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A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd., Tipperary

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**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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005157
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	5
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:
03 June 2015 10:00	03 June 2015 17:30
04 June 2015 09:00	04 June 2015 16:30

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 report sets out the findings of an announced inspection of Group K St. Anne's Residential Services following an application by the provider to register the centre. This was the first inspection of this designated centre. The centre comprised a two-storey house in a small village. The centre was clean, warm, homely and well-maintained with a pleasant private garden to the rear.

As part of the inspection, the inspector met with the residents and staff members. Residents told inspectors that they were happy and liked where they were living. Some residents were retired and were supported to pursue interests of their choice.

Other residents were semi-retired and attended a day service on a part-time basis. Residents outlined how they were supported to be part of the local community. Relationships with family and friends were encouraged and facilitated. Inspectors reviewed questionnaires completed by residents and relatives about their experience of the service. Overall, the feedback provided was very positive. One relative said that they would like to see "more activities for their loved one" and this is further discussed in the body of the report.

However, inspectors found a high level of non-compliance and significant deficits in the quality of care provided to residents. Of a total of 18 outcomes inspected, there were 10 at the level of major non-compliance.

Inspectors found that the service had failed to protect residents residing in the centre from all forms of abuse. An arrangement in place whereby the centre was being used to provide a day service for a resident not residing in the centre had resulted in incidents of peer-to-peer abuse directed towards residents living in the centre. In addition these incidents of peer-to-peer abuse had not been notified to the Authority, as required. Staff also described to inspectors potential institutional practices relating to residents being called in turn to the office to receive medications. This was not actually seen on inspection and was not verified by the person in charge. However, there was a behaviour management plan seen by inspectors which outlined the practices described by staff.

The residents who resided in the centre were generally of an older age-group and some residents had restricted mobility. Residents also had complex healthcare needs and staff said to inspectors that they didn't have enough knowledge of care planning, particularly in relation to these healthcare needs. Inspectors found that there was limited nursing support for staff. Inspectors found that this was compounded by the lack of multidisciplinary input into key areas such as annual reviews, personal planning reviews and behaviour support plans for residents.

While the house was clean, homely and nicely decorated, there were issues relating to accessibility and in particular, residents being able to get to the upstairs bedrooms. Also, the facilities provided did not reflect the Statement of Purpose.

The person in charge, while a registered nurse, was also responsible for a number of other centres. Inspectors were not satisfied that this arrangement provided for effective governance, operational management and administration of this centre.

Other areas for improvement identified included: the admission process; risk management; medication management; general welfare and development; use of resources and; records management.

Inspection findings including non-compliances 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 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:

The inspector found that residents were consulted with and participated in decisions about their care. However, the inspectors found that improvements relating to the use of residents' personal and living space were required.

The residents' home was also used to provide a day service for a resident who did not reside in the designated centre. This was presenting difficulties for some of the residents in the centre as there was evidence of peer-to-peer abuse as a direct result of this arrangement. The person in charge had taken steps to mitigate the negative impact on residents in the centre and additional staff hours had been secured in an attempt to manage the situation. However, the situation was on-going and had not been satisfactorily resolved. Due to nature of the impact on residents residing in the centre, this failing was at the level of major non-compliance.

The inspectors observed that staff treated residents with dignity and respect and interacted with residents in a warm and appropriate manner. Bedroom doors were kept closed, privacy was afforded during personal care and residents' personal belongings were respected. Residents all had their own bedroom. However, staff described that residents were called into the office to receive their medications. Inspectors found that this practice was not person-centred. This was discussed with the provider nominee and person in charge and senior nurse manager at the close of inspection. The person in charge said that she had never seen how medications were distributed in the centre so could not comment on the practice as described. The provider nominee told inspectors that this practice would cease immediately.

During the inspection it was observed that personal information relating to one service user was being stored inappropriately in another resident's healthcare records. Inspectors also saw that some information relating to the follow up of one resident's review by a psychologist was in the person's records on a "post-it" note. These practices did not respect residents' privacy and confidentiality in relation to their personal information.

Inspectors saw a communication board in the kitchen with residents' names on it and what activities they were doing that day. The board contained a lot of personal information that was clearly on display. The information was removed on the first day of inspection.

