

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre B1
Centre ID:	OSV-0005389
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Suzanne Corcoran
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	22
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, 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 decision. This monitoring inspection was unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 July 2017 08:00	13 July 2017 18:40
14 July 2017 08:00	14 July 2017 16:50

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 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection.

This was the second inspection of the designated centre as a standalone centre. Prior to the last inspection the centre had been part of a larger designated centre which the provider had reconfigured.

The inspection was unannounced, the purpose of which was to follow up on actions from a registration inspection completed in December 2016, to follow up on notifications submitted to HIQA and to inform a registration decision.

At the last inspection there were significant failings across a number of outcomes and the provider had submitted an action plan outlining how these failings would be addressed. A new provider nominee had been appointed since the last inspection of the centre.

In response to the findings of this inspection, the provider attended a meeting with

HIQA to discuss the non-compliances and to provide assurances that these would be addressed. This meeting was attended by the provider, a member of the board of management and another senior member of staff.

Description of the Service.

This centre is operated by Peamount Healthcare and is situated on a campus-based setting in County Dublin. It comprises of five units and provides care to both male and female residents who require supports in line with their assessed needs. Direct care is delivered by healthcare assistants and nurses are responsible for residents' healthcare needs and medication management.

How we gathered evidence.

Over the course of this inspection, inspectors met all of the residents living in the centre, except one. Inspectors engaged with residents throughout the inspection in order to ascertain their views on the quality of services provided in the centre. Some of the residents were unable to express their views on the quality of services in the centre but inspectors observed mealtimes, reviewed personal plans and observed interactions between staff and residents.

The person in charge was available throughout the inspection. A clinic nurse manager two who supported the person in charge was also present on the first day of the inspection. One unit was not visited during the inspection as the resident was out at the time.

Overall judgment of our findings.

Inspectors found that of the 29 actions required from the last inspection, 20 were either not completed or were still in progress. One action had not reached the timeframe for completion at the time of this inspection; this was in relation to the annual review of the centre.

Some improvements had been made in relation to residents' rights, personal plans, some fire safety measures and the presence of the person in charge in the centre, however a number of actions had not been implemented or were still in progress from the last inspection. Some of the findings in this inspection were therefore consistent with the findings at the last inspection.

Inspectors found that staff treated residents with dignity and respect. Staff were found to be well intentioned and endeavored to meet residents' needs in the centre. However, inspectors found that insufficient staffing levels in the centre were contributing to the significant failings found at this inspection and that the provider had not addressed this as part of their actions from the last inspection. Inspectors acknowledge that the provider is still endeavoring to employ additional staff in the centre in order to meet residents' social care needs

Notwithstanding this, assurances were sought from the person in charge on the first day of the inspection in response to the implementation of safeguarding plans in one unit. Immediate actions were issued in relation to two other units on the second day of the inspection in relation to safeguarding plans and risk management processes. Inspectors were satisfied that the provider was responsive and had mitigated the risks by the end of the inspection.

The inspectors found that the actions in relation to the premises had not been addressed since the last inspection. However, HIQA acknowledges that the provider had received confirmation that the funding was available to address this prior to the end of the inspection.

In addition to this, the inspectors found that the arrangements in place to monitor and review the safety and quality of the services provided were not effective.

Major non-compliances were found in six of the outcomes inspected against. These included, Outcome 5: social care needs, Outcome 7: health and safety and risk management, Outcome 8: safeguarding and safety, Outcome 11: healthcare needs, Outcome 12: medication management, Outcome 14: governance and management and Outcome 17: workforce.

Three moderate non-compliances were found under Outcome 1: residents' rights, Outcome 5: social care needs and Outcome 6: safe and suitable premises. Two outcomes were found to be substantially compliant under Outcome 13: statement of purpose and Outcome 18: documentation.

The action plan at the end of this report addresses the improvements required.

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:

Overall, inspectors found that some of the actions outlined by the provider from the last inspection had not been fully implemented and improvements were required in residents' rights, privacy and respect in the centre.

Staff members were observed to treat residents with dignity and respect at all times over the course of the inspection. However, inspectors found that some practices required review as they did not ensure that each resident's privacy, dignity and rights were respected.

The practices which required review included: the use of hospital style bibs for some residents, residents' access to their finances which were now stored in a separate unit and, the use of walkie talkies in the units, which were observed by inspectors to be very loud and disturbed residents' meal times when campus checks were completed in the morning time.

