whole-time equivalent in her governance of this centre. This plan was not yet formalised.

Judgment:

Non Compliant - Moderate

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:

The provider was aware of their responsibility to notify HIQA of the absence of the person in charge where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, whether planned or unplanned.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The centre was adequately resourced to ensure aspects of the effective delivery of care and support in accordance with the statement of purpose. However, these resources required on-going review to ensure that the needs of residents were met.

There was a suitable mix of care staff and nursing staff available to assist residents. Residents had choice in relation to activities. The centre was maintained to a good standard internally and externally and had fully equipped kitchens and laundry facilities across all of the units.

However, throughout this inspection inspectors found that there was a need for the on-going review of resources to meet residents' assessed needs and to provide the service as outlined in the statement of purpose. This is also commented on in outcomes 14 and 17. The closure dates of the units and the impact that this may have on the family members receiving the residents into their care also required on-going review to ensure that residents had adequate support and care during times that their homes were closed to them. The person in charge demonstrated awareness of these issues and her response to same. However, there was no formal gap analysis conducted at provider level of these issues. This is actioned in outcome 14.

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):

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

Findings:

Inspectors were satisfied that residents were supported by the staff team in place.

Throughout the inspection positive and warm interactions were observed between residents and staff members who appeared to have a close relationship. Residents who met with inspectors spoke positively of the staff team place and the support that they

offered to residents. Rosters reviewed indicated that a continuity of staff was provided for. Family representatives confirmed a high level of satisfaction in how staff cared for their family member.

Training records reviewed at this inspection showed that staff had received training in areas such as manual handling, medicines management, safeguarding and fire safety. However, as mentioned under Outcome 8, one staff member was overdue refresher training in de-escalation and intervention, while evidence was not provided that agency staff working in the centre had undergone such training.

The previous inspection found that there were a number of volunteers involved with this centre for whom there was no written agreement in place. During this inspection the person in charge had files in place in relation to volunteers and was aware of the requirements to supervise volunteers. A sample of staff files were reviewed and contained all of the required information such as proof of identity and evidence of vetting. However, an inspector viewed a personnel file of an agency staff member and the required documents were not on file in accordance with Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

On this inspection, inspectors were satisfied that there were appropriate staff levels in place to meet the needs of residents present while nursing care was also provided for. However, it was observed that the levels of staff in one unit of the centre during evening times required on-going review with regard to the number of residents present and the size and layout of the unit. The provider had risk assessed this issue and was looking to address this. This issue was also raised in the annual review of the centre conducted shortly before this inspection.

A performance management system was in place within the centre, a process of formal staff supervision was not yet in place within the provider.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Records and policies were in place within the centre; however, a number of improvements were required. An action pertaining to healthcare records identified at the previous inspection was not implemented in full.

A directory of residents was maintained for each unit of the centre and was made available to the inspector, one of which was found to contain some gaps such as date of admission. The day-to-day attendance of residents was not recorded consistently by staff. The person in charge attended to most of these gaps during the inspection.

An inspector reviewed the resident guide for the three units that formed the centre and found that they contained the information set out by the regulations.

The inspector was provided with a copy of an insurance certificate which confirmed that there was up-to-date insurance cover.

During inspections of other designated centres under the auspices of the registered provider in 2017, it was found that a number of the required policies had not been reviewed for over three years as required by the regulations. During the inspection of this centre, inspectors reviewed the policies that were in place in this centre and it was again observed that a number of the policies were dated 2014 and therefore had not been reviewed within the required timeframes.

During the course of this inspection, inspectors viewed a wide range of records and found that there were gaps in aspects of record keeping, for example, there was inconsistency in the frequency of recorded nursing care notes about residents and their day-to-day experience while in the care of the centre. This meant that there were few records available to the inspector on how a resident newly admitted to the centre was experiencing residential care and the care they were receiving. The person in charge accepted that the regularity of record keeping required formalisation. Written agreements between respite recipients and the provider were not all on-site.

