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:	Rosanna Gardens
Centre ID:	OSV-0001711
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Company Limited by Guarantee
Lead inspector:	Michael Keating
Support inspector(s):	Karina O'Sullivan
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
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
▪ 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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
15 February 2018 09:20	15 February 2018 14:20

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the ninth inspection of this designated centre, since the commencement of the regulatory process in the disability sector in November 2013. Previous inspections found this designated centre continued to operate in breach of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

This unannounced inspection was carried out to monitor progress in relation to a representation plan submitted to HIQA (Health Information and Quality Authority). HIQA had issued a notice of proposal to cancel the registration of this centre on 9 February 2017 and this was the third inspection since then to monitor progress. The incompatibility of residents was the core issue identified throughout all previous inspections impacting upon the quality of life of residents and therefore leading to significant breaches in regulation. The provider had consistently failed to address this issue despite submitting plans to provide more suitable accommodation to residents in line with residents assessed needs.

How the inspectors gathered evidence:
This inspection took place over one day, the person in charge and deputy manager were on site at the commencement of the inspection. Subsequently, members of the senior management team including the service manager and Chief Executive Officer

of Sunbeam House Services came to meet inspectors and provide information and updates in relation to revised governance arrangements and transitional plans for residents.

Inspectors met six residents and spoke with three residents. Residents discussed the recent changes in the centre including management changes and of visiting a resident who had recently moved from the centre. One resident also showed inspectors around their new apartment area and expressed their satisfaction with their new living arrangement.

Description of the service:
The designated centre comprised of three houses located on the same grounds. The designated centre was operated by Sunbeam House Services Limited by Guarantee (hereafter called the provider) which is a company registered as a charity.

Overall judgment of findings:
Inspectors found that a number of actions had been taken since the last inspection which had brought about improvements in the care and support provided to residents. The numbers of residents in the centre had reduced by one, as a resident had transitioned to more suitable living arrangement in line with their assessed needs. In addition, further measures had been taken to stabilise the workforce and to increase the support available to residents. While the core issue remained in relation to the incompatibility of residents living in the centre; the reduction in numbers, increased staffing levels and improved risk management had brought about improvements in the centre.

This inspection focused upon seven outcomes in response to findings from previous inspections and the representation received. The centre remained in non-compliance in relation to safeguarding and safety, healthcare and medication management. However, improvement was recognised across all outcomes assessed except within medication management which for found to be in major non compliance the regulations.

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

Theme:
Effective Services

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

Findings:
This outcome was inspected in terms of the transfers and discharge plans in relation to a number of residents. Inspectors found there were suitable person-centred practices in place in relation to the transition of residents, in accordance with their wishes.

Inspectors were informed one resident had moved to another designated centre and this had a positive impact on this resident's quality of life. One resident informed inspectors that they went and visited the resident with staff members in their new home and they planned to do it again in the near future. The resident identified they wanted to see where the resident had moved to and both residents wanted the visit to take place.

Another resident moved internally within the designated centre, this resident spoke with inspectors and showed them around their new apartment. Inspectors also viewed the transition plan in place for this process and noted that the resident had requested a longer time frame for this to occur which had been facilitated. This plan was discussed and agreed with the resident before any changes occurred within the resident's live.

No other component of this outcome was inspected during this inspection.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
This inspection found improvement in the identification, assessment and review of risk in order to promote the health and safety of all residents and staff.

Measures were being taken to help mitigate the risks in the centre with appropriate control measures in place. However, incidents continued to occur which were attributed to the compatibility of residents. The provider had now begun to implement their plan in relation to transitioning of residents, with one resident now moved into more appropriate accommodation in line with their assessed needs. Progress was also acknowledged in relation to the transition of three more residents to more appropriate accommodation. The initial transition had resulted in reduced resident numbers, while the staffing levels were maintained to provide support to the remaining residents. In addition, this had provided more space to residents.

There was a risk register in place which had been recently reviewed in January 2018. There was a clear process in place to refer risk profiles over a specific score to the senior management team and organisational risk committee. Recent referrals included risks in relation to transport and the risk of peer to peer assaults. It both cases it was clear that prompt actions were identified and implemented. Staff spoken with were also knowledgeable on the risk matrix and measures to be implemented. In relation to the identification of environmental risks, it was identified a sharps box was in use which had no tagging system or label for identification purposes this was also identified during the previous inspection.

There were adequate precautions against the risk of fire in place. All residents had up-to-date personal evacuation plans and there was adequate means of escape. There were fire drills at suitable intervals and the fire alarm, emergency lighting and fire equipment were serviced on an annual basis.

