

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002972
Centre county:	Dublin 24
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Linda Moore
Support inspector(s):	Liam Strahan (Day 1) Valerie McLoughlin (Day 2)
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
18 March 2015 10:30	18 March 2015 18:30
19 March 2015 10:00	19 March 2015 18:50

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration inspection was announced and took place over two days. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors received questionnaires from residents which were complimentary of the service being provided at the centre.

Inspectors visited three locations where residents resided. They met with residents and staff in these locations. Inspectors also met the management of the service and a fit person interview was carried out with the person in charge. She was found to be

knowledgeable of her role and the requirements of the Regulations.

As many of the residents are out during the day, part of the inspection took place in the late afternoon and evening, when residents had returned from their day activities. All residents had an intellectual disability.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met effectively. Inspectors found that residents' healthcare needs were met. Residents were supported to develop and maintain personal relationships and links with the wider community.

The houses were clean and had a warm, hospitable atmosphere and inspectors found that the residents were comfortable and confident in telling the inspectors about their home. However, not all of the premises met the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. There was currently no plan to address the deficits in the premises.

While evidence of good practice was found across all outcomes, some areas of non compliance with the Regulations were identified.

These included the arrangements for the management of residents' finances in line with the policy, aspects of fire safety and the provision of training to staff around the specific care needs of residents, aspects of medication management. Other areas for improvement included the development and implementation of residents' personal plans, implementation of the risk management policies to guide staff practices, the complaints procedures, the contract for provision of services and the statement of purpose. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that resident's rights, dignity and consultation were well maintained. There was evidence that residents have opportunity to contribute in how the centre is planned and run.

Residents gave numerous examples of how they were involved in the running of the centre for example, deciding on their own meals and assisting to keep their bedrooms clean.

Residents told inspectors about their involvement with their local community including trips to the supermarket, visiting family members, going to the hairdressers and local shops and going out for a meal and a drink.

Inspectors reviewed the complaints recorded, a complaints log was in place which showed that complaints were being addressed. The complaints procedure was available in an accessible format. The Person in Charge was knowledgeable of her role within the procedure. However the policy did not fully meet with the requirements of the Regulations. See outcome 18 regarding policies. Residents expressed familiarity with who they could make a complaint to, and they described how the staff were available if needed. Meetings were held with an external advocate if required.

Inspectors reviewed resident's personal plans. They informed residents on issues such as rights, diet and their goals.

During inspection, staff were seen to treat residents with dignity and respect, facilitating

individual routines and practice in a manner maximising residents' independence. Support plans showed that staff facilitated residents to exercise civil, political and religious rights. Residents were supported to access mass in the local church.

There were some opportunities for residents to participate in activities that are meaningful and purposeful and reflected their interests and capacities, however this could be further developed. Activities are planned for the residents with the residents. However many of the residents and staff said that there was insufficient staffing levels on duty at times to provide meaningful activation for residents, for example, many of the residents went out to group activity as there was not the staff to take them for an individual activity they enjoyed. Some residents had to cancel activities if some of the older age residents did not want to go out. This did not meet the individual needs of residents in line with their age range and needs.

There were many examples of where residents were supported to be independent and develop skills within the home or learn leisure skills. Inspectors found that the way in which staff supported residents showed their understanding of each person and the unique way that their disability impacts on them individually.

Many of the residents were seen to be facilitated with day services which they said they enjoyed. Others chose to remain at home and their choice was facilitated.

There was a policy protecting residents' property and monies which overall was seen to be implemented in practice. Residents retained control over their property and where monies are held by the centre there is transparent procedures around this to protect both residents and staff.

The provider had developed a policy to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. However, inspectors found that resident's finances were not fully managed in accordance with their own policy. Balances were checked and were correct; however, all entries were not always signed by two staff members or the resident. See outcome 18.

Judgment:

Substantially Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the person in charge and staff responded very effectively to the

communication support needs of residents. However there were small areas for improvement.

Relevant information was available throughout the centre in accessible formats. For example, menu choices were available in picture format to support residents making a choice. However, this could be further enhanced to include the resident's daily routine, which was not presented in pictorial form to support residents communication needs.