Judgment:

Non Compliant - Moderate

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:

Carol Maricle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003707
Date of Inspection:	31 January & 01 February 2018
Date of response:	28 March 2018

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

There were concerns raised by some family representatives of the weekly closure dates of the home of the residents and the impact that this had on the family members who received them to their care.

1. Action Required:

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

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

A review of closures for one area within the designated centre have been carried out. This centre has now reduced its closure times and all families have been informed.

Proposed Timescale: 28/03/2018

Theme: Individualised Supports and Care

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

Residents in the shared double bedrooms had to share furniture.

2. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

A budget has been allocated for the purchase of wardrobes and bedside lockers for residents whom share bedrooms. Residents within these rooms will now have access to their own personal storage space. Awaiting the delivery of furniture.

Proposed Timescale: 02/04/2018

Theme: Individualised Supports and Care

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

Between March 2015 and February 2017 no verbal complaints in one unit were recorded in the complaints log.

3. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

The PIC has provided updated training on the organisations complaints policy to all staff working within the centre. All staff are now aware of the process in how to record complaints.

Proposed Timescale: 28/03/2018

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:

There had been no formal assessment of need carried out in the case of a new admission to the centre.

4. Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

The PIC arranged an MDT assessment of needs for this resident which was carried on 25-1-18. The PIC has scheduled a PCP meeting with the resident's family.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

An adequate assessment of need was not in place for all respite recipients.

5. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC has arranged an MDT review for all respite residents who attend the designated centre.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

A personal plan had not been created for a new admission within 28 days of their transition to the centre.

6. 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.

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

The PIC has identified a person to develop a support plan for the specific resident. A PCP meeting has been arranged with the resident and their family to inform the support plan.

Proposed Timescale: 09/04/2018

Theme: Effective Services

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

Personal planning arrangements for respite recipients did not demonstrate a review of same.

7. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

The PIC has developed a schedule for reviewing all respite support plans. The PIC has arranged for staff to meet with respite service users, their GP and their families to complete OK health checks and to obtain full up to date information on all of their medical needs to inform their health action plans.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

Not all residents had been involved in the review of their personal plan.

8. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The PIC will ensure that all residents are present for their PCP meeting and that there is documented evidence of same.

Proposed Timescale: 28/03/2018

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 resident did not have a risk assessment in place relating to choking. The risk assessments of a new admission required updating. Not all hazards pertaining to individual residents had been identified as such and therefore lacked an assessment of their risk.

9. 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 PIC has completed a risk assessment on choking for the specific resident. Individual risks are currently being updated and reviewed where risks have been identified a risk assessment will be carried out and documentation of the risk will be kept within the persons support plan.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

Fire doors were required in one unit of the centre. In another unit fire doors were observed being held open by furniture.

10. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The PIC has reiterated to all staff that fire doors are not to be held open by any objects.

The organisation facilities manager carried out a survey which involved all designated centre around fire precautions/safety where fire doors and or magnetic locks were appropriate required. The CEO has submitted this survey finding with a request for additional funding to carry out these recommendations to the HSE the organisation is

awaiting response from the HSE.

Proposed Timescale: 31/03/2018

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:

One staff member was found to require refresher training in de-escalation and intervention while evidence was not provided that agency staff working in the centre had undergone such training.

11. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

The PIC has arranged for updated training in de-escalation and intervention. This is scheduled for the 29-03-18. The staff member has been informed and has agreed to attend this training. The organisation HR department has liaised with agency service provider to ensure any staff allocated to the centre will have evidence of participation in training in de-escalation and interventions submitted to the organisation HR files.

Proposed Timescale: 29/03/2018

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:

An incident of a safeguarding nature had not been notified to HIQA as required.

12. 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 PIC met with the Designated Officer and a plan was made to meet with all staff to outline the importance of notifying all incidents of peer to peer abuse to relevant stakeholders.