The training records identified that two staff members required training in people moving and handling and two staff members required training in the area of fire.

Judgment:
Substantially Compliant

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:
A number of measures had now been introduced to address safeguarding concerns in the centre. However, there remained a high number of peer-to-peer incidents occurring in the centre, which were impacting upon the safety and welfare of residents.

The numbers of peer-to-peer incidents in the centre were reducing but remained at unacceptable levels. However, a number of interventions had recently taken place and there was evidence that these initial measures were continuing to reduce the number of peer-to-peer incidents. These measures included:

-revised staffing levels with an additional staff member on during the day (now six members of staff on each day)
-reduction by one in the number of residents
-reorganising of some rooms to better meet the needs of individual residents
-introduction of improved 'social activity plans' in the evening time when increased incidents had been identified as occurring
-enhanced clinical support with improved access for residents including clinical psychology and psychiatry, access to the HSE mental health team and enhanced behavioural specialist support
-review and reduction in the numbers closed circuit television monitors (CCTV) and door alarms.

The inspectors reviewed all recent safeguarding incidents and the associated actions and control measures. It was determined that all incidents were well managed with appropriate actions taken, such as those listed above, to reduce the likelihood of reoccurrence.

Behaviour support plans were in place as required and these were currently under review. Through the contracting of external clinical psychology services, a priority had been identified to review all of these plans and make them more specific. A training plan had been put in place to involve staff in the development of these plans which was scheduled to commence on the 20 February 2018.

Designated officers were identified and were reviewing all adverse events with the HSE local area safeguarding team.

Rights restrictions were closely monitored and all CCTV cameras had been removed in one of the three houses with a reduction in the number now assessed as required in the other two houses. There was a plan in place to further reduce the number of cameras

following a implementation of a plan to separate the three houses, the main aim of which is to prevent residents freely accessing one another's home without invitation.

Clinical psychology has also reviewed the use of restrictive practices in the centre including the use of medication used to alter behaviour. This review had also involved a referral to a forensic psychiatrist, independent advocate and mental health intellectual disability team (MHID) in order to review and reduce the use of mediation to control specific behaviour.

From viewing 22 staff members' training records, one staff member required training in the area of safeguarding residents and the prevention, detection and response to abuse. Four staff members required training in the area of the management of behaviour that is challenging including de-escalation and intervention techniques.

Judgment:
Non Compliant - Moderate

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:
Healthcare needs of residents were documented within a new health and wellbeing plan. However, inspectors identified these plans contained no date of completion to identify how current this information was; some of these plans were also unsigned by staff members involved in the development of these.

Inspectors identified some healthcare plans did not reflect practice in the service, as some interventions being completed by staff members were not documented. In addition, inspectors also found some interventions were not taking place as specified; for example, fortnightly urinalysis and heart rate monitoring, other examples were identified within other plans. Inspectors viewed another plan in relation to the management of hypertension. There was no evidence of the interventions being carried out as specified within the plan. This was also identified during the previous inspection. These areas were identified to staff members on the day of inspection.

Inspectors also identified healthcare plan reviews did not access the effectiveness of the healthcare interventions in place.

Residents had access to various multi-disciplinary team members such as a G.P. (general practitioner), chiropodist, psychiatrist, optician and counsellor in accordance with the assessed needs of residents.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors identified the medication management system required significant improvement in relation to the management and administration of medication to ensure safe medication management practices occurred within the centre.

During this inspection the following was identified:

- resident's administration sheets did not correspond with what was contained within the label of the resident's medication in terms of dosage and the brand names and generic names where used interchangeably.

- some short-term medications were not discontinued within the administered charts

- some discontinued medications remained within the medication cupboard without being returned to the pharmacy or separated from the medication which was currently prescribed.

- one resident's medication was not recorded as administered. It was unclear if the resident had received the medication, or if the medication went missing from the designated centre.

- one resident's medication was recorded as being administered twice and another medication was not recorded as being administered. This was identified as an administrative error, as the medications were pre-dispensed. Inspectors were informed all medication administrations were to be signed by two members of staff in an effort to reduce errors; however, inspectors found this was not yet effective.

- inaccuracies in relation to the stock balance of one PRN medication compared to the

record of administration. From the records maintained it was unclear if the medication went missing from the centre or if it was an error within the pharmacy when dispensed.

- there was no system in the form of a risk or capacity assessment in place to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences.