As part of the action plan from the last inspection to address the use of personal assistants in the centre the provider had stated that an additional healthcare assistant had been employed in the centre. Inspectors found that this had not been implemented. This is discussed and actioned under Outcome 17 of this report.

The other actions outlined from the last inspection had been addressed. One personal assistant was still in place; however it was evident that the centre had discussed this with the resident and their next of kin.

Inspectors reviewed a sample of intimate care plans. There was improvement in some care plans however; inspectors found that not all care plans were detailed enough to guide practice in supporting residents in personal care in line with their preferences. This had been an action from the last 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):

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

Findings:

Residents did not have access to the Internet in the centre. This was identified on the previous inspection. The provider nominee submitted evidence during the inspection to demonstrate that the IT department were in the process of installing Internet in each unit of the centre.

Not all aspects of this outcome were reviewed as part of this inspection.

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:

Inspectors found that each resident had a personal plan in place and that while improvements had been made to some personal plans viewed, this was not evident in all plans. In addition, some of the actions from the last inspection had not been implemented so as to ensure that residents' social care needs were being met in the centre.

As part of the actions from the last inspection the provider had outlined that a healthcare assistant would be employed in the centre in order to support residents' social care needs. This had not been implemented and the staffing arrangements remained the same since the last inspection. This is discussed in Outcome 17 of this report.

Inspectors acknowledge that the provider is in the process of addressing staffing issues in the centre in order to meet residents' social care needs, including the appointment of a meaningful day services coordinator.

A sample of residents' personal plans was viewed and inspectors found that an assessment of residents' healthcare needs had been completed by a registered nurse. However, this had not been updated to include all healthcare needs and some health action plans were not in place to identify how these needs should be met.

A new social care assessment of need had also been developed for residents. This assessment formed part of the resident's annual review, from which goals were identified.

These assessments were completed by a healthcare assistant who was the resident's allocated key worker. However, the goals identified varied from meaningful goals such as independent travelling and holidays, to activities such as attending hairdressers, buying a mobile phone charger and a walk. Some goals included environmental changes such as widening doors and removing a locker from their bedroom. Inspectors also found that goals were not always reviewed and followed up.

In one unit inspectors found that residents had a varied activation programme during the day and were involved in activities in the community. For example, residents talked about holidays they had been on, going out for coffee and attending an activation unit. However, this was not consistent in some of the other units inspected.

For example, staff spoken with in one unit said that it was difficult to improve social activities for residents as the resources were not always available. Inspectors observed this in practice in another unit whereby a staff member was unable to assist a resident with personal care in order to attend a day activation programme, as there was no other staff available to supervise the care of other residents.

Inspectors acknowledge some residents may not wish to have active social calendars as

they were retired. However, inspectors found that residents were observed sitting for long periods without any activity or meaningful interactions from staff, as staff were busy supporting other residents or completing other tasks in the unit.

Two residents' social care activity records were viewed in one unit. The records indicated that over a 30 day period one resident's activities consisted of a walk four times and the remaining days consisted of watching television, listening to music or no activity was recorded. The other resident's record was similar with the exception of one day where they had attended bowling.

Multidisciplinary meetings were also held regularly to review residents' care in the centre. The minutes viewed by inspectors did not demonstrate how this review was improving outcomes for residents and some of the actions identified had not been followed through.

For example, one resident's behaviour support plan was due to be updated from a meeting held in April 2017 but this had not been completed at the time of the inspection. Inspectors acknowledge that this process is being changed by the provider as part of a wider service improvement plan.

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):

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

Findings:

The inspectors found that the actions from the last inspection had not been implemented.

As part of the actions from the last inspection the provider had agreed to have refurbishment works completed in three of the units in this designated centre so as to ensure that:

- Doorways in one unit were widened to allow for wheelchair access.
- Floor coverings and paint works were updated in three of the units.
- One resident would be provided with a larger bedroom which would in part address

the limited storage available to them.

Inspectors found that none of the actions had been addressed and were informed by the provider that a business proposal had been submitted to the HSE, however to date funding had not been secured to address this. Inspectors acknowledge that the provider submitted an email prior to the end of the second day of the inspection stating that approval had been given for the refurbishment work and the installation of fire doors, which would include widening of door frames.