Inspectors reviewed minutes of the weekly residents' meetings which showed that residents have input into their menu and house activities, as well as the opportunity to express any issues, shopping needs or individual activities that they would like to plan for that week. The activities were seen to be meaningful, purposeful, appropriate to residents' needs and affirming individual talents.

Staff were aware of the communication needs of residents and these were clearly described in the communication passport on file for each resident.

Residents told inspectors that they had access to magazines, radio, TV, and telephone. Internet access was not consistently provided to residents to enhance their communication needs and promote their full capabilities.

Judgment:

Substantially Compliant

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

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

There were no relatives visiting at the time of the inspection. Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly. While residents visit their families, they often requested to return to the centre as they described this as their home. Residents were supported to maintain friendship with those they knew in their day centre.

While staff told inspectors that family were very involved in the residents' annual assessment goal setting, there was no evidence of this participation.

Both residents and staff confirmed that there was limited space available to meet a visitor in private, they could use the residents bedroom, the office or the sitting room if this was free at the time. See outcome six.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors reviewed and found that the admissions policy set out the arrangements and guided practice regarding admitting new residents to the centre. The admission process considered the wishes, needs and the safety of all residents in the centre.

A draft contract of care template was shown to inspectors, this had not been provided to residents as yet. The contract when completed would detail the supports, care and welfare of the residents in the designated centre and include details of the services to be provided for that resident.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

Each resident had a personal plan and inspectors reviewed six of the plans. There was not a consistent approach to the development of the plans. The current model of personal plans did not support the development of current needs and choices of all residents. In particular for those residents with a diagnosis of dementia. The personal plans were not available in an accessible format.

The records of the goal setting and evaluation of the plans did not demonstrate the good practices delivered. There was some evidence of regular review and participation of residents in the development of their plans, these were reviewed at the weekly team meeting. However, the assessment did not have multidisciplinary input and did not inform the personal plans. Staff found the documentation cumbersome and it was difficult to find relevant information in the files. It was not apparent if the goals set had been realised.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. While there were individualised risk assessments completed for some residents to ensure continued safety of residents, these were not consistently completed for all residents and did not detail the actual risk and additional control measures required to minimise the risk of future occurrences.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The physical environment in the centre does not meet the requirements of the Regulations. Adequate private and communal accommodation including adequate social, recreational, dining and private accommodation was not provided in all service units.

There were an insufficient number of accessible baths, showers and toilets available for residents. There was no plan available to address the deficits in the premises.

The centre consisted of three service units. There were two semi detached houses which had access to each other and another service unit in the same housing estate.

One service unit contained six single bedrooms, five of the bedrooms were used by residents and the other bedroom was used as an office space and a bedroom which was

used by the sleepover staff. One of these bedrooms was ensuite and was located on the ground floor. Other facilities included a separate kitchen and dining area, separate sitting room and dining room with limited accessibility to the back garden area. There were two bathrooms on the first floor, one of these contained a shower, toilet and sink. The shower had a step into it and was small therefore, it posed challenges for staff supporting residents with a shower. The second bathroom had a step into the room. It contained a bath, sink and toilet. Many of the residents said this bathroom was inaccessible to them.

The second service unit had four bedrooms, one of these was a twin room and another bedroom was used as an office space and a bedroom which was used by the sleepover staff. There was a separate kitchen area, the sitting room was adjoined to the dining room. There was one bathroom on the first floor, which contained a shower, toilet and sink.

The third service unit was a detached two story house for six residents which contained two bedrooms on the ground floor, one of these was ensuite, which was inaccessible to the resident using the room due to its size. There are four single bedrooms on the first floor. There is one bathroom on the first floor, which contained a bath, sink and toilet. Staff told inspectors this was used by two residents.

All other residents used the bathroom which was located off the dining room on the ground floor. Communal space was limited, it included a kitchen/lounge area and a conservatory off the kitchen area. There was space for five residents to sit in the lounge area. The dining area which is in the conservatory at the back of the house accommodates six persons. Staff told inspectors and they observed that the lack of communal space was exacerbating residents behaviour that was challenging.