- improvements were required in the system in place to review medication errors as inspectors viewed a sample of the 11 errors since the previous inspection. These were reviewed by management; however, some preventative measure were not put in place to mitigate the risk of future reoccurrences. For example, a process to alert staff members to regular medication which was not contained within the pre-dispensed system.

- there was no oversight of the medication management system within the centre as staff members who administered medication completed a weekly self-audit. From viewing these the fundamental deficiencies in relation to medication management were not identified. Inspectors were informed that the person in charge would commence an audit to gain better oversight. While the management in the centre would view the weekly audits, some of the basic components as outlined within the organisations policy were found absent in the sample viewed as outline above.

Medication was supplied to the designated centre from a community pharmacy. Staff members identified the centre had changed pharmacy since the previous inspection. Staff members recorded and checked in the medication once received. There was also daily counting of all medications within the centre, this was implemented in an effort to reduce the volume of errors within the centre.

Inspectors acknowledged some positive changes which had occurred in relation to medication management since the last inspection. Such as, the medication cupboard had been moved from the kitchen to the staff office in one house. The recording system and administration charts had changed; however, as these changes were only recently implemented they had yet to bring about a positive effect to residents.

The designated centre had a written policy and procedure related to the administration, transcribing, storage, disposal and transfer of medicines. This had been reviewed since the previous inspection and was dated 05 January 2018.

Most regular medication was pre-packaged in a pharmacy within an individual self-contained monitored dosage system. PRN medicine was maintained lose within segregated containers supplied by the pharmacist.

Judgment:
Non Compliant - Major

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

Findings:
Management systems had been enhanced to promote and monitor the effectiveness and safety of care to residents. Since the previous inspection changes had been made to the local and organisational management structures. The board had recently appointed a new CEO who was interviewed on this inspection. In addition enhancements had been made to the area management structure, to the person in charge and team leader arrangements within the centre.

The CEO (provider representative) had visited the centre on a number of occasions and was familiar with the key issues in the centre and outlined his short and longer term plans to address these issues. Management at all levels recognised the need to continue to consider the compatibility issue in the centre and to progress with the plan to reduce the number of residents. In this regard the provider's representative outlined the status of properties which were being acquired by the HSE (Health Service Executive) for this purpose. It was confirmed that contracts of sale had been signed for both properties, and the provider was confident that they would be ready to be occupied within 5/6 months. The provider representative also confirmed that that they were not intending to replace residents who moved from this centre. This commitment was confirmed in writing following the inspection. The provider stated they were now seeking to reduce the number of residents the centre was currently registered for from 13 to12. They also committed to submitting an application to reduce the number further to 9 when residents had moved to the new properties referred to above.

There was a clearly defined management structure in place with regular reviews. There was also a revised board structure and membership which had now appointed a sub-committee with responsibility for quality assurance and risk management. The board had also developed an overall governance plan for the organisation. In addition it was noted that the provider had made appointments to a number of key roles, through recruitment or through the appointment of external consultants. These included the appointment of a new complaints and compliments manager, service manager(s) and contracting relevant specialist services such as, clinical psychologist and psychiatrist services.

External training was being provided to the person(s) in charge (across the organisation) in relation to their regulatory responsibilities. Performance management supervision systems were also being implemented with all staff. The person in charge in this centre

was found to be adequately involved in the governance, operational management and administration of the centre on a regular and consistent basis.

There was an annual review of the quality and safety of care in the designated centre and, at the current time, the provider had assigned the responsibility of six-monthly visits and reports to external consultants. The providers representative was clear on his responsibility in this regard in relation to the oversight of these reports.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
There were appropriate staff numbers available to meet the assessed needs of residents.

Recent measures had been taken to provide one to one support to some residents in line with their assessed needs and this a review of rosters indicated this had been maintained. In addition, and extra shift was allocated between 10:00am and 10:00pm in response to the needs of residents. This had increased the overall staffing compliment.

The continuity of care provided to residents has been enhanced through recruitment and the retention of staff which reduced the need for agency staff unfamiliar to residents. The provider had also determined that an additional staff member was required during the night in response to specific needs of residents which they were currently recruiting for. While vacancies remained, recruitment was underway to fill these posts, which included the staffing requirement for a location where some residents are planned to be moving to. It was noted that that 14 staff had been recruited since January 2017.

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:

Michael Keating
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee
Centre ID:	OSV-0001711
Date of Inspection:	15 February 2018
Date of response:	15 March 2018

Requirements

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

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

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
One sharps box was in use which had no tagging system or label for identification purposes.

1. Action Required:

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

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
A new service provider has been sourced. A tagging and labelling system will be provided. Services to commence by 17th March 2018.