Residents were consulted as to how the centre was run and minutes of monthly resident house meetings were available to inspectors. Recent minutes included discussion of topics such as menu planning, staff moves, the daily activity timetable, organisation of household tasks and a discussion of an easy-to-read document about what to do if feeling sad or worried. However, while the provider had demonstrated that there were arrangements in place to ensure that residents were consulted with, it was not demonstrated that residents had a say in the organisation of the designated centre. It was not clearly demonstrated whether residents were consulted in relation to the use of their home to provide a day service for another resident and this was not included on the agenda at recent residents' meetings.

Minutes demonstrated that the provider nominee was in the process of addressing a service-wide gap in relation to internal advocacy services. Recent minutes from May 2015 outlined the proposed new advocacy structure and meetings that will take place every four to six weeks. This will involve a resident representative and a clear structure was in place for addressing unresolved issues. Residents had access to external advocacy if required. A charter of rights was displayed in the centre in an easy-to-read version.

There were policies and procedures in place for the management of complaints and these were also available in an easy-to-read version. There was evidence that complaints were documented and that complaints were discussed at staff team meetings and with management if necessary. Residents were supported to make any complaint that they might have.

Activities and interests pursued were individual and based on residents' wishes and preferences and appropriate. Residents enjoyed their own interests such as making jigsaws, listening to music and reading the newspaper. Individual residents said that they enjoyed going bowling, to the cinema, swimming pool, for walks or to meet their friends and family. One resident was training for the special Olympics. Other residents said that they were looking forward to attending a concert in Dublin over the summer. Residents were facilitated in exercising their religious rights and residents who wished to do so were supported to attend the local church. However, the inspectors found that there were times when activities and interests were curtailed by staffing levels, particularly at weekends. The house manager and person in charge demonstrated that they had commenced reviewing staff rotas in an attempt to address this. This will be further addressed under Outcome 17: Staffing.

There was a policy on residents' personal possessions and residents' property was kept safe via appropriate record keeping seen in the residents' personal files.

Judgment:

Non Compliant - Major

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:

There was a policy on communication and in the sample of care plans reviewed there was evidence that residents were assisted and supported to communicate. A number of residents had communication boards in their bedrooms with pictures of various things they were going to do that day, like a picture of going to work and a picture of drinking coffee in the local village.

There was evidence of review and assessment of communication needs by speech and language therapists as required. Staff were aware of the recommendations from these reviews and were seen going through the visual schedule of the day with one resident so that they know what they were going to do that day.

Television was provided in the main living room and a number of residents had televisions with multi-channel access in their own room. One of the residents explained to inspectors that she liked bringing her radio to the living room in the afternoon "to listen to her shows."

Inspectors saw that residents with hearing impairment were being reviewed by an audiologist every two years. One resident with a hearing impairment demonstrated to the inspector the use of the specialised smoke alarm. There was a vibrating pad placed under the pillow which activated when the smoke alarm sounded. This was interconnected with the conventional audible alarm. If the alarm sensed smoke it went off and the pad vibrated.

Judgment:

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:

There were opportunities for residents to engage with their families and to maintain links with the wider community.

Residents' files included contact details for close family members and friends and other people important to the resident.

There was evidence of regular contact between residents and their families and friends. Residents said that they visited and were visited by friends and relations and some residents went home or on holiday with family members. Residents were supported to visit the graves of loved ones who had passed away. Residents also visited their friends who resided in other designated centres and said that they very much enjoyed these social occasions. Residents showed inspectors life stories, photo albums and family trees that they had been supported by staff to put together.

Residents were part of the local community and described how they enjoyed regular trips to local café, pharmacy, shop, library, post office and to the hairdresser or beautician. One resident described how she went out with a volunteer for a coffee or to the cinema or for other social trips. Staff endeavoured to explore new opportunities for residents in the community and some residents enjoyed attending a community-based arts and crafts class or attending the nearby swimming pool.

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:

The admission practices and policies did not take account of the need to protect residents from abuse by other service users. The house was being used to provide a

day-service placement for a resident of another centre. There was evidence that this service user had assaulted residents and so the needs of the people already living in the house were not being taken into consideration.

