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:	A designated centre for people with disabilities operated by Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Centre ID:	ORG-0011334
Centre county:	Carlow
Email address:	mark.blakeknox@cheshire.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Provider Nominee:	Mark Blake-Knox
Person in charge:	Shauna Bradley
Lead inspector:	Kieran Murphy
Support inspector(s):	Mairead Harrington
Type of inspection	Announced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
11 March 2014 10:00	11 March 2014 18:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was a monitoring inspection of a residential service which provided accommodation and support to people with physical disabilities and neurological conditions. The main building provided accommodation in eight single rooms for service users. There were also eight modern bungalows, located around a landscaped courtyard and linked to the main house by a covered passageway.

Inspectors met with the person in charge, members of the management team, staff, volunteers and residents. There was good evidence based care being provided in particular in relation to person-centred planning. All residents spoken with were satisfied with the care. A number of residents expressed to inspectors their anxiety about the future of the centre in relation to transfer of services to community based care. These transfer of care provisions were part of an overall organisational strategy and the service had put robust arrangements in place to support residents through this process.

The inspectors found that the service did not meet all of the requirements of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons(Children and Adults) with Disabilities) Regulations 2013 in relation to:

- risk management
- medication management
- staffing
- adult protection training.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Judgement:
Compliant

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

Findings:
During the inspection the biggest issue raised by residents was their concern about a move from the centre to community based living arrangements. The person in charge outlined that following the publication of the report "Time to Move on from Congregated Settings - A Strategy for Community Inclusion" HSE (2011) there had been an organisational policy that all those living in congregated settings would move to community based residences. The service quality officer was present during the inspection and outlined how residents were facilitated in making this transition to new community options. In the first instance a person had to express a desire to move out. Three current residents had expressed such a wish. A community transition coordinator completed a distinctive identity portrait which was a narrative journey through a person's life. This process also identified the person's wishes regarding where they wanted to live. Further stages in the process involved meeting with other stakeholders like family members, HSE and community housing representatives. Comprehensive documentation regarding this transition was seen by inspectors.

The service also supported residents who did not want to move to community based living. Inspectors saw care plans outlining individual lifestyle needs for 2014 which contained the supports that the service was providing for residents in terms of engaging with their wider circle of support. This included encouraging residents to communicate with county councillors, HSE and the chief executive officer regarding their wishes.

In relation to personal planning each resident had an active file which contained a comprehensive personal care plan. There was evidence that the residents were actively involved in the assessment process to identify their individual needs and choices.

Inspectors reviewed a sample of residents' care plans and found they that had been agreed with each resident. There was evidence also of multi-disciplinary input from the residents' key worker, occupational therapist, general practitioner(GP), speech and language therapist, optician and chef.

A lifestyle facilitator was employed to provide supports to residents to link in with their families, friends and the wider community. The lifestyle facilitator coordinated all the personal assistants for residents and she also matched volunteers with a service user's specific requirements. Each resident also had designated social programme staff who supported residents to participate as fully as possible in the wider community by going to local shops, attending the cinema and any other activities that the resident wished to participate in.

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

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

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

Findings:
There was an up to date risk management policy which outlined hazard identification and assessment of risks. The policy also outlined the measures and actions in place to control risk. However, it did not include measures to control specified risks including unexpected absence of a resident, accidental injury, aggression and self harm.

There was a policy on reporting of high risk events including the use of a notification template for the reporting of incidents to the Authority. There was an incident reporting system in place and inspectors reviewed a sample of incidents for the last six months. Each incident was reported and followed up appropriately. The incidents relating to medication management are discussed in more detail in Outcome 12. In response to reported incidents of falls a prevention and management programme had been introduced and there was an up to date policy available. Each resident had falls risk assessment on admission and an advanced falls assessment was then completed as required.

There were six vehicles available for transporting residents. Inspectors saw evidence that these were all roadworthy, regularly serviced and insured. There was one full time driver who had completed a certified driver's training course. This qualification was valid until 2015 and he was competent to assess other staff members who drove the vehicles.

Inspectors reviewed a comprehensive major emergency plan dated October 2013. This outlined in detail the layout of the building, response processes and contact details in the event of an emergency. Each resident had a personal emergency evacuation plan in their active file in their room. Each evacuation plan was current and included evacuation equipment considerations, means of evacuation and the escape route. As part of the evacuation plan each resident had an individual pendant alarm which could be worn on their person and when pressed notified staff that the resident required assistance.