In addition, inspectors found from observation and a review of one resident's care plan, that the resident was required to hold their hands inside the wheelchair to prevent injury to them while being supported through doorways in the unit.

Judgment:

Non Compliant - Moderate

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:

Overall, the inspectors found that the systems in place to promote the health and safety of residents, visitors and staff required significant improvements to include effective risk management, fire containment and fire safety practices in the centre. An immediate action was issued relating to risk management due to the significance of the issues identified during inspection.

On the second day of the inspection, inspectors observed practice in one unit and observed a resident left unsupervised near the end of their meal who required full supervision. The inspectors had to intervene to inform staff of the risk associated with this practice. The staff member attempted to get assistance from other staff in other units however none were available.

Inspectors reviewed information contained in personal plans for the residents in this unit and found that three residents were at risk of falls, one resident had sustained two unwitnessed falls from their wheelchair, one resident's records indicated that they may require close supervision in the event of leaving the unit and in response to behaviours of concern. It was not clear how risks could be managed for residents in this unit as only one staff member was rostered on duty to support all of the residents.

An immediate action was issued to the provider to provide assurances that appropriate risk management procedures were in place. Inspectors were satisfied that this risk was mitigated by the end of the inspection as additional staffing was put in place by the provider in order to ensure residents' safety in this unit.

The centre had a health and safety statement in place and completed a health and safety audit of each unit monthly.

There was a risk management policy in place which contained the four specified risks as required under Regulation 26. A risk register was maintained in the centre and outlined risks including: fire, falls and medication. Individual risk assessments were in place in residents' personal plans. However, inspectors found that not all risks were appropriately managed in the centre as detailed above.

In addition, in another centre the control measures in place to mitigate the risk of choking for one resident who was identified as being at high risk included the requirement to have all staff trained in basic life support. However, on review of the staff rota and staff training records this had not been fully implemented.

There were systems in place for the prevention and management of fire. There was certification to show that the fire alarms, emergency lighting and fire equipment were serviced on a regular basis. The procedures to be followed in the event of fire were displayed in a prominent place.

Staff and residents spoken with were able to tell inspectors what to do in the event of a fire. The centre completed regular fire drills and each resident had a Personal Emergency Evacuation Plan (PEEP) in place.

However, the issues identified in a fire drill were not appropriately followed up to ensure the safe evacuation of residents. For example, a number of residents in one unit did not take part in a night time drill and their PEEPs were not updated to reflect this and guide staff.

In addition, there were no fire containment measures in some units of the centre. This was identified at the previous inspection. The provider nominee informed inspectors post inspection that funding had been secured to install fire doors in each unit.

The inspectors found that there were appropriate infection control practices in place. The centre employed household staff. Adequate hand washing facilities and personal protective equipment were available throughout the centre.

Staff spoken with were aware of the procedures to be followed for two identified health care associated infections in one unit. There were systems in place for the management of clinical waste.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The inspectors found that there were procedures in place to safeguard residents in the centre. However, improvements were required in the implementation and review of safeguarding plans, behaviour supports plans and staff training.

There was a safeguarding policy in place in the centre; however this had not been reviewed in line with the regulations. Staff met with were aware of the different types of abuse and the procedures to be followed should this arise. However, inspectors found that not all staff had completed safeguarding training in the centre.

Inspectors found that the person in charge and the provider had responded to safeguarding concerns reported in the centre. However, from a review of the notifications submitted to HIQA, from which safeguarding plans had been devised, inspectors found that the safeguarding plans could not be fully implemented. The plans had also not been reviewed to assess their effectiveness, given that similar incidents had been notified after these safeguarding plans had been devised.

Safeguarding plans viewed stated that close supervision of residents was required by staff. Inspectors found that this could not be fully implemented in two units in the centre as there were times during the day when only one staff member was present to support five residents in one unit and six residents in another unit.

For example, on the first day of the inspection the inspectors found from a review of risk assessments, a safeguarding plan and talking to staff that the supervision levels recorded in the safeguarding plan could not be effectively implemented when staffing was reduced to one in the evening times as all residents were assessed as being at risk of falls, two residents were at risk of choking and one resident required close supervision when behaviours of concern escalated.