Proposed Timescale: 20/03/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Two staff required training in the areas of fire safety and management.

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

Please state the actions you have taken or are planning to take:
Staff requiring training are confirmed for 29/3/18.

A training calendar is in place for the year for all mandatory and elective trainings. This is displayed in the centre and online internally.

Proposed Timescale: 30/03/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From viewing 22 staff members' training records, four staff members required training in the area of the management of behaviour that is challenging including de-escalation and intervention techniques.

3. 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:

All staff requiring MAPA training trained by 31/03/18.

Proposed Timescale: 31/03/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There remained an unacceptable number of incidents occurring in the centre which were negatively impacting upon residents.

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

Please state the actions you have taken or are planning to take:
Incidents are continuing to reduce. A Forensic Clinical Psychologist has commenced training with staff team and will provide oversight with behavioural support plans.

One training session has taken place on the 20 Feb 2018. 2 more are scheduled on the 21/03/18 and the 5/4/18

The Decongregation process has progressed since the inspection & the purchase of Phase 2 property will be completed by 30th March 2018. The refurbishment of that property will commence at that stage, HSE are carrying out the works required SHS are confident that the process of moving residents for phase 2 will be completed by 31/08/18. Once SHS are informed of the purchase of a property, the provider will seek to begin the registration of the proposed new designated centre.

This will further enable residents to move within the centre which has been an effective measure in reducing incidents to date.

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From viewing 22 staff members' training records, one staff member required training in the area of safeguarding residents and the prevention, detection and response to abuse.

5. 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:

This staff member will complete the required training on 25/3/18

Proposed Timescale: 25/03/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some healthcare plans were not reflective of practice.

Some healthcare areas were not monitored as outlined in residents plans.

Reviews did not access the effectiveness of the healthcare interventions in place.

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

Please state the actions you have taken or are planning to take:
The Pic and Deputy have reviewed all plans in relation to healthcare. All are updated and reflect the assessed needs of residents. Specific health care needs have been discussed with residents' GP and pharmacist on 07/03/2018 and guidance has been given re healthcare supports.

All healthcare interventions are documented in Daily Care Plan Log on our internal online system. When a change to healthcare practice is carried out by GP the healthcare plan is updated.

Proposed Timescale: 30/04/2018

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate and suitable practices relating to the receipt, prescribing and administration of medicines was not evident within the designated centre.

A. Brand names were used within some documents and generic brand names where used within other documents.

B. The dosage of some medications was documented in different formats.

C. Some short term medications were not discontinued within the administered charts.

D. One resident's medication was not recorded as administered.

E. Inaccuracies in relation to the stock balance of one PRN medication was evident.

F. The was a system in place for reviewing medication to mitigate the risk of future reoccurrences required improvement.

G. The auditing system required improvement to ensure effective oversight in medication management.

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

Please state the actions you have taken or are planning to take:
A full medication audit is scheduled for 16/03/2018.

All healthcare documentation is cross referenced for consistency in terms of generic or brand-named medication.

All medication dosages have been updated on documentation.

Weekly Kardex audit includes identifying discontinuation of short term medication.

Medication refreshed training has been scheduled 26/03/2018. This is location specific training and all regular agency staff will be required to attend.

Nightly stock balance is in place which is signed by two staff members and has weekly oversight by CSM or Deputy CSM

Documentation on Kardex is provided by pharmacy in relation to medication not dispensed in blister pack.

Oversight by PIC / Deputy PIC is recorded on audit documentation.

Proposed Timescale: 31/03/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate and suitable practices were not in place to ensure returned medicines were stored in a secure manner that was segregated from other medication.

8. Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
A separate locked press has been ordered and will be installed on the 22/03/18. Medications for return will be segregated and returned to pharmacy weekly, the pharmacist will collect medications from the centre and this will be documented accordingly.

Proposed Timescale: 22/03/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No risk and capacity assessment, was completed to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

9. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
Medication Risk & capacity assessment is carried out in the centre. All residents are undergoing medication assessments.

This process considers the will and preference of the resident.

The process is reviewed at specific points and the review informs supports in an individualised manner.

As part of a focused training process (specific to this centre) with our internal medication auditor, training will be provided in terms of all medication storage, administration, and documentation, with specific reference to all aspects of risk assessment and organisational process in line with regulation 29(5)

Proposed Timescale: 31/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From viewing 22 staff members' training records, two staff members required training in the area of people moving and handling and two staff members required training in the area of fire.

10. 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:
Both staff are prioritised for training and this will take place on the 29/3/18

Proposed Timescale: 29/03/2018