Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Gahan House
Centre ID:	OSV-0000545
Centre address:	High Street, Graiguenamanagh, Kilkenny.
Telephone number:	059 972 4404
Email address:	lillianbolger1969@gmail.com
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Graiguenamanagh Elderly Association Limited
Lead inspector:	Ide Cronin
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	1

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
▪ to carry out thematic inspections in respect of specific outcomes
▪ 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 wellbeing 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
16 January 2018 09:35	16 January 2018 16:15

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection which took place following an application to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre. The inspector also followed up on areas of non-compliance identified at the previous inspection which took place in July 2017.

As part of the inspection, the inspector met with the provider nominee, person in charge, residents, relatives, visitors and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records.

Funding for the service is granted under a service level agreement with the Health Service Executive (HSE) under section 39 of the Health Act, 2004, voluntary fundraising, and residents' own contributions. This centre caters for low dependent and independent residents and if dependency needs of residents change alternative accommodation is sought for the resident.

The care provided was based on the social model of care as residents had been assessed as not requiring full-time nursing care. A nurse attended the centre 10 hours per week. The inspector was satisfied that this arrangement was adequate and met residents' needs. Nursing documentation reviewed and care observed was to be of a good standard and in-line with evidence based practice.

Overall, the inspector found that residents received assistance and care that was individualised and person centred. Residents reported to be well cared for, happy and content. Residents were supported to participate in meaningful activities. There were strong links between the centre and the community and residents reported that visitors were always made feel welcome.

Residents provided feedback on the service during conversations with the inspector and in feedback questionnaires received by the inspector on the day of inspection. The inspector found that residents could exercise choice in a meaningful way. Residents described what time they got up and went to bed and how they spent their day.

The action plan at the end of this report identifies areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland (2016).

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is 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:
Governance, Leadership and Management

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

Findings:
The statement of purpose consisted of the aims, objectives and ethos of the centre and a statement as to the facilities and services that were to be provided for residents. Non-compliances found in 2015 at the previous registration inspection had not been addressed. Some items listed in Schedule 1 of the regulations were not detailed in the statement of purpose including:

• Information set out in the certificate of registration
• size of the rooms
• arrangements for the management of the designated centre where the person in charge is absent from the centre
•total staffing complement in whole time equivalents.

The inspector noted that the statement of purpose was made available in the front reception area for residents, visitors and staff to read.

Judgment:
Non Compliant - Moderate

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Gahan House is a voluntary centre operated by a board of directors. The board of directors oversee the organisational and financial management of the centre. The board meet on a monthly basis. The person in charge attends these meetings. Minutes of meetings were available for inspection. The person in charge said that the provider nominee would call to the centre on a weekly basis and was always available by phone.

There was evidence of a clearly defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. The inspector was satisfied that the management system in place ensured that service provided was safe, appropriate, consistent and effectively monitored.

Staff with whom the inspector spoke were clear about the management structure and the reporting mechanisms. The inspector saw evidence of continued investment in the centre to ensure effective delivery of care in accordance with the statement of purpose including provision of a clinical room and sluicing facilities. The kitchen prep area had also been refurbished since the last inspection.

The system for reviewing quality and safety of care had improved. An audit program was in place and the inspector saw that a schedule of audits had been undertaken and was planned to ensure clinical indicators were regularly reviewed. The inspector reviewed audits completed by the management team. Some areas reviewed included medicines management, health and safety, infection control, hygiene, nutrition and care planning.

There was evidence of consultation with residents and relatives. Residents and relative questionnaires received by HIQA reflected a high level of satisfaction with care received in the centre. Policies had been reviewed and updated. There was an annual review for 2017 available in relation to the quality and safety of care delivered to residents as required by legislation. This was also readily accessible to residents and relatives.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge changed since the last registration cycle of the centre. She assumed this role in November 2017 and had completed a fit person interview prior to this inspection as she had previously deputised in the role of person in charge for a long period. The person in charge facilitated the inspection process by providing documents and having knowledge of residents' care and conditions.

She demonstrated an adequate understanding of his responsibilities as outlined in the Health Act, 2007, regulations and standards. The person in charge had deputising and on call arrangements in place to ensure management of the centre during her absence. She would often call into the centre in the evenings and at weekends and both staff and residents confirmed this to the inspector.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Only the component of the previous inspection was considered as part of this inspection. On the previous inspection it was found that policies had not been reviewed, implemented or reflected practices in the centre.

On this inspection the inspector saw that for the most part this action plan was completed with the exception of the fire management policy which had not been reviewed since 2013.