In response inspectors contacted the provider who was unavailable at that time. In their absence the person in charge was asked to provide assurances that additional staffing would be put in place until the assessed needs of the residents had been appropriately

reviewed and risk assessed. Inspectors were assured that this risk had been mitigated prior to leaving the centre, as additional staffing had been employed in the centre from 20.00hrs to 24.00hrs.

On the second day of the inspection, an immediate action was issued to the provider for another unit where inspectors found that a safeguarding plan could not be implemented. Inspectors were satisfied that this risk was mitigated by the end of the inspection as additional staffing was put in place by the provider in order to effectively implement safeguarding plans.

Other measures outlined in residents' safeguarding plans included the use of familiar staff where possible and that all staff should have completed an induction process to these units highlighting the safeguarding measures in place. Inspectors found that this was not consistently implemented.

There was a policy in place for the management of behaviours of concern. However, inspectors found that some of the behaviour support plans did not guide practice and some of the information contained in the plans could not be implemented in practice.

For example, one support plan viewed stated that all staff should implement a response which required staff training, however not all staff were trained in this area. Another plan stated that staff should refer to a medication protocol in the event that a resident may require it in response to behaviours of concern. However, this protocol did not guide practice as it stated that the reader should refer to this protocol for guidance.

Since the last inspection the use of one environmental restriction had been stopped in the centre. Chemical restraint was being used in the centre in response to behaviours of concern. This medication had been reviewed, however there were no details of how this practice could be minimised so as to ensure that the least restrictive practice was being used.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The inspectors found that residents had good access to allied health professionals. However, improvements were required in a number of areas so as to ensure that residents' healthcare needs were met.

From a sample of personal plans viewed inspectors found that some residents' healthcare needs were not appropriately responded to and there were no records to demonstrate how one healthcare need was being followed up. Staff spoken with said that this would be completed in line with the resident's needs and while clear about how the resident could be supported with this, there was no plan around when staff were going to implement this. The details pertaining to this are not included in this report to protect anonymity and were discussed at the feedback meeting.

There were some plans in place for identified needs; however inspectors found numerous examples of where there were no health action plans in place to guide practice. This had also been a finding at the last inspection.

Health action plans were being reviewed on a four-monthly basis. However, the review did not detail the effectiveness of the plan.

Residents had access to allied health professionals in line with their assessed needs. However, the recommendations were not always fully implemented. For example, one resident's health action plan stated that an increase in activities would improve outcomes for this resident and this had not been implemented.

Another plan stated that a resident's daily food intake should be recorded, however the records only recorded whether meals were eaten and did not outline what the meals consisted of.

In addition, some residents had a detailed meaningful activity assessment completed by an occupational therapist, which outlined varied activities that residents were interested in. However, inspectors found that the vast majority of these recommendations were not implemented for residents and were not incorporated in their annual review.

Inspectors found that residents who had refused treatment had this recorded in their personal plan and that the resident's GP had been made aware of this. However, given the significance of one healthcare need identified inspectors were not satisfied that the appropriate information had been imparted to the resident or their representative in order to make an informed decision around their care.

Breakfast was observed in one unit where it was found to be relaxed and staff were supporting residents in line with their personal plans. However, as outlined in this report the advice of allied health professionals in relation to supports around mealtimes could not always be implemented in other units.

Judgment:
Non Compliant - Major

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:

The inspectors found that the actions from the previous inspection had been implemented. However, improvements were required in a number of areas. Not all aspects of this outcome were inspected against.

There were policies and procedures in place supporting medication management practices in the centre. However, some of the standard operating procedures outlined in these policies did not guide practice in some areas. For example, inspectors found that the procedure for the management of residents who refused medication was not in line with best practice, nor was it being fully implemented. This was discussed at the feedback meeting and is not contained in the body of this report as it may be information that is identifiable to the resident.

Over the course of the inspection, inspectors found some concerns in relation to recording practices that are not in line with best practice. For example, some prescribed topical creams which were over the counter products were not being administered by the nurse who had signed the administration sheet.

In addition, inspectors found that two nursing staff who were responsible for the administration of medication in all the units of the centre were observed to be still administering medications at 10.30am. This was outside the recommended recording times as outlined on residents prescription sheets. Inspectors also observed the administration of medication by nursing staff in one unit were interrupted on several occasions in order to assist residents in the centre.

There were protocols in place for the administration of medication of as required (p.r.n) medication. Staff spoken with were clear about a sample of the protocols viewed by inspectors. For example, the management of epilepsy.