Inspectors found that the service units were clean, warm and homely. However the bathrooms and some of the bedrooms were in need of painting.

All residents except two had their own bedroom, the two residents enjoyed sharing the room. The regional manager said that resident would not share a room when these residents no longer requested this. Inspectors found that there was sufficient communal space in two of the service units, this was not the case in the third location where six residents and up to three staff lived.

There was an inappropriate numbers of bathrooms, showers and toilets to meet the resident's needs. There were no toilets on the ground floor in two of the units and this did not promote the independence or continence of these residents.

Residents in the third service unit accessed the toilet and shower unit through the living area.

Inspectors were invited by some residents to visit their bedrooms which were well kept and of suitable size to meet their individual needs. Rooms were decorated in accordance with the wishes of the resident and contained personal items such as family photographs, posters and various other belongings.

The entrance to the units was sufficiently accessible for all the current residents who lived there, this was not the case from the rear of the house due to the steps from two of the houses.

Inspectors saw invoices of regular maintenance in the house and there were records that any maintenance requirements were attended to promptly.

There was sufficient storage in residents' bedrooms for their clothes and other personal items.

There was a kitchen/dining and sitting room in each apartment. Residents had unrestricted access to their kitchen.

Residents had limited access to a back garden, but could access this with support from staff.

Inspectors observed that the unit used by a resident with dementia were not designed in accordance with best practice for residents with dementia. The layout did not include any landmarks, cueing or highly distinctive visually unique elements to help to orientate residents with dementia. These areas did not include appropriate signage, and did not use colour and lighting in line with best practice dementia care principles.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors generally found that the provider had put risk management measures in place; however, they needed to be improved. For example, risks associated with fire safety. The systems for the identification, assessment and management of risk required improvement and measures put in place following adverse incidents to prevent them recurring required improvement. The centre has policies and procedures relating to health and safety and these were seen in practice. There was however no policy for infection control.

Inspectors found that there were Health and Safety Statement for each location.

There was a risk management policy in place. This had been recently developed and was in the process of being rolled out. Staff had not received any training on the policy. While staff had started to populate a local risk register, it did not include all risks

associated with the premises.

At the time of inspection, there was no infection control policy available to inspectors. Inspectors found there was an absence of appropriate measures, such as hand sanitizer, within the units.

Staff were not knowledgeable in the development of the register, for example, the control measures recorded were not adequate to mitigate the risk. They told inspectors they had requested this training. All risks were also not included, such as skill mix and limited access from the rear of the units, for example. The person in charge and regional director said they were actively addressing this. There was no date confirmed for this training.

The person in charge undertook a review of all incidents and accidents and the findings of this review were discussed with staff at the weekly management meetings by the team leaders and discussed at the quality and safety meetings. Inspectors reviewed the reports and noted that the information was not being fully analysed to improve the service and this was a missed opportunity to share any learning for the period.

Inspectors found that a number of the incident reports were incomplete, they did not fully include the incident which occurred and the outcome to the resident. This was similar for reporting of and learning from medication errors. Staff were provided with a report spreadsheet of the incidents, which they said did not provide meaningful information and they said that they did not have access to the necessary information following an incident to effect change. Investigations were not always robust and did not ensure that the learning had taken place and improvements implemented as a result.

Inspectors found that there were centre specific emergency plans in place and staff were familiar with them. This detailed the procedure for evacuation, contact numbers and the location of mains valves for electricity, water and gas (where applicable). The plan also included the location of alternative accommodation and means of transport should these be needed.

Fire safety

Overall while fire safety was well managed, however, there were areas for improvement. Inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the Regulations. However, the fire training did not include the use of fire fighting equipment, inspectors were informed that this was planned to be included in the next training.

The records of fire drills were detailed and included learning outcomes. However, there was no plan to address the areas identified. For example, Inspectors found that the staff had not taken all measures to ensure one resident who used a chair lift in the event of a fire could be safely evacuated. The person in charge said this would be reviewed the day after the inspection.