All staff have received training in safeguarding the vulnerable adult.

All PIC's in the organisation met with the DO who again reiterated the importance of

reporting all incidents of abuse and the systems for reporting these incidents.

Proposed Timescale: 28/03/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Not all residents had a formal assessment of their healthcare needs completed. Not all residents had healthcare management plans in place to address established healthcare needs.

13. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

The PIC has put in place a schedule for key workers in consultation with the relevant allied healthcare professionals to review and develop health care plans for all residents.

Proposed Timescale: 30/06/2018

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:

Medication administration records had gaps where staff should have signed to confirm administration.

14. Action Required:

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

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

A meeting was held with all staff in the designated centre to discuss a new protocol which has now been put in place to ensure daily recording on all administration charts. The PIC has developed an audit of medication administration charts which will be carried out monthly.

Proposed Timescale: 28/03/2018

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:

While there was a defined management structure this required review as the person in charge was actively managing a second centre across a broad geographic area. This issue had also been identified in the annual review of the centre conducted by the provider.

15. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The Provider nominee has liaised with the HR department a commitment has been made to transfer a PPIM to the second designated centre this process has commenced and a date for the commencement of the PPIM to the centre has been agreed with relevant personal.

Proposed Timescale: 16/04/2018

Theme: Leadership, Governance and Management

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

The findings of this inspection in areas such as personal planning, healthcare and medicines management were indicative of better oversight required by those involved in the management and governance of this centre. There was no formal gap analysis conducted at provider level of issues pertaining to the opening of the units and staffing levels.

16. 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 PIC has put in place an auditing schedule and has identified a specific staff with appropriate skills and knowledge to carry out the audits. The provider nominee will meet with the relevant stakeholders involved with setting opening/closures dates within one of the centres. An agreement has made to reduce the number of closures during the coming year and staffing levels to provide a service during these changed times has been discussed and a plan is in place to deliver a service to residents.

Proposed Timescale: 28/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The levels of staff in one unit of the centre during evening times required ongoing review with regard to the number of residents present in the unit and the size and layout of the unit.

17. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

The Provider nominee is liaising with the HR department and PIC to review the staff levels allocated to the centre specific during evenings.

Proposed Timescale: 31/03/2018

Theme: Responsive Workforce

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

An agency file did not have all of the information contained within it to satisfy the requirements of the Regulations.

18. 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 HR department have been in contact with the agency provider to ensure all information pertaining to schedule 2 is available within the agency staff member file.

Proposed Timescale: 28/03/2018

Theme: Responsive Workforce

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

The annual review of the centre cited a lack of formal supervision and accompanying

policy at the centre.

19. 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 organisation has developed a draft policy on supervision. The organisation has engaged with an external agency who will facilitate clinical peer to peer supervision for the nursing staff on a pilot scheme. The facilitator will meet with level 2 managers on the 27/3/18 to commence this work.

Proposed Timescale: 27/03/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of the required policies had not been reviewed since 2014.

20. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Policy development committee have reviewed policies. Policies which required updating has been approved for circulation a print run date is currently been identified.

Proposed Timescale: 30/04/2018

Theme: Use of Information

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

There was inconsistency in how staff recorded the dates during which residents did not reside at the centre.

21. Action Required:

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

The PIC has developed a protocol for completing the directory of residents and this protocol has been communicated to all staff within the designated centre. The PIC will

carry out an audit of the directory of residents to ensure the protocol is being adhered to.

Proposed Timescale: 28/03/2018

Theme: Use of Information

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

There was inconsistency in the frequency of recorded nursing care notes about residents and respite recipients and their day-to-day experience while in the care of the centre.

22. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The PIC has liaised with the relevant stakeholders and a protocol has been devised for daily records of events for all residents.

The PIC has met with all staff in the designated centre and has informed support staff of the importance of keeping daily records for all residents in the designated centre.

Proposed Timescale: 28/03/2018