However, one protocol in response to behaviours of concern did not guide practice. For example, the protocol which was in draft format stated that the reader should refer to the p.r.n. protocol for guidance on the administration of this medication. The protocol did not outline clearly when this medication should be administered.

A medication audit had been completed in the centre since the last inspection. Inspectors were informed that only one medication error had occurred in the centre since the last inspection.

Judgment:

Non Compliant - Major

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):

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

Findings:

The inspectors found that there was a statement of purpose available in the centre, however some improvements were required in one area which included:

- The specific care needs that the designated centre is intending to meet was not upholding residents' rights to privacy as the information recorded may identify specific residents. This was an action from the last inspection.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspectors found that the systems in place to ensure that the service provided was

safe and appropriate to residents' needs was not effectively reviewed and monitored as identified in the findings of this report.

The person in charge, who was present over the course of the inspection, informed inspectors that since the last inspection changes had been made to their roles and responsibilities for other areas of the campus and they now spent most of their time in the designated centre. This was confirmed by staff, who stated that they felt supported in their role by the person in charge and a clinic nurse manager.

Supervision meetings were held with staff in the centre and staff said that they felt they could raise concerns at these forums. Staff meetings were held approximately every two months in the centre.

The person in charge reports to the assistant director of health and social care and the director of health and social care. Meetings between the person in charge and the director of health and social care had recently begun to discuss issues arising in the designated centre. In addition, the assistant director of health and social care meets with all persons in charge in the centre on a regular basis.

A clinical audit policy had been completed and a committee had been formed to ensure that actions from audits were being completed in the centre. Two meetings had been held by this committee and a schedule of audits for the year had been established for designated centres. This had been part of the action plan from the last inspection.

An unannounced quality review had not been completed since the last inspection on the quality and safety of care provided in the centre. Inspectors acknowledge that the provider had started unannounced quality walk arounds by senior nursing staff in the centre and a record of these were maintained in the centre.

However, it was not clear how the findings were implemented into practice or discussed with staff. For example, the person in charge informed inspectors that the findings of audits were discussed at staff meetings. However, there was no evidence of this in the records of staff meetings viewed by inspectors.

Judgment:

Non Compliant - Major

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):

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

Findings:

The inspectors found that there was insufficient staffing available in three units in the centre in order to effectively implement safeguarding plans and risk management processes as outlined throughout this report. In addition, three of the actions from the last inspection had not been fully implemented around the review of staffing, staff training and a review of the skill-mix to ensure that residents' needs were being met.

As part of the actions from the last inspection the provider had undertaken to complete an internal review of staffing levels in the centre so as to ensure that residents' needs were being met and that the skill-mix was appropriate to meet those needs. This had not been completed. In addition, the inspectors found that the staffing available in some units of the centre was not sufficient as discussed under Outcome 5, 7 and 8.

Inspectors found that some changes had been made to the nursing supports available in the centre. The person in charge and the clinic nurse manager stated that two nurses were now rostered in the centre from 8.00hrs to 20.00hrs every day.

However, this was not consistently maintained as viewed on staff rotas. In addition, the clinic nurse manager was providing some managerial cover to the entire campus in the evening times while also on the staff roster for this centre and there were no arrangements in place for how this was managed.

Inspectors found that since the last inspection the provider had taken responsive action to the use of agency staff in the centre. The provider had recruited a relief panel in order to reduce the use of agency and provide consistency of care for residents.

A new staff rota had been introduced in the centre that reflected where staff were rostered each day. Changes to the roster were now managed by senior nursing personnel. Any changes to the planned rotas were recorded by these staff and a copy of this was maintained on the centre's computer. Two personnel files were reviewed as a follow up to the actions from the last inspection. Inspectors found that they contained the necessary documents.

Training records were also viewed as a follow up to the actions from the last inspection. Inspectors found that these actions had not been fully implemented and a considerable number of staff had not completed training in the management of diabetes, epilepsy, behaviours of concern and first aid.

Mandatory training records were also reviewed and found that four staff were due refresher training in fire safety, three staff had not completed manual handling refresher training and four staff had not completed safeguarding training. In addition, not all staff had completed training in basic life support despite it being a control measure in place in residents risk management plans.