There was evidence that fire equipment was serviced regularly. There was evidence that the fire extinguishers, fire alarms and emergency lighting were serviced. Inspectors found that all fire exits were unobstructed on the day of inspection. While there was adequate means of escape, Inspectors also noted that the provider had not ensured that there were adequate arrangements for containing fires. There were a limited number of fire doors in the houses and those that were there, inspectors found that the intumescent strips had been painted over, therefore they would not provide an appropriate seal to prevent the spread of smoke in the event of a fire. The regional manager said they were aware of this and were actively addressing this.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff had received training on safeguarding vulnerable adults. Further training was planned to include the national policy.

The policy on safeguarding residents from abuse contained guidelines on how any allegations of abuse would be managed. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had. Residents were knowledgeable of who they could talk to if the need arises.

There was evidence that incidents of all allegations of abuse were appropriately investigated and managed in accordance with the centres policy.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff maintained resident's privacy during the delivery of intimate care. All residents had an intimate care plan in place, but they did not consistently guide care. Overall residents confirmed that they felt safe and described the staff as being very kind and supportive.

There was a policy on the management of behaviours that challenged, which was being used to guide the care delivered. Training had been provided in this area and staff said that further training was being planned. There was evidence that the General Practitioner (GP), psychology and Psychiatric services were involved in the care as required.

Inspectors noted that the consistency of staff in one unit had been instrumental in the management of residents behaviours. Residents were reviewed at the positive behaviour supports committee, however staff did not receive meaningful feedback from this meeting to effect change. Multi element behaviour support plans were in place for all residents with behaviour that challenges.

Overall restrictive practices were used infrequently in the centre. However, not all staff had received training in restrictive practices. Staff had identified that they were using one type of restrictive practice in two of the locations in the centre. Inspectors found that the processes needed to be improved in line with the Regulations. Residents who used any form of restrictive practice were not reviewed at the positive behaviour supports committee and the incidents of the use of the restraint were not all recorded.

There was no documentary evidence to demonstrate who initiated all restrictive practice. There were no risk assessments in place to include the alternatives that were tried prior to its use.

There was no record maintained of the frequency of its use in all instances. The regional director said that they were in the process of developing a rights committee to review any restraint in place.

Judgment:

Substantially Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the person in charge and staff had maintained records of all accidents and incidents that had occurred in the centre. These were reviewed by the person in charge and programme manager. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector by the person in charge.

Judgment: Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that residents' general welfare and development was being facilitated. Most of the residents attended a day service for a period of time during the week which provided a range of activities. Residents told inspectors that they enjoyed attending the day service as it gave them an opportunity to meet with their friends and chat with the staff who worked there. Residents also told inspectors that they were supported to pursue a variety of interests, including joining various clubs of interest in the local area. Some of the residents enjoyed volunteering in the local area and their work experience.

Many of the residents were encouraged to be independent in the service units and the community as much as possible. Some of the residents travelled unassisted within the community with the appropriate supports.

One of the residents was being supported to learn to read and write in the community and was enjoying this very much.

Judgment:
Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that there were appropriate arrangements in place to support

residents' health care issues as they arose. The social care leaders were very familiar with residents needs and had responded when the need arose. Staff had created links with the health services in the community. While residents had some care plans in place for epilepsy, diabetes and dysphagia, there was a lack of care plans in place to guide staff following the health assessments.

Inspectors reviewed the personal plans and medical folders for six residents and found that they had access to a general practitioner (GP), including an out of hour's service. There was evidence that residents accessed other health professionals such as chiropodists, opticians and dentist. Health assessments provided valuable information for staff in the care of residents but were not consistently up to date for all residents. The health action plans were not specific to guide the care.

Overall residents appeared to enjoy their evening meal when they returned to the centre. Residents decided what they wanted for their evening meal and if any resident did not like what had been prepared, there was a range of alternatives available. Residents were supported to have a snack at any time of the day or night if they preferred and this was supported. Residents enjoyed the take away night and they participated in doing the shopping for the house.

Inspectors found that there was an ample supply of fresh and frozen food. Fresh fruit and juice was available during the day which residents could access

However inspectors observed that in one unit the staff endeavoured to ensure the meal time was meaningful, however due to the number of residents and staff in the house, they could not all sit at the table together and staff confirmed there may be nine adults in the house at one time and the table and space only accommodated six persons. Residents appeared frustrated with other residents due to the lack of space. See outcome six.