Inspectors reviewed a sample of resident contracts of care and found that they had been signed either by the resident or their representative. The contracts seen outlined the residential charges for accommodation of the resident.

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):

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

Findings:

A comprehensive assessment of residents' health, personal and social care needs had not been completed. While all residents had an individual personal plan, improvement was required to the personal planning process. Given the level of needs and the ageing profile of the residents in this centre, inspectors found that the failure to complete a comprehensive assessment of residents needs, to ensure that the personal plan review was multi-disciplinary was at the level of major non-compliance.

A specific tool was used to document each residents assessment of their health, personal and social care needs, abilities and wishes. However, the assessments were not comprehensive. For example, where a resident had mobility needs, a written assessment had not been completed. Where residents had health needs, a comprehensive assessment had not been completed. This failing was at the level of major non-compliance.

Each resident had a written personal plan. Personal plans were individual and person-centred and contained information such as key people in the resident's life, special events, favourite outings or places and a range of likes and dislikes. Information was in an accessible format, for example, a resident's personal preferences were displayed in pictorial format. However, improvements were required to the personal planning process, the setting of personal goals and the review of personal plans.

While goals were based on residents' expressed wishes and choices and were important to the residents, long-term goals were not set and goals were not based on an assessment of residents' needs. As a result, there were no planned goals to address some identifiable needs. For example, for residents nearing retirement, there was no evidence of planning for this key life event. For residents with mobility needs, the personal planning process did not consider future accommodation needs. In addition, the supports needed for residents to achieve their goals were not specified and it was not clear how goals contributed to improving residents' quality of life.

The review process did not meet the requirements of the Regulations. While all residents' personal plans had been reviewed within the previous 12 months, the review of the personal plan was not multi-disciplinary as required by the Regulations. One resident had not had a multi-disciplinary team (MDT) meeting since 10 July 2012 (three years previously). Given the level of needs and the ageing profile of the residents in this centre, inspectors found that the MDT input provided was insufficient. In addition, where MDT input had been sought, there was no link between MDT meetings and the residents' personal plans. This failing was at the level of major non-compliance.

A record of the review of the personal plan and any challenges to meeting goals was maintained for each resident. Any challenges to achieving such goals were documented as was progress made in relation to challenges encountered. Resident and family involvement in personal planning was documented.

Due to an unexpected injury one resident had recently had to move to another centre to sleep at night time as due to an injury the resident couldn't go upstairs to the bedroom. There was no evidence of any written or coordinated plan in place to support the resident in relation to this temporary sleeping arrangement. There had been a medication error which occurred when medication wasn't given to the resident while staying in the other centre.

There had been a number of recent admissions of residents to an acute general hospital. Both medical and nursing treatment letters from the hospital were available on file. However, it was not always clear if the identified healthcare need had been followed up by the centre. In addition a plan of care for the identified healthcare need had not been created following discharge from hospital.

Judgment:

Non Compliant - Major

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 centre consisted of a two storey house located in a village. The people living in the house were generally elderly and some with restricted mobility. The house was clean, homely and well decorated. However, there were issues relating to the accessibility and in particular residents being able to get to the upstairs bedrooms.

There was good accessibility to the house on the outside with ramps and handrails available at both entrances. Inside the house on the ground floor significant changes had been made after recommendations from an occupational therapist in relation to accessibility. Wooden floors had been placed in the hallway and living room. The downstairs shower room had been upgraded and was used by all residents to have a shower.

There were two bedrooms upstairs and inspectors saw the two residents using these bedrooms had difficulty going up and down the stairs. In a plan seen for one resident there were instructions that staff were to follow the resident when they were going up the stairs and to go in front of the resident when they were going down the stairs. This was not a safe practice. In September 2014 an occupational therapist had recommended a review of the stairs and to look at the option of a stair lift. However, the survey of the stairway by a stair lift supplier had only been completed in April 2015. The occupational therapist had said that if a stair lift could not be used by the resident then a ground floor bedroom was needed. The upstairs bathroom had a shower in it but staff outlined that it was too narrow for residents to get into so they used the shower room downstairs.

There was a large living room which residents said they "loved". One resident had a table set up where she completed jigsaw puzzles. Some of these puzzles had been framed and were on display throughout the house. All residents used this room either to read the paper, listen to the radio or watch television.