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in

charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no period of 28 days or more when the person in charge was absent from the centre. The person in charge is on-call at evenings and at weekends. The deputy person in charge was the assistant manager who has been employed in the centre for a number of years. During periods of leave the inspector was informed that the assistant manager undertook the duties and roster of the person in charge and these arrangements were satisfactory.

Judgment:
Compliant

Outcome 07: 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 provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Measures to protect residents being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place in accordance with Health Service Executive (HSE) procedures which incorporated the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (2014).

Staff who spoke with the inspector demonstrated a good understanding of elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. However, three staff still require up-to-date training in detection and prevention of and responses to abuse. This was also an outstanding action from the last inspection.

The person in charge informed the inspector that there were no residents who displayed responsive behaviours. Training had been provided for all staff in this area as observed by the inspector. There was access to mental health services if required.

A policy, which gave guidance to staff on how to manage responsive behaviours was also available. There was a policy on restraint but the person in charge said the practice in the centre was one of a restraint free environment. The inspector saw that restraint was not common place in the centre and none were in use on this inspection. The inspector saw that the systems in place to manage residents' finances were robust and there were no additional fees payable by residents. The centre did not act as a pension agent for any residents.

The centre did not hold money on behalf of residents for safekeeping. Residents manage their own finances. The inspector saw that each resident had their own personal lockable storage in their bedroom for same.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
Overall, there were measures in place to protect and promote the health and safety of residents, staff and visitors.

There was an up-to-date health and safety statement in place. The health and safety statement was augmented by a risk management policy. The risk management policy outlined broad safety statements, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the regulations were included in the risk register. There was evidence that risk assessments had been implemented in practice and were kept under continual review.

The inspector reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedures to follow in the event of an emergency. The inspector saw that accidents/incidents were recorded. Learning from any incidents that had occurred and any changes to practice was documented in a corrective action plan in the health and safety folder as observed by the inspector.

Staff who spoke with the inspector were knowledgeable around infection control procedures. Hand gels, disposable gloves and aprons were appropriately located within the centre. Clinical waste and containers for used sharps and needles were stored in a secure manner and there was an arrangement in place for the collection of clinical waste.

There were procedures in place for the safe evacuation of residents in the event of a fire. There was a fire safety management policy. However, this has not been reviewed since 2013. This is actioned under Outcome 5: Documentation. Adequate signage was in place displaying the procedure to be followed in the event of a fire. There was a fire safety register that detailed the annual maintenance of fire safety equipment and lighting and the fire alarm was serviced quarterly. Records indicated that there were regular fire drills, the fire alarm was tested weekly and there were daily checks of means of escape.

Training records indicated that all staff had received fire safety training in 2017. Staff members spoken with by the inspector were knowledgeable of what to do in the event of a fire and regular fire drills were undertaken. Residents also told the inspector what they would do in the event of a fire. Emergency exits were seen to be free of obstruction on the day of inspection.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEPs were detailed and outlined any mobility, visual, cognitive and auditory impairments of each resident and the supports required for evacuation. The PEEPs were updated on an ongoing basis by nursing staff to reflect any changes in a resident's condition.

Training in moving and handling of residents was facilitated for staff. Residents were promoted to maintain their independence when mobilising. The inspector observed and staff reported that residents did not have routine manual handling requirements.

Judgment:
Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
There was a centre specific medicines management policy available. The policy outlined

the procedures for ordering, collection, storage, record keeping and administration.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet her obligations to residents, including medicine reviews and resident counselling.

Medicines were stored securely. A designated refrigerator was available to store medicines that required refrigeration and the temperature was recorded daily when the refrigerator was in use as observed by the inspector. Staff confirmed that controlled drugs were not stored in the centre at the time of the inspection but procedures were in place for storage and documentation in line with current guidelines and legislation.

The inspector reviewed a sample of prescription records and saw that they complied with best practice and included the maximum doses of p.r.n (a medicine given as the need arises) to be administered over any 24 hour period. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medicine and reduce the risk of a medication error. The prescription sheets reviewed were clear and the signature of the general practitioner (GP) was in place for each drug prescribed in the sample of drug charts examined.

There was evidence of residents' medicines being reviewed by the pharmacist, nurse and GPs on a regular basis. The staff nurse conducted medicine management audits on a yearly basis. All care staff were trained in medicines management. Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the delivery and collection by the pharmacy, and checking, storage, return and disposal of medicines.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
Residents had been assessed as not requiring full time nursing care. A nurse was employed who attends the centre for 10 hours per week. Additional nursing hours could

be made available as required, for example if a resident was receiving palliative care. Based on these inspection findings, the inspector was satisfied that a good level of evidence based nursing care was delivered to residents in line with their assessed needs.