Judgment:

Substantially Compliant

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management. There were a small number of improvements noted.

Inspectors read a sample of completed prescription and administration records and saw that overall they were in line with best practice guidelines. However, one residents prescription for warfarin would not guide practice. The maximum dosage of as required medication was not always recorded. The pharmacist was involved in medication safety and provided support and advice as required. Information pertaining to each resident's medication was available in the resident's files. There was a system to check the balances of medication every evening and a discrepancy report was completed if deficits were noted.

Staff had received training in this area and were familiar with the medications in use. There was no medications that required strict controls in place, but staff outlined the procedure they would follow.

There was no separate fridge in place for the safe storage of medication. Medication was stored in a food fridge in the kitchen that was accessible to residents and visitors and therefore may pose a hazard. In addition, the thermometer in the fridge indicated a temperature of -1 degrees, whereas the medication should be stored between 2 and 8 degrees.

Staff knew about the procedures for reporting medication errors and inspectors noted that errors had been responded to and investigated by the social care leaders. The systems were in place to minimise the risk of future incidents needed improvement. The detail of the medication error was not comprehensively recorded. This was being addressed as a variance policy and supporting documents had been recently implemented.

Medication audits were not completed to identify areas for improvement, therefore there was a missed opportunity for learning.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the statement of Purpose did not fully meet the requirements of the regulations. It reflected the centre's aims, ethos and facilities. It did not fully describe the care needs that the centre is designed to meet, as well as how those needs would be met. The complaints procedure did not meet the regulations. The room sizes were also not included.

Feedback was provided to the person in charge and the management team on the deficits in this document.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

The provider had undertaken a number of audits and reviews of the safety and quality of the service. The person in charge and social care leaders were working through the action plans from the recent audits. The provider had established a management structure, while the roles of managers and staff were clearly set out, they were not fully understood.

There was a management system in place on the day of the inspection which supported and promoted the delivery of quality services. However, this needed to be improved. The role of the person in charge was carried out by the residential coordinator who was supported by the programme manager who reports to the regional director of the service. The person in charge was responsible for a number of designated centres. Inspectors noted that the role was relatively new and the staff in the houses were not fully familiar with her role and that of the programme manager. There was no current formal system for team leaders to meet the person in charge to discuss resident's needs. The person in charge said she met the social care leaders regularly to review the action plans from the audits but there was no evidence that this had taken place. While the person in charge met the programme manager regularly, this was not minuted and had not been formalised.

The person in charge was appropriately qualified and had continued her professional development, she was full time in the role and met the requirements of the regulations.

The provider had established monthly regional management meetings, quality and safety committee, residential quality improvement and the supervisors forum meetings where the managers of services could meet to discuss common areas of interest and share their learning.

An audit on the service was completed by the quality and safety department within the organisation. These were un-announced visits and took place up to twice a year. Inspectors reviewed the audits and the action plans which included risk and quality. However, an overall report of the quality and safety of care and support in the designated centre was not in place, or available to residents. Inspectors found that there were appropriate deputising arrangements in place. There were robust on call arrangements in place.

There was not an effective arrangements in place to support, develop and performance manage all staff as outlined in outcome 17.

Judgment:

Substantially Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements were in place through the availability of the programme manager to cover any absences of the person in charge.

The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent.

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there were insufficient resources had been provided at times to meet the needs of residents. There were insufficient staff on duty at times and the layout of the houses did not meet the resident's needs. The provider had ensured that sufficient personal equipment had been provided.

While the houses were suitably furnished, they were not well maintained and did not meet the needs of six residents in one service unit, see outcome six.

Judgment:

Substantially 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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there was a very committed and caring staff team who work well to ensure that the needs of residents are met. Staff were well supported by the social care leaders.

While there appeared to be sufficient staff on duty in some of the service units and additional staff had been allocated to meet the needs of one resident, the skill mix was not sufficient to meet the changing needs of residents with health care issues in one unit. Inspectors found that the staffing levels were based on historical data and not on the current support needs of residents. As previously stated, there were insufficient staffing levels on duty at times to provide meaningful activation for residents.

Staff files were reviewed and contained all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Staff meetings took place regularly however; there was an inconsistent approach to formal supervision of staff. See outcome 14. The social care leaders had a date set for these reviews to take place.

Induction training was also reviewed. This had three elements; induction to the Providers' service and ethos; introduction locally to the particular service unit and

participation in the training days centrally scheduled. Inspectors found however, that the current induction programme for new and agency staff was not satisfactory and was inconsistently been applied across the service. While some of the new staff were rostered in addition to the scheduled staff on occasion, this was not consistent and did not apply to the agency staff. This was being addressed by the management team.

Training records were held centrally which outlined the actual training for all staff. Actual training provided in 2014 and 2015 included areas such as, policy training, medication management, fire safety and safeguarding. Staff had not received training to care for residents with specific needs such as diabetes, restrictive practices, risk management, dementia and infection control.

There were some gaps noted in the mandatory training (fire response training, moving and handling of residents and prevention and awareness of abuse). However the provider was aware of these gaps and inspectors reviewed a schedule of training which responded appropriately and in a timely fashion. Complete training records for agency staff were not available at the time of inspection.

Judgment:

Substantially Compliant

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

This was the centre's first inspection by the Authority.

Findings:

The provider and person in charge had ensured that residents were provided with a residents' guide which was in an accessible format and included information in pictures, photographs and words. The residents' guide provided residents with information on the service, and included a section on how to make a complaint.

The provider had developed and implemented a range of policies and procedures to guide staff in the delivery of services to residents and the running of the centre in line with Schedule 5 of the Regulations. However, they were not being used to guide practice, for example, the policy on residents' personal property, finances and possessions. In addition, some of the policies that were in place did not provide

sufficient direction to staff. For example, the policy on complaints as referred to in outcome one. This policy did not include the nominated person as referred to in Regulation 34 (3).

Inspectors viewed an insurance certificate which confirmed that there was up to date insurance cover in the centre.

The provider was maintaining records in a secure and safe manner. Staff records were kept centrally and residents' records were stored in a locked cabinet in the units. Records were easily retrieved by inspectors during the inspection, however the residents records were cumbersome for the staff.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002972
Date of Inspection:	18 and 19 March 2015
Date of response:	29 April 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The complaints policy did not include the nominated person as referred to in Regulation 34 (3).

Action Required:

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

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

- (1) The complaints policy will reviewed and a local procedure will be developed.
- (2) The Statement of Purpose will be updated to include all recommendations including a clear guide to the complaints policy.

Proposed Timescale: (1) 24/07/2015 (2) 20/03/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Some residents did not have access to the internet or other assistive technology to promote their full capabilities.

Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

- (1) Residents will be supported to access the internet if they wish to do so.
- (2) The keyworker and social care leader linking with residents to identify their needs in relation to accessible technology

Proposed Timescale: (1) 30/06/2015 (2) 28/05/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The contract of care had not been provided to residents.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

- (1) A contract of care will be provided for all residents in this designated centre in

conjunction with families.

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

The personal plans were not available in an accessible format.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

(1) The Social care Leader will review all personal plans with the resident and their representatives to ensure a consistent approach to meeting the needs and choices of residents.

(2) The personal plans will be reviewed to ensure the personal plans are accessible

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

Personal plans did not reflect the assessed needs of residents.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

(1) All assessments will be reviewed and updated and used to inform the residents personal plan

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

The assessment did not have multidisciplinary input and did not assess the effectiveness of the plan.

Action Required:

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

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

1. All future assessments and reviews will include relevant multidisciplinary/circle of support where appropriate and input and will be evidenced on the Personal Plan.
2. Where input from a particular discipline has been completed for a resident this will be evidenced on their Personal Plan. Any subsequent requirement for clinical inputs will be on a new referral basis.
3. All reviews will be discussed at the weekly staff team meetings to ensure communication with all staff and ensure the effective implementation of the plan.

Proposed Timescale: 28/04/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The rear of the house was inaccessible to some of the residents.

Action Required:

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

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

- (1) The Person in Charge will arrange for a ramp to be put in place at the rear of the house.
- (2) The Person in Charge will review the layout of the designated centre annually or more frequently if required.

Proposed Timescale: (1) 31/07/2015 (2) 31/12/2015

Theme: Effective Services

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

Adequate private and communal accommodation including adequate social, recreational, dining and private accommodation was not provided in all locations.

There were an insufficient number of accessible baths, showers and toilets available for residents.

Action Required:

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

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

1. There will be a review of accommodation to identify the scope for provision of additional bathrooms
2. An architect will be engaged to identify the scope of renovations required to increase the physical space in this designated centre
3. The plan arising from the architects meeting will be submitted to the Authority

Proposed Timescale: (1) 30/06/2015 (2) 30/07/2015 (3) 30/09/2015

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 was not being implemented in practice in relation to the identification, assessment and management of risk.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

1. The Person in charge will review the risk management policy to identify and target the risks in relation to fire safety, skill mix and limited access from the rear of units.
2. Risk assessments for these areas will be put in place that will identify, assess and establish adequate and clear control measures for the risks identified.
3. Refreshers training will be undertaken with staff on the risk management policy
4. A review of the adverse incident system will be undertaken to identify an agreed method of shared learning and set a date for implementation of same.
5. Person in Charge will meet with social care Leader on a monthly basis for regular review and update adverse incidents including learning from these incidents

Proposed Timescale:

1. 30/06/2015
2. 30/06/2015
3. 30/07/2015
4. 29/05/2015
5. 28/04/2015

Theme: Effective Services

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

the following respect:

Staff had not received training in the use of fire extinguishers.

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:

- (1) A schedule of training for staff in the use of fire extinguishers will be developed.
- (2) All staff will receive training in the use of fire extinguishers

Proposed Timescale: (1) 14/05/2015 (2) 30/09/2015**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no plan to address the learning identified from the fire drills.

Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

1. The person in charge will continue to ensure that quarterly fire evacuation drills are carried out and reports forwarded to the Health & Safety committee
2. After each fire drill the social care leader will identify with staff any learning that came from the fire drill. A risk assessment identifying learning from each drill will be completed. Each individual's personal evacuation plan will be updated and communicated to all staff.
3. The social care leader is to notify the person in charge if there are any issues in relation to the fire drill.
4. The learning from all fire evacuation drills will be discussed quarterly, after each fire drill, at the team meeting with staff.
5. The evacuation plan for the resident who uses a chairlift has been reviewed so that the chairlift will not be used in the event of fire. A risk assessment has been completed and the residents doctor has been consulted.

Proposed Timescale:

- (1) 30/04/2015
- (2) 30/04/2015
- (3) 30/04/2015
- (4) 30/04/2015
- (5) 20/05/2015

Theme: Effective Services

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

There were a limited number of fire doors in the houses and the intumescent strips had been painted over on the fire doors in place.

Action Required:

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

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

- (1) All fire doors where the intumescent strip has been painted over will be replaced
- (2) Necessary additional fire doors will be identified and installed

Proposed Timescale: 31/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some aspect of the use of restrictive practices was not in line with national policy

Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

1. All occasions where a restriction, relevant to the Positive Behaviour Support Committee, is implemented will be recorded and will be reviewed on a monthly basis by the Positive Behaviour Support Committee
2. The rights committee is in the process of being re-established and all rights restriction, relevant to the human rights committee, will be forwarded to the committee when operational.
3. A review of all restrictive practices in this designated centre will be undertaken and alternatives to these restrictions will be explored with the staff team where possible.
4. Risk assessments will be completed with regards to any rights restrictions in place as appropriate.
5. Staff will receive training in what constitutes a rights restriction.

Proposed Timescale:

- (1) 30/03/2015
- (2) 30/09/2015
- (3) 28/05/2015
- (4) 28/05/2015
- (5) 28/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The health action plans were not specific to guide the care to be delivered. There was a limited number of care plans to guide practice.