The living room led to the kitchen via double doors. There were some accessibility issues for residents who used walking aids to get into the kitchen. The kitchen was long and narrow and when people were sitting at the kitchen table it was difficult to move the walking aid. The kitchen led to a large garden that was well maintained and had garden furniture there for people to relax.

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):

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

Findings:

Improvement was required in relation to how the designated centre was managing risk and fire safety.

The centre was visibly clean with a cleaning schedule identifying areas to be cleaned and cleaning frequencies. Staff spoken with were knowledgeable about cleaning and control of infection. Residents described to inspectors how they helped "to wash their clothes by bringing them to the utility room".

While there was a process in place for hazard identification and assessment of risk throughout the designated centre, it was not understood by staff. For example there was a risk assessment in relation to slips, trips and falls which said it was a medium risk. However after staff reviewed the risk assessment it was recorded as a low risk without any additional controls being put in place to reduce the risk of slips. The risk assessments available to provide guidance for staff on lifting of residents did not have any input from staff qualified in manual handling. This could lead to unsafe practice in relation to manual handling. There was a policy available on risk assessment guidelines but it didn't provide enough information for staff on the process of risk assessment.

There was an incident reporting system to identify hazards and from January 2015 to May 2015 there had been:

- 4 resident falls
- 4 accidents
- 5 times that bruises or scratches were noted on residents
- 2 incidents of residents engaging in self injurious behaviour
- 1 incident of a resident displaying behaviour that challenges.
- 1 incident of a resident assaulting another resident.

Inspectors identified a number of areas for improvement in relation to fire safety. There was a document called a fire risk assessment mobility status which outlined the help that residents would need in the event of an evacuation. However, this document was unsigned and undated and it was unclear if the information contained in it was valid. While there was a senior manager on call system for staff to ring if there was an emergency there weren't clear instructions as to where residents would go if the centre needed to be evacuated.

There were monthly fire evacuation drills being undertaken involving the resident. One resident said to inspectors that the fire evacuation point was in the "front garden". The fire documents for the centre indicated that complete evacuation drills were to take place every three months. The last recorded complete evacuation was in December 2014 with night time staff levels i.e. one staff member on duty with all residents in the house.

The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel April 2015
- fire extinguisher servicing and inspection October 2014
- servicing of emergency lighting April 2015.

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 a positive approach to behaviour that challenges was demonstrated. However, inspectors found that the systems in place, including MDT input and specialist behaviour support were not sufficient to support staff to manage behaviours that challenge in this centre. In addition, a major non-compliance was identified in that the provider had failed to protect residents residing in the centre from all forms of abuse.

Incidents that met the criteria for peer-to-peer abuse occurred in the centre and took the form of verbal and physical abuse. Inspectors found that the arrangement in place whereby the centre was being used to provide a day service for a resident not residing in the centre had resulted in incidents of peer-to-peer abuse directed towards residents living in the centre. Inspectors found that this failing was at the level of major non-compliance due to impact on the residents in the centre and the fact that it was on-going. The impact of the situation on one resident was documented in a risk assessment dated 18.10.2014 and the first MDT meeting to review that situation only took place on 22.4.2015. The inspector noted that the risk rating in risk assessments pertaining to this issue was consistently described as 'low', which does not correspond with other available information including incident reports, referral to MDT for the person causing concern and referral to the organisation's MDT committee (a 'concern and welfare committee') that reviews issues of concern to residents' safety or wellbeing. Following an incident involving a second resident dated 26.3.2015, the organisation's internal process had been followed and included initiation of a request for review of the situation by the organisation's aforementioned 'concern and welfare committee'.

Relevant policies were in place, including in relation to the protection of vulnerable

adults, restrictive practices, and behaviours that challenge, the provision of personal intimate care and residents' personal finances and possessions.

With respect to behaviour that challenges; staff were able to articulate antecedents to individual resident's behaviours and how to respond to specific signs in a positive way, such as using distraction or diversion. Staff were observed to support residents to prevent escalation of any such signs. Charts that tracked 'antecedents, behaviour and consequences' to a particular behaviour (known as 'ABC charts') were maintained as required.