There was good practice seen in relation to control and prevention of infection. Cleaning staff were observed using a colour coded system for cleaning in accordance with evidence based practice. Cleaning staff were knowledgeable about the correct cleaning techniques to prevent the spread of infection. All laundry was completed on site in a purpose built facility. Residents clothes were marked to identify who they belonged to and there were separate storage space for each residents clean clothes. All linen and towels were washed separately and laundry staff had a good knowledge of infection control principles, in particular the use of alginate bags for any potentially soiled bed linen.

The inspectors reviewed a policy on closed circuit television (CCTV). Inspectors found that CCTV cameras were only operational at all external doors and internal corridors.

Each resident had an individual manual handling assessment which was available for all staff. Personalised hoists and slings were available for residents who required the use of a hoist to transfer. Fixed ceiling track hoists were available in some rooms also.

There was an up to date policy for the management of fire safety. The fire alarm control panel was located on the main corridor and was fully addressable and identified each room with a unique code. The fire alarm system had been tested and serviced in January 2014. There were up to date records of fire drills with the latest fire evacuation drill completed on one week prior to inspection. There were records of weekly and daily fire safety checks being undertaken. Daily checks included escape routes, alarm system and walkie-talkies for use in the event of a fire activation. Weekly checks included lighting, break glass units, signs and smoke detectors. All fire extinguishers had been serviced and certified as fit for use.

In relation to fire training there was evidence of all staff receiving either basic fire training or fire warden training. Training had also been provided on the use of evacuation sheets. In the event of an alarm sounding staff and residents spoken with were aware of the arrangements for evacuation in the event of fire.

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

Judgement:
Non Compliant - Moderate

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

Findings:
There was a robust complaints process and the service quality officer was the designated adult protection training officer. This training encompassed complaints and protection of residents from abuse. Staff with whom inspectors spoke knew what constituted abuse and were aware of the procedures to respond to any allegation of abuse. However the adult protection training officer outlined that approximately 25 per cent staff had not yet been trained in the protection of adults from abuse as required by the legislation. The adult protection policy had not been reviewed since 2008 and required review.

There was an up to date policy on the use of restraint which was in line with evidence based practice. The policy outlined that consent to the use of restraint had to obtained from the resident, and also that there had to be multidisciplinary assessment of the appropriateness of restraint. Restraint in this context included lap belts, bed rails and belts on wheelchairs. The care plans reviewed by inspectors reflected the key points of the policy in relation to multidisciplinary assessment and consent. Care plans outlined risk assessments for the use of a lap belt, use of a bed rail and use of a bed table when in bed. Each risk assessment outlined the consideration of alternatives to the use of restraint. Each restraint was subsequently risk rated and appropriate risk controls were seen. Inspectors also saw a register of all the types of restraint which were in use.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Compliant

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

Findings:
Residents healthcare needs were met through timely access to GP services. Each resident had their own GP and residents were supported to organise their own

appointments for medical issues. Residents had access to allied health care services which reflected residents' diverse needs. There was a physiotherapist employed two days per week and a physiotherapy assistant attended for two hours each day. Inspectors reviewed a sample of residents' medical records. They were found to be comprehensive and contained up to date reviews by speech therapists, neurologists, occupational therapists and audiologists.

One issue that did arise with residents' records was that the records were contained in three different locations. The resident's active file, which detailed personal care planning, was contained in the resident's own apartment; the support file, which contained allied health professional details, was kept in the treatment room; contracts for the provision of care and historical medical records were maintained in the main centre office. The person in charge outlined that this tri-location of records could be reviewed to avoid a communication failure regarding a health issue.

In relation to nutrition the inspectors saw a weekly menu plan with a choice of different dishes for each day. Residents outlined that they could request a different option to the menu if they so desired. The inspectors observed a pleasant dining experience at lunchtime. Any resident who required assistance with eating and drinking was supported in a discrete and sensitive manner.