Inspectors were informed that no volunteers were employed in the centre.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

The actions from the last inspection had been implemented; however improvements were required in the policies and procedures maintained in the centre and residents records. Not all aspects of this outcome were inspected.

Inspectors found that the safeguarding policy in the centre had not been reviewed in line with the regulations. In addition, the medication policy required review as it did not guide practice in some areas and did not reflect the actual practices of the centre in relation to the administration of medication and residents who refused medication.

Inspectors also found that narrative notes were not completed daily for residents and therefore were not assured that identified needs were appropriately followed up. For example, one resident's notes stated that a rash had been observed, a nurse had reviewed this and recommendations had been documented. However, there were no further records after this date noting whether the treatment had been effective.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anna Doyle
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 Peamount Healthcare
Centre ID:	OSV-0005389
Date of Inspection:	13 & 14 July 2017
Date of response:	15 August 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Some intimate care plans in place to support residents were not detailed enough to guide practice.

Some practices in place did not ensure that each resident's privacy and dignity is respected and required review as outlined in the report.

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

1. Action Required:

Under Regulation 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:

1. Practice of using bibs in the centre has now ceased and residents are offered napkins at mealtimes.
2. Residents can now access personal finances in their own homes. In addition a safe will be provided for each individual bungalow in the centre.
3. To reduce noise in the centre the use of Walkie talkies has been reviewed. Usage is to be limited to emergencies only. Daily checks will take place outside of the bungalows at planned times which doesn't impact residents mealtimes.
4. Intimate care plans will be reviewed and details required to guide practice will be included. An audit will be completed to ensure that all intimate care plans guide practice.

Proposed Timescale: 1. Complete, 2. 15/9/2017, 3. Complete, 4. 30/9/2017

Proposed Timescale: 30/09/2017

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:

The assessment of need in some residents' personal plans did not include all identified healthcare needs.

2. 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:

All residents personal plans will be reviewed to ensure that all healthcare needs are included and health action plans will be developed to ensure that these needs are met.

In order to ensure that all care plans are regularly updated a schedule of weekly house meetings for all homes will be implemented. The purpose is to review residents care plans and discuss any concerns arising. An audit will inform improvement in practice.

Proposed Timescale: 30.09.17 & ongoing

Proposed Timescale:

Theme: Effective Services

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

There were no health action plans in place to guide how residents' health care needs were being met.

Some identified goals for residents were not meaningful and some were not followed up on.

Social care activities for some residents were limited in the centre.

3. Action Required:

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

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

1.All Health Action Plans are now in place for residents.

2.In order to ensure that all care plans are regularly updated a schedule of weekly house meetings for all homes will be implemented. The purpose is to review residents care plans and discuss any concerns arising taking account of any changes in healthcare needs. An audit will inform improvement in practice.

3.Social care needs are being reviewed service wide as part of the provider staffing and service review. A new meaningful activities manager has commenced in post to drive the overall social care needs plan for Peamount. This will ensure that goals set for residents are meaningful.

Proposed Timescale: 1. Completed 2/3 Ongoing

Proposed Timescale:

Theme: Effective Services

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

The review of residents needs through mutli-disciplinary meetings held in the centre did not demonstrate how outcomes were improving for residents.

4. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

The MDT process has been reviewed to ensure that personal outcomes and relevant details for each resident are completed and followed up.

Proposed Timescale: Ongoing

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The doors in one unit were not wide enough for wheelchair access.

5. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

This will be addressed as part of the centre's refurbishment works planned to take place in the coming months.

Proposed Timescale: 30/11/2017

Theme: Effective Services

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

Some floor coverings in the centre required updating

Paintwork in some of the units in the centre required redecoration.

6. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

This will be addressed as part of the centre's refurbishment works planned to take place in the coming months.

Proposed Timescale: 30/11/2017

Theme: Effective Services

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

One resident's bedroom in the centre was small and did not provide adequate storage facilities.

7. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

This will be addressed as part of the centre's refurbishment works planned to take place in the coming months.

Proposed Timescale: 30/11/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The systems in place were not robust enough in managing and reviewing risk. It was identified in one unit that residents at risk of falling or choking did not have adequate supports in place to mitigate the risk.

8. 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:

An increase in staffing was put in place to mitigate risk during the last inspection. The provider has completed a full staffing review and recommendations have been made to the HSE around staffing for this centre. The Risk Register has been updated to reflect identified risks. BLS Training has now been completed for all staff in the centre.