However, a number of areas relating to practices and the documentation of the management of behaviours that challenge required improvement. While residents had access to MDT in relation to managing their own behaviours, the MDT input into the behaviour support plans viewed in the centre was limited. Inspectors reviewed behaviour support plans for residents with behaviour that challenges and found that they did not provide adequate guidance for staff. Neither plan identified the reasons or possible reasons for specific behaviours. For one resident, relevant information about contributing factors to behaviours detailed in their 'challenging behaviour risk assessment' was not included in the behaviour support plan e.g. that the resident may become upset if a planned activity is cancelled. As a result, the behaviour management plan did not outline proactive or reactive strategies to manage identifiable antecedents or 'triggers'. For another resident, an identified trigger was if the resident was unsure of what was happening next; while the behaviour support plan referenced the resident's communication board in their day service as a proactive strategy, it did not reference their picture sequence board used in the centre which was necessary to support the resident to manage their own behaviour. Finally, there was insufficient review of strategies through the personal plan.

Documentation pertaining to the use of restrictive practices was maintained. There was one restrictive practice in use in the centre. The rationale for the practice was documented. Alternatives had been explored. There was evidence of MDT input and consent of the resident.

While overall there was evidence that incidents were recorded and reported, inspectors found that an incident of verbal abuse that involved residents from both day and residential services had not been identified as requiring reporting in the residential service. As a result, there was underreporting of incidents affecting residents residing in the centre. Those incidents that were recorded were completed in full and corresponded with behaviour logs. Monthly review logs clearly tracked the number of incidents for each resident.

Inspectors reviewed records pertaining to the house budget and individual residents' records that recorded the management of day-to-day monies. Residents' bank accounts were in their own names. While receipts were kept for all items and all expenditures were clearly logged, not all entries were double-signed, as per the organisation's policy to protect against financial abuse.

Inspectors spoke with a sample of staff on duty and they articulated what to do in the event of an allegation or suspicion of abuse. Staff training records indicated that

mandatory training in relation to behaviour that challenges was not up-to-date for all staff. All staff had received training in relation to the protection of vulnerable adults.

Judgment:

Non Compliant - Major

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:

A written report at the end of each quarter in relation to incidents occurring in the house was submitted as required.

Adverse incidents were notified in writing to the Authority. However, not all incidents of peer-on-peer abuse had been recorded as incidents nor had they been notified to the Authority, as required by the Regulations. The person in charge submitted any outstanding notifications to the Authority by the close of inspection.

Judgment:

Non Compliant - Major

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:

Overall, inspectors found that residents participated in training and skills development. However, a formal assessment was required of each resident's training, educational and personal development goals.

A policy was in place in relation to access to education, training and development.

Some residents were active retirees and other residents attended a day service. For residents who attended a day service, this was on a part-time basis and reflected their wishes as they were nearing retirement age. The inspector reviewed a sample of residents' personal plans and found that only one resident had a formal assessment of their educational, employment and training goals. A template had recently been introduced that considered residents' numeracy and literacy, time telling skills and independence skills. However, this was not an assessment as it did not assess residents' educational, employment and training goals or whether their current day programme was suitable to their individual capacities and needs and was enjoyed by them.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The centre had limited nursing input into care and staff said to inspectors that they didn't have enough knowledge of care planning, particularly in relation to healthcare needs. In one example staff informed the inspectors that one resident had a specific healthcare diagnosis. On reviewing the healthcare information available inspectors saw that there was not a definitive diagnosis recorded in the medical notes.

Healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan to direct care. For example, one resident had an epilepsy profile record. However while this recorded when the person last had an epileptic seizure it did not reference a review by a consultant specialist in December 2014. In addition this resident had a recognised deficiency which the consultant specialist identified as a potential side effect of medication to control epilepsy. However, a test undertaken in 2007 which identified this deficiency hadn't been followed up as recommended. This information wasn't included in the epilepsy profile record.

In the sample of resident healthcare file seen by inspectors each resident had access to a general practitioner (GP) who saw residents at regular intervals. While there was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required, the recording and follow up care planning required improvement. In one example a resident had an investigation in 2013 and a follow up investigation in 2014. There was no care plan available to indicate whether this identified healthcare issue was an ongoing problem or if it had been resolved. In another example one resident had been referred for an x-ray following an

admission to the Emergency Department. However, there was no indication as to whether this x-ray had been done.