Inspectors saw evidence that each resident had a malnutrition universal screening tool (MUST) completed. There was evidence that residents were supported and enabled to eat and drink when necessary. For example, one resident with specific dietary requirements had a specific risk management plan for mealtimes. This plan identified swallowing difficulties and instructions were recorded from the speech and language therapist regarding food consistency. The kitchen communication book contained a record of this food consistency plan. As another example of good practice in relation to nutrition inspectors saw a signed agreement with one resident regarding choice at mealtimes that had been co-signed by a doctor. Catering staff had completed recently a course on dysphagia (swallowing difficulties). All catering staff had up to date food safety and hygiene training. Inspectors saw an environmental health officer report from February 2014 which indicated that operational hygiene was generally satisfactory.

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

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
There was a policy on prescription of medication which had been approved in 2011. Inspectors saw that the pharmacist transcribed the prescription on to the medication administration sheet. This transcription was then signed as accurate by the GP.

Inspectors saw evidence that the pharmacist was involved in the reviewing of residents' medications on-site on a regular basis and provided advice and support to staff. The input of the pharmacist had been sought in relation to medication management policies and procedures. Medication was dispensed in blister packs for each resident. Unused medication was stored in a closed tamper proof box and then returned to the pharmacy.

There was a standard operating procedure on the administration of medication from a blister pack system. Each medication administration record had a picture of the resident and a picture of the prescribed medication available. The procedure outlined that, in accordance with best practice, medication must be administered at the right time. However, the medication administration record outlined that medication was to be administered at breakfast, lunch, tea and dinner time. This did not accord with the centre policy as it did not have a specific time for the administration of medication.

There was evidence that each resident was encouraged to take responsibility for their own medication in accordance with their wishes and preferences. There was a policy on self administration of medication. Two residents had been risk assessed as being suitable to take their own medication. The staff monitored the daily self administration of medication by the resident. As an example of good practice inspectors reviewed a record of a meeting which outlined that a discussion had taken place with the resident on the management of their own medication. Following this meeting the resident had a preference for staff to administer the medication and this choice was respected.

There was a current standard operating procedure on the reporting and recording of medication errors. Inspectors reviewed the reported incidents relating to medication since June 2013. There had been six incidents relating to medication management. Care staff had been trained in the safe administration of medication which was a two day course. Some staff spoken with felt that more comprehensive medication management training was required.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. The quantity of controlled medications was checked by two staff at 08:00 hrs and 20:00 hrs. Nursing staff displayed a good knowledge of controlled medications and the procedure outlined for administration.

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
The person in charge had responsibility for another centre. The person in charge was a registered general and psychiatric nurse with extensive experience of healthcare provision in both the acute and social care settings. There was an assistant manager who deputised in the absence of the person in charge. Both the person in charge and the assistant manager demonstrated sufficient knowledge of the legislation and their statutory responsibilities.

There was a clearly defined management structure which identified the lines of authority and accountability. The head of care had responsibility for clinical practice. There was a recently appointed care team leader who had responsibility for ensuring that each resident had care which was appropriate and evidence based. The management team also consisted of a head of support services and a residents' life style facilitator whose main responsibility related to resident's choice in relation to coordination of support to residents. The management team was well supported by the service quality officer, particularly in relation to the transition of residents to community based living. Residents spoken with were satisfied that the centre was managed and administered in a consistent manner.

There was an annual review of the quality and safety of care and support. The person in charge conducted an annual individual service review with the resident, their family, key worker and their GP. This service review included issues like supports needed by the individual, what support networks were in place in the wider community for the person, medical supports, civil rights requirements like voting and the resident's wishes about where they wanted to live. A copy of this service review was kept by the resident.

There were management systems in place to review whether the service was safe and appropriate to residents' needs. The registered provider attended the centre on a six monthly basis. During this visit care and support issues were identified and the person in charge implemented an action plan in relation to quality of the service. Some issues identified included reporting and follow up of incidents and enhanced falls prevention programme. Inspectors saw evidence that these items had been implemented.

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

Theme:
Responsive Workforce

Judgement:
Non Compliant - Moderate

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

Findings:
The centre employed 63 staff. There was also an extensive volunteering programme in place which included community employment participants on a community employment scheme in association with FAS.

Inspectors reviewed a sample of staff files and all files met the regulatory requirements in relation to Garda Síochána vetting, documentary evidence of relevant qualifications, photographic identification and two written references.