Proposed Timescale: 31/08/2017

Theme: Effective Services

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

Information in residents PEEPs were not reflective of residents needs as identified in a recent fire drill

9. Action Required:

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

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

PEEPS will be reviewed and updated to reflect assistance required by each resident.

Proposed Timescale: 31/08/2017

Theme: Effective Services

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

There was no fire containment measures in some units of the centre

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:

This will be addressed as part of the centre's refurbishment works planned to take place in the coming months.

Proposed Timescale: 30/11/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some staff had not completed training in response to behaviours of concern.

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:

4 outstanding staff completed PMAV Training on 10th, 11th August. 10 staff will be booked for refresher training 7th, 8th September.

Proposed Timescale: 30/09/2017

Theme: Safe Services

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

The details set out in some of the behaviour plans viewed did not guide practice for staff.

12. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

All positive behaviour support plans are being reviewed to ensure they guide practice for staff. In addition PMAV refresher training has been scheduled.

Proposed Timescale: 30/09/2017

Theme: Safe Services

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

There were no details of how the use of medication in response to behaviours of concern could be minimised so as to ensure that the least restrictive practice was being used.

13. 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:

1.All positive behaviour support plans are being reviewed to ensure they guide practice for staff. In addition PMAV refresher training has been scheduled.

2.Medication PRN protocols are all being updated following roll out of a new template campus wide. Chemical Restraint is being reviewed with the Medical Team.

Proposed Timescale: 30/09/2017

Theme: Safe Services

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

Safeguarding plans could not be effectively implemented in two of the units in the centre.

14. Action Required:

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

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

An increase in staffing was put in place to mitigate risk during the last inspection. The provider has completed a full staffing review and recommendations have been made to the HSE around staffing for this centre. The Risk Register has been updated to reflect identified risks. Safe guarding plans are being monitored for effectiveness.

Proposed Timescale: 31/08/2017

Theme: Safe Services

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

Some staff had not completed safeguarding training in the centre.

15. 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:

The remaining staff for safeguarding training completed the course on August 15th.

Proposed Timescale: 15/08/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There were no records to demonstrate that appropriate information had been imparted to a resident or their representative in order to make an informed decision around one healthcare need.

16. Action Required:

Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

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

Appropriate health information will be imparted to the resident and staff will record when they discuss this with individual residents. Easy read information will be made available to residents.

Proposed Timescale: Ongoing

Proposed Timescale:

Theme: Health and Development

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

The assessment of need did not include all residents' healthcare needs.

17. 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:

In order to ensure that all personal plans and health care needs are updated a schedule of weekly house meetings for all homes will be implemented. The purpose is to ensure that all healthcare needs are identified and appropriate plans completed.

Proposed Timescale: 30/09/17 & Ongoing

Proposed Timescale:

Theme: Health and Development

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

One health care need had not been followed up in a timely manner.

There were no records to demonstrate how one resident's healthcare need would be responded to or followed up on.

18. Action Required:

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

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

1.A full MDT to discuss healthcare needs of one resident has taken place and records updated accordingly.

2.In order to ensure that all care plans are regularly updated a schedule of weekly house meetings for all homes will be implemented. The purpose is to review residents care plans and discuss any concerns arising. This will ensure that all residents healthcare needs are followed up going forward.

Proposed Timescale: 1. Completed, 2. 30/09/2017 and ongoing

Proposed Timescale:

Theme: Health and Development

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

Recommendations from allied health professionals were not implemented as outlined in this report.

19. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

- 1.The care plans are being reviewed to ensure that all Allied Health Recommendations are being implemented.
- 2.In order to ensure that all care plans are regularly updated a schedule of weekly house meetings for all homes will be implemented. The purpose is to review residents care plans and discuss any concerns arising. An audit will inform improvement in practice.

Proposed Timescale: 30/09/2017 & Ongoing

Proposed Timescale:

Outcome 12. Medication Management

Theme: Health and Development

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

The procedure for the management of residents who refused medication was not in line with best practice, nor was it being fully implemented in the centre.

Prescribed over the counter products were not being administered by the nurse who had signed the administration sheet.

Staff were administering medications outside the recommended recording times as outlined on residents prescription sheets.