There was evidence that residents were referred for treatment by allied health professionals including speech and language therapy in relation to swallowing difficulties. Some residents had recommendations available from a dietician regarding diet and meal planning.

Residents were involved in the day to day activities around mealtimes like setting the table, preparing the vegetables and writing up the menus. Menu plans for lunch, dinner and tea were available in the kitchen with pictures of the meal available so residents knew what was for dinner. The inspectors found adequate quantities of food available for snacks and refreshments.

Judgment:

Non Compliant - Major

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:

Medication was dispensed from the pharmacy in a monitored dosage system which packaged the medication for each resident for the correct time each day. The residents said that they went down to the pharmacy to collect their own medications. The pharmacist had provided training to staff on the use of a prescribed inhaler required for one resident.

All medication was stored securely and medication that required it was put into a fridge. The temperatures on the fridge were being recorded daily to ensure that the medication was being kept at the appropriate temperature.

There had been 6 recorded medication errors since January 2015. Three incidents related to drugs not being given and one related to a prescribed medication not being available on that day. There were two errors recorded relating to potential adverse reactions to medication. These two events had been followed up immediately with the doctor reviewing the residents and putting a note on the prescription sheet alerting staff that the resident may have an allergy to the particular drug.

The inspectors saw that adequate systems were not in place to minimise the risk associated with the practice of transcription in line with guidance issued by An Bord

Altranais agus Cnáimhseachais. Medication prescription records contained the signature of the nurse who transcribed the record. However, additional controls, such as an independent verification, were not implemented to safeguard this practice.

Judgment:

Non Compliant - Moderate

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:

The Statement of Purpose contained a statement of the aims, objectives and ethos of the centre. However, it did not meet the requirements set out by Schedule 1 of the Regulations.

For example, the specific care needs and services to be provided by the centre to meet those care needs were not clearly set out, including nursing support. The arrangements for residents to access employment were not outlined. In addition, the number, age range and gender of the residents for whom it is intended that accommodation should be provided was not accurate. The admissions criteria was not specified. Separate facilities for day care were not adequately outlined. The description of the rooms was not sufficiently detailed. An inaccuracy was noted in that it was stated that behaviour support plans were devised in conjunction with the Psychologist, which was not found to be the case. Other areas requiring minor amendment were discussed with the person in charge.

Judgment:

Non Compliant - Moderate

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:

Improvements were required to the governance and management of the designated centre.

The person in charge was full-time and had commenced as person in charge in March 2015 (3 months prior to this inspection). The person in charge had 25 years experience in the service, was a nurse in intellectual disability and held a diploma in first line management. The person in charge demonstrated commitment to her own professional development and for example, held certificates in multi-element behavioural support and person centred-planning. The person in charge demonstrated that she was aware of her responsibilities under the Regulations and was involved in the management of the centre on a regular basis. However, she was the person in charge for four designated centres in total spread over a broad geographical area. It was not demonstrated that this arrangement was satisfactory given the high and increasing needs of the residents in this centre.

Overall, it was not demonstrated that the annual review and bi-annual visits contributed satisfactorily to improving the quality and safety of care delivered in the centre.

An annual review of the quality and safety of care of the service dated 29.4.2015 had been completed by the Quality and Risk Officer and was reviewed by the inspector. The annual review summarised audits completed and progress on actions from previous audits. However, the annual review did not provide for consultation with residents and their representatives, nor was a copy of the review made available to residents. In addition, not all 'outcomes' in the audit tool were reviewed, meaning that the review was not comprehensive. For example, the suitability of the centre to meet the residents' needs had not been reviewed. As a result, an opportunity to assess this area had been missed with the result that there was no action plan in place to plan for this key issue. In addition, there is no dedicated MDT support to St. Anne's Service and this had not been identified in the annual review.