A lifestyle facilitator coordinated all the personal assistants for residents, community employment workers and volunteers. Three volunteers had been placed via the European Voluntary Service (EVS) programme. Each of these volunteers had to submit an expression of interest and an independent assessor inspected the service to see if it was suitable for placement. A police check was undertaken by the EVS programme. Twelve local volunteers were on placement. There was a handbook for all volunteers, a completed garda vetting form, a signed application form, three references and photographic identification. Two people were on placement via the community employment scheme coordinated by FAS. These community employment placements were subject to garda vetting by FAS.

In relation to staffing levels there was a minimum of four staff on duty between 08:15 hrs and 22:00 hrs. Two night staff were on duty between 22:00 hrs and 08:15 hrs. Nursing staff were employed between 08:00 to 17:00 between Monday and Friday. There was no nursing staff on duty at night and nurses were not on duty at the weekend. However, there were arrangements in place for a nurse to attend for three hours at some stage during the weekend. There was an on call system at the weekend for nurses and management should staff have any queries. The centre also provided support to two former residents who lived independently in the community. In the event of an emergency situation for one of these residents between 22:00 hrs and 08:15 hrs the arrangements were that one of the two staff members on duty would respond, thereby leaving only one staff member behind in the centre. Inspectors formed the opinion that staff levels at night in relation to responding to external emergencies and

nursing cover should be formally reviewed.

The care team leader who was a registered nurse had responsibility for ensuring that each resident had care which was appropriate and evidence based. This responsibility extended to clinical supervision of all non-nursing staff. Inspectors formed the opinion that while the quality of care was good this level of supervision of care was not adequate. The person in charge did clarify at a 0.5 whole time equivalent nursing post had recently been filled and this position was due to be part of the roster from 31 March 2014.

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Kieran Murphy
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Cheshire Foundation in Ireland (t/a Cheshire Ireland)
Centre ID:	ORG-0011334
Date of Inspection:	11 March 2014
Date of response:	28 April 2014

Requirements

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

Outcome 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 risk management policy did not include measures to control the specified risk of the unexpected absence of any resident.

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

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (i).

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

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the specified risk of accidental injury to residents, visitors or staff.

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

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (ii).

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the specified risk of aggression and violence.

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

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (iii).

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the specified risk of self-harm.

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

Please state the actions you have taken or are planning to take:
Cheshire Irelands current Risk Management Policy to be reviewed and revised based on the requirements outlined in Regulation 26 (1) (c) (iii).

Proposed Timescale: 31/05/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received training on the protection of residents from abuse.The adult protection policy had not been reviewed since 2008.

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:
All identified staff to receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse or participate in refresher training.

Cheshire Irelands current Adult Protection Policy to be reviewed and revised by the Service Quality Manager and Service Quality Team.

Timescale:
1) All identified staff to receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse or participate in refresher training: (Proposed Timescale 31st August 2014) Person responsible: Service Manager
2) Cheshire Irelands current Adult Protection policy to be reviewed and revised by 31st May 2014, Person responsible: Service Quality Manager.

Proposed Timescale: 31/08/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The medication administration record did not have a specific time for the administration of medication.

Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated

centre is stored securely.

Please state the actions you have taken or are planning to take:
Mars sheet will be amended to include times.

Proposed Timescale: 31/05/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive medication management training was required for non-nursing staff.

Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
The current Medication Management training programme has been reviewed by the Head of Clinical Support Services, further training and education has been developed.

Proposed Timescale: 31/05/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels at night in relation to responding to external emergencies and nursing cover on the weekends should be formally reviewed.

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:
1) 0.5 whole time equivalent nursing post commenced on 31st March 2014, vacant position at time of inspection-now filled

2) This has been reviewed and a Nurse to be rostered over the weekend period.

3) Manager on call system will provide 24 hour / 365 day out of hours cover

Proposed Timescale: 31/07/2014

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Non nursing staff did not receive adequate supervision.

Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
(a) To support supervision of non-nursing staff, a Regional Education Facilitator has been appointed, to monitor and feedback on the quality and appropriateness of care and clinical supports provided by staff.
(b) Formal 1.1 supervision will take place once per month, person responsible: Human Resources Manager.

Proposed Timescale: 31/05/2014