There was evidence that timely access to health care services was facilitated for all residents. Three GPs were attending to the needs of the residents and an ''out of hours'' GP service was available if required. The records confirmed that residents were assisted to achieve and maintain the best possible health through medicine reviews, blood profiling and annual administration of the influenza vaccine.

Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including dietetics, speech and language therapy, diabetic clinic, chiropody, ophthalmology, dentist and physiotherapy.

The inspector reviewed a selection of care plans. There was evidence of a pre-assessment undertaken by the nurse and a member of care staff prior to admission for residents. After admission, there was a documented comprehensive assessment of all activities of daily living, including communication, social care needs, mobility, elimination, personal hygiene, nutrition and sleep.

This assessment was reviewed and updated at least every four months or in line with a resident's changing condition. There was evidence of a range of assessment tools being used and ongoing monthly monitoring of nutritional need, falls and pressure sore risk. Each resident’s care plan was kept under formal review as required by the resident’s changing needs or circumstances. The development and review of care plans was done in consultation with residents or their representatives and the inspector saw that this consultation was current for the care plans reviewed.

Wound management was seen to be in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. Wounds were examined on a regular basis. The dimensions of the wound were documented and photographs were used to evaluate the wound on an ongoing basis. There was evidence of appropriate input being sought from specialist tissue viability services.

Residents' social care needs were met and residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. There was a range of activities offered including gentle exercise, cards, bingo and music. Residents enjoyed going into the local town to meet friends and to socialise. Residents told the inspector that they were very satisfied with activities and there was always something going on.

Judgment:
Compliant

Outcome 13: Complaints procedures

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:
Person-centred care and support

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

Findings:
The inspector saw that there was a centre-specific complaints policy. However, it did not contain an adequate independent appeals process as required by legislation. A summary of the complaints procedure was not displayed prominently in the centre as required by the regulations.

The inspector reviewed the complaints log detailing the investigation, responses, outcome of any complaints and whether the complainant was satisfied or not. No complaints had been received since June 2017. Residents with whom the inspector spoke with stated that if they had a complaint they would be happy to raise it with staff.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. 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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Gahan House accommodates low dependency residents and there is not a requirement for nursing staff to be present in the centre at all times. The person in charge works Monday to Friday and is on-call at night and weekends. There was also a staff nurse that worked 10 hours per week and is also available to staff at all times. There was a care assistant on duty at all times during the day and night. Staff confirmed that an 'on call' system was in operation to support the periods of lone working and reported that the system was responsive. The inspector was satisfied that there were adequate staffing levels and skill mix to meet the needs of residents.

The inspector reviewed a sample of four staff files and found that they were in accordance with Schedule 2 of the regulations. The person in charge said that all staff members had Garda vetting in place. There were three volunteers working in the centre. The inspector reviewed three files and found that Garda vetting was in place for all volunteers and their roles and responsibilities were set out and agreed in writing. There was a volunteer policy in place dated April 2017.

The inspector saw that all staff had access to relevant statutory instruments, guidance published by HIQA and other statutory agencies in relation to designated centres for older people. The inspector saw that these documents were available to all staff.

Mandatory training in relation to fire and manual handling was up-to-date. Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents. Further education and training completed by staff included first aid, dementia care, medicines management, end of life and nutrition.

Staff with whom the inspector spoke were able to articulate clearly the management structure and reporting relationships. Residents spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Residents told the inspector that call-bells were answered in a timely way. There was evidence of good communication amongst staff with staff attending handover meetings. The inspector viewed minutes of regular staff meetings.

Judgment:
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:

Ide Cronin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Gahan House
Centre ID:	OSV-0000545
Date of inspection:	16/01/2018
Date of response:	01/02/2018

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some items listed in Schedule 1 of the regulations were not detailed in the statement of purpose including:

• Information set out in the certificate of registration
• size of the rooms
• arrangements for the management of the designated centre where the person in charge is absent from the centre

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

•total staffing complement in wholetime equivalents.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose has been updated.

Proposed Timescale: 31/01/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The fire safety management policy had not been reviewed since 2013.

2. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Fire Statement policy has been updated.

Proposed Timescale: 31/01/2018

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Three staff still require up-to-date training in detection and prevention of and responses to abuse.

3. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Training has been booked.

Proposed Timescale: 28/02/2018

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A summary of the complaints procedure was not displayed prominently in the centre as required by the regulations.

4. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
A copy of the complaints procedure has been put on display at the front door entrance.

Proposed Timescale: 31/01/2018

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The complaints process did not contain an adequate independent appeals process as required by legislation.

5. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
Discussions are taking place with some local independent persons.

Proposed Timescale: 28/02/2018