The provider had ensured that unannounced visits to each house within the designated centre had been completed by the Quality and Risk Officer. The inspector reviewed the outcome of the bi-annual visit and found that some areas pertaining to governance and management of the centre had not been adequately considered. For example, in relation to whether the design and layout of the centre was suitable to residents' needs, the response was that it was suitable to residents' needs and comments related to the recently refurbished downstairs bathroom and noted that the kitchen/dining area was small. However, it was not demonstrated that the report writer had considered whether the centre itself was suited to the residents in the centre, who had an older profile and increasing needs, including mobility needs. In addition, it was well documented that

where residents slept in upstairs bedrooms, that this was presenting difficulty for those residents.

Other audits took place within the service including in relation to medication management, fire safety, health and safety and hygiene.

Staff were clear in relation to lines of authority and were able to identify the person in charge. All staff, the house manager and the person in charge identified the need for more clinical support in this centre to support the increasing needs of the residents. This was evidenced by the gaps in residents' assessments and care plans discussed under Outcomes 5 and 11. This gap had not been addressed in the annual review or bi-annual unannounced visit by the provider.

In addition, the deputising arrangements in place in the event of the absence of the person in charge for 28 days or more had not been formalised.

There were systems in place to support the person in charge, including a house manager, who held a diploma in disability studies, a certificate in front line management and a certificate in multi-element behavioural support. The house manager had been identified as a person participating in the management of the centre and commenced as house manager for this house three months prior to the inspection. However, the house manager was part-time in this centre (17.5 hours per week) with no allocated supernumerary hours. It was not demonstrated that this arrangement was satisfactory given the high and increasing needs of the residents in this centre.

Regular house meetings took place and minutes were kept of such meetings. Inspectors viewed such minutes and found that included discussion of issues relevant to the quality and safety of care provided to residents. Monthly managers meetings were held that included the person in charge, provider nominee and which were attended by other persons depending on specific topics under discussion. A structure had been introduced for 1:1 meetings between the provider nominee and person in charge but to date such meetings had not commenced.

There was a system in place for the completion of annual staff appraisals. Inspectors spoke with staff who confirmed that such appraisals took place.

Judgment:

Non Compliant - Major

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:

There had been no case where the person in charge had been absent in this designated centre for 28 days or more, nor had there been emergency absence that required notification to the Authority. Arrangements relating to the absence of the person in charge were previously discussed and included in the action under Outcome 14: Governance and Management.

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:

The facilities provided did not reflect the Statement of Purpose. The statement of purpose outlines that the centre will ensure that "appropriate accommodation / environment is provided". As previously discussed under Outcome 6; the design and layout of the centre did not meet all of the residents' needs.

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):

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

Findings:

The inspector found that it was not demonstrated that the number and skill mix of staff was appropriate to the needs of the residents in the centre. Mandatory training for all staff in relation to the management of behaviour that challenges was outstanding.

There was a staff rota, which was properly maintained. However, as previously mentioned under Outcome 1, the inspector found that there were times when activities and interests were curtailed by staffing levels, particularly at weekends. The house manager and person in charge demonstrated that they had commenced reviewing staff rotas in an attempt to address this. This failing was also identified by a relative in a questionnaire submitted to the Authority.

As evidenced under Outcomes 5 and 11, it was not demonstrated that staff had the required skills and qualifications to ensure that: each resident had a comprehensive assessment of their needs; that residents' health needs were met; that personal plans were effective and took into account changes in circumstances and new developments and; to support residents with behaviours that may challenge. In relation to the meeting of health needs, while the person in charge was a qualified nurse, she was also the person in charge for four designated centres comprising eight houses over a broad geographical area. Inspectors found that this failing was compounded by the lack of MDT input into key areas such as annual reviews, personal planning reviews and behaviour support plans for residents.

There was a training plan in place and the annual staff appraisal system facilitated the identification of staff training needs. The inspector reviewed staff training records for regular and rostered agency staff. Most, but not all, mandatory training was up to date. Mandatory training in relation to the protection of vulnerable adults and fire safety was up to date. Mandatory training in relation to the management of behaviour that challenges was not up to date for all staff. This was previously addressed under Outcome 8: Safeguarding and Safety.

A previously identified area for development at service level, and in this centre, related to the finding that a number of care staff did not possess a formal recognised qualification relevant to the role of care assistant, such as the FETAC Level 5 Healthcare Assistant course or equivalent. A funded plan is in place to address this gap. Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to hand hygiene, safe moving and handling and food safety.