The administration of medication by nursing staff in one unit was interrupted on several occasions in order to assist residents in the centre.

One protocol in response to behaviours of concern did not guide practice for staff as it

did not clearly outline when this medication should be administered.

20. 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:

1. Positive Behaviour Support Plan has been completed for the resident who refused medication.
2. The PIC will ensure all nurses are educated on each medication event procedure following the medication events policy guidelines.
3. The Staff Nurses are responsible for the administration of and recording of all prescribed medications including OTC medications and topical creams.
4. The PIC will ensure there is sufficient staffing in place when medication rounds are being carried out so as to ensure there are no interruptions or delays.
5. PRN protocol for one service user has now been reviewed.

Proposed Timescale: 15/08/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The specific care needs outlined in the statement of purpose was not upholding residents rights to privacy as the information recorded may identify specific residents.

21. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Statement of Purpose is being reviewed and a revised copy will be submitted to HIQA.

Proposed Timescale: 31/08/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The systems in place to ensure that the service provided was safe and appropriate to residents needs were not effectively reviewed and monitored as identified in the findings of this report.

It was not clear how the findings of reports generated from unannounced quality walk around by senior nursing staff in the centre were implemented into practice or discussed with staff.

22. 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:

- 1.The PIC meets with Director of Nursing & Social Care on a weekly basis.
- 2.A schedule of weekly house meetings for all homes is being implemented. The purpose is to ensure that all healthcare needs are identified and appropriate plans completed. These meetings will also be used as an opportunity to keep staff informed of quality walk around feedback and relevant service developments.

Proposed Timescale: Ongoing

Proposed Timescale:

Theme: Leadership, Governance and Management

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

A six monthly unannounced quality and safety review of the centre had not been completed.

23. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

An unannounced quality and safety review was completed on July 18th and actions are being followed up in conjunction with this action plan.

Proposed Timescale: 30/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staffing levels in the centre were not sufficient to meet the needs of the residents in the centre in relation to:

- Effectively implementing safeguarding plans in the centre.
- Effectively ensuring that risk management processes could be implemented.
- Ensuring that residents social care needs could be met in the centre.
- To ensure that the skill mix in the centre was appropriate to meet residents' needs.

24. 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:

An increase in staffing was put in place to mitigate risk during the last inspection. The provider has completed a full staffing review and recommendations have been made to the HSE around staffing for this centre.

The Risk Register has been updated to reflect identified risks. Risk Management Training is being provided for all staff.

Safe Guarding Plans are now being effectively implemented in the centre and are monitored through weekly house meetings. Safe Guarding Training is 100% compliant.

Social care needs are also being reviewed service wide by the provider. In this centre a further 0.5 WTE has been requested from HSE to help meet residents needs. A new meaningful activities manager has commenced in post to drive the overall social care needs plan for Peamount. In addition a dedicated activities co-ordinator has been allocated to this centre since 11th August.

Proposed Timescale: 30/09/2017

Theme: Responsive Workforce

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

Some staff had not completed training in order to support residents needs in the centre. This included:

- Basic Life Support
- Challenging behaviour
- Diabetes Management
- Epilepsy Management

25. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- 1.All staff are now trained in BLS, HS/AED
- 2.4 outstanding staff have completed PMAV 10th, 11th August. 10 staff are booked for refresher training between 7th and 8th September.
- 3.Diabetes and epilepsy training is being rolled out at local level.

Proposed Timescale: 1. Complete, 2. 30/9/2017, 3. 30/9/2017

Proposed Timescale: 30/09/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

The safeguarding policy in the centre had not been reviewed in line with the regulations.

26. 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 Safeguarding Policy on the Protection of Vulnerable adults was reviewed and was effective from 13/12/2016.

Proposed Timescale: Complete

Proposed Timescale: 15/08/2017

Theme: Use of Information

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

The medication policy in the centre required review to reflect the actual practices in the centre and to guide staff practice.

27. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with

Disabilities) Regulations 2013.

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

Medication policy has been updated. The policy has been standardised across all centres in disability. The roll out of this policy is underway.

Proposed Timescale: Ongoing

Proposed Timescale:

Theme: Use of Information

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

Daily narrative notes were not consistently maintained for residents in the centre.

28. 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:

Narrative notes will be completed daily and reviewed at the weekly house meetings.

Proposed Timescale: Ongoing

Proposed Timescale: