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 St John of God Community Services Limited
Centre ID:	OSV-0002934
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Philomena Gray
Lead inspector:	Julie Pryce
Support inspector(s):	Sheila Doyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 September 2015 10:30	21 September 2015 18:30
22 September 2015 10:30	22 September 2015 19:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 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

HIQA became significantly concerned about the safety and the quality of life for residents in St Raphael's campus, a residential service operated by St John of God Kildare Services. St Raphael's residential campus contains seven designated centres providing residential services to 137 people with intellectual disabilities.

Following the initial inspections in 2015, inspectors undertook a series of ten planned inspections to assess the progress of the provider in addressing the issues of concern which were impacting on the lives of residents.

These unannounced inspections found evidence of institutional practices, poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued a series of immediate actions and warning letters, and held regulatory and escalation meetings with the provider and members of senior management.

Due to a failure of the provider to implement effective improvements for residents, HIQA issued notices of proposal to cancel the registration of three of the centres on

this campus. The provider subsequently issued HIQA with plans for the closure of one designated centre, and transitional plans to provide alternative living arrangements for a number of other residents which addressed the residents' safety, welfare and quality of life.

The most recent inspections have confirmed that the provider has undertaken substantive changes in governance and management across this campus. There have been improvements in staffing, persons in charge and other management positions. While there continue to be non compliances, and further improvements are required in relation to the quality of life for residents, the provider has demonstrated that it is now taking effective action to achieve these improvements.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection report specifically relates to one designated centre on this campus. This unannounced inspection was conducted in order to monitor ongoing regulatory compliance and to follow up on findings from the previous inspection. In particular inspectors reviewed the implementation of agreed actions from the previous inspection, having regard to the high levels of non compliance with the regulations which were identified at that time.

Some progress had been made towards the completion of the actions proposed by the provider in order to bring the centre into compliance with the Regulations. For example there had been improvement in the quality of personal plans, in the management of healthcare and in risk management.

However the actions proposed did not address all the areas of non compliance and significant improvements were still required across most outcomes, in particular in the provision of a meaningful day for residents and in the availability of adequate staffing levels to meet the needs of residents.

In addition, further areas of non compliance were found during this inspection. The management of residents’ finances did not protect residents from the risk of financial abuse. Therefore there were continuing concerns about the management and governance of the designated centre.

Major non compliances were found in residents' contracts, social care needs, safeguarding and safety, staffing and governance and management. Moderate non compliances were found in the management of healthcare needs. These issues are discussed in the body of the report and in the action plan at the end of the 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 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were no written agreements in place which outlined the services to be provided to residents, or the equipment or personal items to be provided as opposed to those which residents were expected to provide themselves.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Improvements had been made in the structure and content of personal plans. They

were now indexed and sectioned so that information was easily retrievable and available to guide staff. Each resident now had an introductory assessment which included a summary of important information about them, for example, likes and dislikes, healthcare needs and communication. Many aspects of healthcare examined by the inspectors had a plan of care in place in sufficient detail as to guide staff. All residents now had an intimate care plan in place which for the most part gave appropriate and detailed guidance to staff. Some residents also had an additional communication plan which outlined details of the best way to communicate with them, and the meaning of some of their behaviours or gestures. Staff members were very familiar with the communication needs of residents, and could explain to the inspectors the meaning of interactions with residents.

There was evidence of the commencement of involvement of families and residents in the personal planning process, this had occurred for four of the residents, and a schedule of family meetings was available for the others. In addition some progress had been made towards developing an accessible version of personal plans for residents by the inclusion of symbolic representation of some of the information in the plan. However these were generic templates and did not reflect the communication needs of residents.

There remained some gaps in care planning for healthcare. For example, the recommendations of a speech and language therapist from June 2014 had not resulted in a plan of care so that there was no evidence of monitoring or review of the interventions. This is the second time that this issue has been identified in an inspection by the Authority. In addition the plan of care for a resident who needed assistance with oral care did not include an oral care plan.

There had been improvements in goal setting in the personal plans in relation to maximising the potential of residents, for example, in relation to building independence in daily activities for one resident, and in improving the community presence for another. Goals were broken down into smaller steps and timeframes for achievement of these steps were identified. However, for the most part timeframes were not achieved and staff reported that this was due to the inadequate staffing levels.

There were still no comprehensive assessments of the social needs of residents, most of whom attended a day service on the campus of the organisation. There was no evidence of an assessment of needs on which the decision to attend these services was based. Links between the day service and the residential centre included the transfer of the daily progress notes with the resident. Entries were occasionally made in relation to the day's activities, but more usually entries only related to accidents or incidents in the day service.

Staff reported that there had been an increase in activities for residents, such as attending local sports events and a plan to have a birthday party in a nearby hotel. However there was no record of activities maintained and a review of the progress notes of residents in which the daily activities were kept did not reflect this. They included occasional weekend activities but there was no evidence of evening activities. Whilst staff reported that residents were happy just to be in their homes in the evenings for the most part, there was no evidence of alternatives having been offered.

As further discussed under outcome 11, the preparation of meals in the residents' home had commenced in one of the two houses on one evening at the weekends, with residents being involved in this activity. The engagement and enjoyment of some of the residents in the preparation of meals was reported by staff.

Where previously activation had been provided in the centre for two residents who did not attend any day service or activities outside of the centre, this was no longer the case, and there was no evidence of any activities during the day for these two residents. One of these residents was confined to bed due to physical and mental health issues, and was alone in his room for the majority of the day. The other was observed by inspectors to be wandering around the house during the day without any planned activity or interaction.

Many of the residents in one of the houses were assisted in personal care in the mornings by night staff, as only two day staff members were available to assist eight residents, all of whom required some level of assistance. There was no evidence that residents had chosen this early start, that it took place for any other reason than the availability of staff, or that it was person centred as opposed to task orientated.

The staffing levels continued to be in need of review in order to ensure that residents' social care needs were met, and to ensure that residents had a meaningful day with interaction and activities suitable to their interests. It was again apparent from observation, discussion with staff and review of activities records, that the provision of activities and facilitating choice of activities was curtailed by the staffing levels. For example, staff reported that any efforts towards daily meal preparation with residents would be curtailed by the availability of staff. No changes had been made to the staffing numbers since the first inspection of the designated centre, and this is the third occasion where this area of non compliance has been identified in an inspection of the Authority. Staffing numbers are further discussed under Outcome 18.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Improvements had been made in relation to the management of fire safety since the last inspection. The personal evacuation plans for residents were now reviewed and in

sufficient detail as to guide staff in an emergency. In addition, the fire emergency plan included an outline of the supports required by each resident in the event of an emergency. All staff engaged by the inspector could describe the actions to be taken in the event of a fire. The required daily checks had continued and all equipment had been maintained and checked within the appropriate timeframes. Fire drills had been conducted on a regular basis, and there was evidence of a system of ensuring that all staff would be involved in a fire drill. However, there had been no night time fire drill in one of the houses, and in the other it had taken place in the morning when several of the residents were already up.

A safety statement was in place in each of the houses, and each member of staff had signed the record that they had read the statement.

All of the risks identified by the inspectors at the previous inspection had been reviewed, and for the most part managed. For example, there was now an appropriate lock on the storage area for cleaning chemicals. Some individual risk assessments were in place for residents, for example, in relation to manual handling for some residents, the management of phlebotomy, the risk of falls and the management of outings for others. However there was still no risk register available for the centre.

There had been improvements in the recording of accidents and incidents since the last inspection. All records reviewed by the inspectors were detailed and there was evidence of the implementation of identified actions. An appropriate system of reviewing and trending of systems was described by the person in charge.

The infection control issues identified in the last inspection had been addressed, and practices observed by inspectors were appropriate. The designated centre was visibly clean and there was appropriate storage and management of cleaning equipment.

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

Findings:
Inspectors were very concerned regarding some aspects of the management of residents' finances.

The centre managed some residents' pocket monies. Details of all transactions and receipts were maintained. Inspectors checked the balances and found them to be correct. However, inspectors noted that a kettle had been purchased for one particular house and the cost of the kettle had been divided amongst the residents in the house with an equal deduction made from each resident. In addition inspectors saw that in one case a resident had been charged for basic equipment such as sliding sheets and a falls sensor alarm. A resident had also been charged for an extension lead. Inspectors were concerned that the system in place was not sufficiently robust to protect the residents from financial abuse. This was discussed in detail with the provider and staff at the feedback meeting and the provider undertook to address this as a matter of urgency.

Inspectors reviewed a sample of intimate care plans which had been put in place in response to failings previously identified by inspectors. Inspectors found that they were detailed and provided sufficient information to guide staff.

Inspectors reviewed a sample of behaviour support plans, which was an area identified for improvement at the last inspection. They were detailed and contained sufficient detail to guide staff. There was evidence of involvement by appropriate members of the multidisciplinary team. For example, inspectors noted that in one case the psychologist attended the centre on an almost daily basis to review progress on a particular plan in place for a resident.

There were some restrictive interventions in place for residents in the designated centre. For example, one resident required physical intervention (a physical hold by staff) in order to receive personal care on a daily basis. Improvement had occurred since the previous inspection and inspectors read detailed instructions which had been put in place following assessment by the multidisciplinary team.

Staff training had been provided on the protection of vulnerable adults and all staff engaged by the inspectors outlined appropriate actions to be taken if abuse was suspected.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Inspectors were satisfied that each resident's wellbeing and welfare was maintained by appropriate medical, nursing and allied health care. Additional improvement was required however to ensure that all residents had a choice of meals available to them and that adequate facilities were available for residents to buy, prepare or cook their own meals, or to be involved in meal preparation.

It was identified at the previous inspection that there were no opportunities for residents to buy, prepare or cook their own meals, or to be involved in any way in meal preparation. Inspectors found that efforts were being made to improve this situation. Since the last inspection, work was completed to provide a cooker in one house and work was underway in the second house. Inspectors saw that the kitchen cupboards and worktops were being changed to accommodate the cooker.

Staff told inspectors that in recent weeks some residents had accompanied staff out to the shops at the weekend and had bought the ingredients to make the evening meal in the centre. Currently this happened on one day at the weekend. Staff told inspectors how much residents had enjoyed this. However, staff told inspectors that staffing shortages made it difficult to both provide adequate supervision to residents and to prepare the meals.

Inspectors also noted that additional food was available in the fridges to enable residents to prepare some snacks. Inspectors saw a resident making himself a sandwich of tomatoes and cheese. He also jokingly tried beetroot but didn't like it. He showed the inspectors where the food was and offered inspectors tea and fruit. A fruit bowl was now available in each house, and residents were seen to enjoy helping themselves to fruit.

Despite these improvements, additional action was required to ensure that adequate facilities were available to residents on an ongoing basis. In addition, these additional choices were not available to residents who required their meal in a modified consistency as there was no equipment available at local level to do this.

Inspectors were previously concerned about the quality and safety of food served to residents. The appropriate procedure for the chilling and reheating of meals was not being followed at that time. Inspectors found that this had been addressed. The temperature of the food which was served from the main kitchen was now checked prior to being served.

Previously required actions relating to the quality of care plans for specific conditions such as catheter care and skin integrity had been addressed. Inspectors saw that in the main detailed care plans were now in place while the remainder were at various stages of development. Inspectors also saw that observations such as weight recording were now regularly documented.

Inspectors were satisfied that residents had access to GP services and out-of-hours medical cover. In addition, a full range of other services was now available on referral including speech and language therapy (SALT) and occupational therapy (OT) services. Chiropody, dental, audiology and optical services were also provided. Inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes. However, this did not consistently result in the development of a care plan as discussed under Outcome 5.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors found that medication management policies and procedures were satisfactory and safe.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked a sample of balances and found them to be correct. Previously required actions relating to the checking of these medications had been addressed.

Some residents required medication on an 'as required' (PRN) basis. Inspectors saw that the maximum dose that could safely be administered in a 24 hour period was recorded. This had been identified as an area for improvement at the last inspection.

Inspectors were satisfied with the progress towards the introduction of a new medications administration recording sheet, in accordance with one of the agreed actions from previous inspections. This was now in use on a pilot basis. Staff were auditing its usage and had identified where some improvement was required to the documentation.

The temperature of the medications fridge was now monitored and recorded on a daily basis. The temperatures recorded were within safe limits.

Frequent medication audits were carried out to ensure practices were safe. In addition staff had attended training in medication administration.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
A clear management structure was in place which included the recruitment of a CNM1 to support the day-to-day management of the centre, and a programme manager to participate in the management of the centre. All staff engaged by the inspectors were aware of this structure.

The role of the person in charge was now filled on a permanent basis. The person in charge interacted with inspectors throughout the inspection process and was formally interviewed. He was found to be appropriately qualified, skilled and experienced for the role, and was aware of his responsibilities under the Regulations. He was a regular presence in the designated centre and was clearly known to residents. Whilst he was currently the person in charge for three designated centres inspectors were told that further recruitment meant that this would only continue for a further four weeks, from which time he would have responsibility for two designated centres.

A system of meetings was in place, and whilst there was evidence of a system of communication between the various groups, some of the meetings were not held regularly. For example, a progress report fortnightly meeting had been held once in June, twice in July and once again in September. A quality and safety governance committee was in place and minutes of these meetings were reviewed. Various issues were discussed at these meetings including a review of complaints.

An unannounced visit had been undertaken by the provider in January 2015, but this had not been conducted on a six monthly basis as required by the Regulations. There was again no annual review of the quality and safety of care and support as required by

the Regulations.

Whilst a template for performance development reviews was available and a schedule of reviews had been developed, none had yet taken place, including those for which the scheduled date had passed.

Inspectors remained concerned that whilst some improvements had been made in the areas of non compliance identified in previous inspections, further non compliances have been found by inspectors on each occasion of inspection. The provider's systems for monitoring the quality and safety of care were ineffective. As a result issues of concern were not detected, for example, the management of residents' finances and the monitoring of all staff on the premises.

During the inspection a person who was working on care planning documentation at the centre refused to engage with inspectors in accordance with the provisions of Section 73 (4) (d) of the Heath Act. The provider did not have systems in place at the time of inspection to ensure that such persons had the appropriate documentation and checks in place. An assurance that this documentation was in place was subsequently forwarded to the inspector.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors were again concerned about the lack of any improvement in staffing numbers since the previous two inspections. There had still been no review of staffing numbers in relation to the needs of residents, and this was the third inspection to identify non compliance with the Regulations in this area. Inspectors again found that the provision of care was resource led, and that the majority of residents' activities and routines revolved around staff availability. For example, morning personal care was delivered before 8am for several residents in the absence of any evidence that this was their preference, and opportunities for activities were limited as discussed under outcome 5.

A resident had been identified on the previous inspection as requiring four members of staff to deliver personal care due to high anxiety and resulting challenging behaviour on these occasions, and these staff were not available in the centre. Inspectors had been concerned during previous inspections that unfamiliar staff from other units were called in to assist. Some progress was reported by the person in charge towards addressing the needs of this resident and there was evidence that meetings and discussions had taken place around this. In addition, some control measures had been introduced, for example, a protocol was in place that required at least one of the staff members involved in the delivery of personal care was to be familiar to the resident. However, the practice of calling in unfamiliar staff due to the inadequate staff numbers within the designated centre continued, so that continuity of care and support in this regard was not ensured.

There had been improvements in the provision of staff training. Training had been provided in fire safety, the management of aggression of violence and the protection of vulnerable adults. However, there was no evidence of training needs assessments or of a schedule of training.

In addition, the provider had organised training in the "person-centred" planning process for some staff in response to a finding from the previous inspection in relation to residents' assessments. The content of this training as provided to staff was reviewed by the inspectors and was seen to identify some of the responsibilities of keyworkers. However, it did not include content on the development of personal plans.

Staff members engaged by inspectors presented with enthusiasm both for the regulatory process and for improving the quality of life for residents. They spoke both to and about residents in a caring and respectful manner, and it was clear that they were familiar with and supportive of the needs of residents.

Judgment:
Non Compliant - Major

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:

Julie Pryce

Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002934
Date of Inspection:	21 and 22 September 2015
Date of response:	20 October 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 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:
There were no written agreements on the terms on which residents would reside in the designated centre.

1. Action Required:

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

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
1. Contract of Care template has been developed.
2. Written agreements on the terms on which residents reside in the designated centre will be agreed with the residents and their representatives

Proposed Timescale:

1. 21/10/2015
2. 31/12/2015

Proposed Timescale: 31/12/2015

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:
There were no comprehensive assessments of social needs.

2. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
1. Any recommendation from SLT and other allied health care professionals will result in plan of care for the resident.
2. All personal plans (MPPs) will be updated to reflect the assessed needs of residents by relevant professionals.

Proposed Timescale:

1. 20/10/2015
2. 31/12/2015

Proposed Timescale: 31/12/2015

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 all of the needs of residents.

3. 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:
All personal plans (MPPs) will be updated to reflect the assessed needs of residents by relevant professionals. The plans will be reviewed on an annual basis.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to meet the social care needs of residents.

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

Please state the actions you have taken or are planning to take:
1. All personal plans (MPPs) will be updated to reflect the assessed needs of residents by relevant professionals. The plans will be reviewed on an annual basis.
2. A visual record of social activities has being developed and kept in the DC.
3. Support will be offered to the residents that do not attend the day centre.

Proposed Timescale:

1. 31/12/2015
2. 20/10/2015
3. 30/11/2015

Proposed Timescale: 31/12/2015

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:
Systems were not in place to ensure the management of all risks

5. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated

centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. The risk register template has been created.
2. The risk register will be populated and all risks identified in DC will be listed.

Proposed Timescale:

1. 23/10/2015
2. 23/11/2015

Proposed Timescale: 23/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all appropriate fire drills had taken place

6. 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. Night time fire drill will take place.
2. Night time fire drill will recreate the true night time circumstances.

Proposed Timescale: 25/10/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place for managing residents' finances was not sufficiently robust to protect the residents from financial abuse.

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

Please state the actions you have taken or are planning to take:
1. The issue of purchasing the items for the DC at the cost of residents was identified as an error and was addressed immediately with subsequent follow up with the relevant staff members involved.

2. The residents affected have been reimbursed.
3. The PIC will ensure that line Mangers will review all residents' transactions on weekly basis.
4. Purchasing basic equipment for the residents will be regulated through Contracts of Care.
5. Financial audit related to residents' finances will take place in DC.

Proposed Timescale:

1. 31/09/2015
2. 27/09/2015
3. 27/09/2015
4. 31/12/2015
5. 30/11/2015

Proposed Timescale: 31/12/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Additional work was required to ensure that residents were able to buy, prepare or cook their own meals.

8. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
The additional work to the kitchen in the Residential setting will be completed to give residents the opportunity to prepare and cook their own meals if they choose to do so

Proposed Timescale: 31/12/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Additional choices were not available to residents who required their meal in a modified consistency as there was no equipment available at local level to do this.

9. Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
Equipment (blender) will be made available in the DC to facilitate the residents who require their meal in modified consistency.

Proposed Timescale: 23/10/2015

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:
Management systems did not ensure that the service provided was safe and effectively monitored.

10. 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. Financial audit related to residents' finances will take place in DC.
2. The PIC will ensure that line Mangers will review all residents' transactions on a weekly basis.

Proposed Timescale:
1. 30/11/2015
2. 29/09/2015

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care.

11. 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:
An annual review of the quality and safety of care will be completed.

Proposed Timescale: 17/03/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not conduct an unannounced visit at least once every six months.

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

Please state the actions you have taken or are planning to take:
1. Unannounced visit by the Quality Team took place in DC on 30/09/2015
2. Written report following the visit will be produced by 31/10/2015.

Proposed Timescale:

1. 30/09/2015
2. 31/10/2015

Proposed Timescale: 31/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff performance development reviews had not taken place.

13. 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 schedule of PDRs has being reviewed by the PIC within the DC will be reviewed and all staff will complete their PDRs.
2. The PIC will monitor the schedule and ensure all PDR 's are completed on time

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured continuity of care and support.

14. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
•An alternative living arrangement is being sourced for this resident to ensure continuity of care and support

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The numbers of staff required review as they were not adequate to ensure that the needs of residents were consistently met.

15. 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:
A review of staff numbers has being undertaken and additional resources will be assigned to this DC

Proposed Timescale: 30/11/2015

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 all appropriate training.

16. 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:
A schedule of training including identified refresher training will be developed for staff

to attend as part of their continuous professional development
Proposed Timescale: 31/12/2015