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:

1. All Outstanding Health Action Plans will be completed/updated.
2. A proactive action plan projecting the resident care into the future will be identified. An action, person responsible and completion date will be assigned to each action identified. This action plan will serve to guide the care of the residents in this designated centre.

Proposed Timescale: 31/08/2015

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:

Aspects of medication practices regarding prescribing and storage of medication were not in line with the centres policy or best practice.

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:

- (1) Guidelines will be written for resident who is prescribed warfarin that will guide practise.
- (2) A fridge will be purchased to store medication in houses that store medication in the fridge. A procedure for the recording of temperature in this fridge will be put in place.

(3) A medication variance procedure has been sent to all social care leaders that details how to address a medication error with staff. A medication variance form must be filled in the event of a medication error. The social care leader will report all medication variances to the programme manager.

Proposed Timescale:

(1) 28/05/2015 (2) 28/05/2015 (3) 16/03/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not fully meet the requirements of the Regulations.

Action Required:

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

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

The statement of purpose has been amended to meet the requirements of the regulations. It now reflects the centres aims, ethos and facilities and describes the care the centre is designed to meet. The room sizes have also been included in the statement of purpose.

Proposed Timescale: 20/03/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The management systems did not ensure the service delivery of services appropriate to the residents needs.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

(1) The Person in Charge will formally meet with the social care leaders once a month and these meetings will be minuted.

(2) The programme manager will meet with the residential coordinators fortnightly and these meetings will be minuted.

Proposed Timescale:

(1) 30/04/2015 (2) 28/05/2015

Theme: Leadership, Governance and Management

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

Performance reviews had not consistently taken place with staff.

Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- (1) The social care leaders will arrange to complete all outstanding Performance Development Reviews (PDR's) with all members of staff. The PDR's will target areas for development and set goals for the individual. All
- (2) The Person in Charge will complete the outstanding PDR's with the social care leaders. The PDR's will target areas for development and set goals for the individual.
- (3) PDR's will be completed at least annually and will be completed more often as required.

Proposed Timescale:

(1) 30/06/2015 (2) 30/06/2015 (3) 31/12/2015

Theme: Leadership, Governance and Management

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

An annual report of the quality and safety of care and support in the designated centre was not available.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

- (1) The quality and safety committee will compile an annual report on the care and support on residents in the service. This will happen every year and will be released in January every year.

Proposed Timescale: 31/01/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

Insufficient resources had been provided at times to meet the needs of residents.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

(1) A review of staffing needs in each area will be conducted by the Person in Charge to identify any changes in resource allocation.

(2) A revised roster will be developed that will incorporate extra support in the evenings and weekends to support residents with their medical and social needs.

Proposed Timescale: (1) 30/05/2015 (2) 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staffing levels were not based on the assessed needs of residents.

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) A review of staffing needs in each area will be conducted by the Person in Charge to identify any changes in resource allocation

(2) A revised roster will be developed that will incorporate extra support in the evenings and weekends to support residents with their medical and social needs.

Proposed Timescale: (1) 30/05/2015 (2) 30/04/2015

Theme: Responsive Workforce

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

Staff did not have access to training as outlined in outcome 17.

Action Required:

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

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

1. An audit of all mandatory training for staff in this designated centre will be undertaken.

Additional training based on the needs of the residents will be provided:

2. Training in diabetes will be provided to staff

3. Staff supporting residents in this designated centre with dementia will receive training.

4. All staff will receive training in restrictive practices

5. All staff will receive refresher training in the risk management policy

6. All staff will receive training in infection control

Proposed Timescale:

(1) 30/09/2015

(2) 30/06/2015

(3) 30/07/2015

(4) 30/09/2015

(5) 30/07/2015

(6) 30/08/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Some of the policies did not guide practice.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. The person in charge will conduct a review of all local operational procedures to ensure they are up to date & available to the staff team.

2. Local procedures relating to residents finances and complaints will receive immediate priority for revision by the person in charge.

3. The orders policies will be reviewed at the staff meeting to ensure all staff are familiar with and implementing the policy.

Proposed Timescale:

(1) 30/07/2015 (2) 30/06/2015 (3) 14/05/2015