A clear system in place for new staff was described to the inspector. Supervision arrangements were in place. The induction log for new staff members included centre policies, observation skills, incident reporting and the management of behaviours that challenge.

There was a volunteer attached to the centre and evidence of vetting, reference checks and supervision was provided. A description of the role of the volunteer was also available.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place. House meetings were held every four to six weeks and minutes were maintained of such meetings.

Staff files were held centrally and reviewed by an inspector who found that they met the requirements of Schedule 2 of the Regulations.

Judgment:

Non Compliant - Major

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 management of records required improvement.

In some healthcare files reviews of residents' healthcare needs by consultant specialists were filed in plastic pockets at the back of the healthcare record and could not be seen. This system did not adequately ensure that relevant healthcare information was available to plan care for residents.

In relation to other records the risk management policy did not meet the requirements of regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The admissions policy did not take account of the need to protect residents from abuse by other service users.

Inspectors saw a copy of the residents' guide but it did not include the terms and conditions relating to residency. This was particularly relevant due to the age profile of these residents and their changing healthcare needs.

A directory of residents was maintained in the centre and was made available to the inspectors.

Judgment:

Non Compliant - Moderate

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 Hennessy
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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005157
Date of Inspection:	03 June 2015
Date of response:	23 July 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 provider failed to demonstrate that residents' participate in a meaningful way in the organisation of the designated centre. It was not clearly demonstrated whether residents were consulted in relation to the use of their home to provide a day service for another resident.

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

Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

The practice is one that was introduced a number of years ago, since the Inspection the Nominee Provider, the Clinical Nurse Manager 3 and the Person in charge have reviewed practices in this centre. The attendance of a Service user from another area to this house had ceased.

Proposed Timescale: 13/07/2015

Theme: Individualised Supports and Care

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

The inspector found that improvements were required to the use of residents' personal and living space as the centre was also used to provide a day service for a resident who did not reside in the designated centre.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The Nominee Provider has increased staffing resources to support the service user residing in another centre; the additional resources support the other resident to be activated from her own centre daily. The nominee provider has met with the Person in Charge and advised her that going forward a house is a home and cannot be used to facilitate a Day Service for an individual Service User who do not reside in the centre. The service users in the centre have been informed of the change.

Proposed Timescale: 13/07/2015

Theme: Individualised Supports and Care

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

Some information management practices did not respect residents' privacy and confidentiality in relation to their personal information.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The Clinical Nurse Manager 3 and the Person in Charge will provide input to the House Manager and Staff Team about the importance of Service Users confidentiality, respect for their privacy and to ensure Service User's information is not placed in a public place within the House.

All information relating to service users will be stored in their own personal files. The clinical nurse manager 3 will audit the care plans and personal information of each service user to ensure information is appropriately stored.

No information with service users name and details will be displayed in public areas in the house, such as on notice boards et. All information relating to service users on the notice boards has since inspection been removed.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

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

Staff described that residents were called into the office to receive their medications. Inspectors found that this practice was not person-centred.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The Clinical Nurse Manager 3 has spoken to all staff and the manager in the centre at the house meeting, and this practice is now stopped.

Proposed Timescale: 05/06/2015

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:

There was evidence that residents were being assaulted by a service user coming to the house and using it as a day-service.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

The Nominee Provider has stopped this Practice and Service Users are no longer being assaulted by the Service User who received a Day Service in the Centre. The Centre no longer provides a Day Service to the Service User from another Centre

Proposed Timescale: 13/07/2015

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:

A comprehensive assessment of residents' health, personal and social care needs, abilities and wishes had not been completed.

Action Required:

Under Regulation 05 (1) (b) 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

All Service Users care plans will be reviewed by the Person in Charge, the House Manager and with the support and training from the Clinical Nurse Manager 3. Where needs have not been appropriately assessed an assessment will be completed by a Registered Nurse and members of the Multidisciplinary Team where required and plans of care will be developed.

The plan of care will have a review date and a named person responsible to ensure that reviews are completed in a timely manner. There will be a day assigned where relevant team members and multi disciplinary remembers, facilitated by the clinical nurse manager 3 to review all care plans for individuals in the centre. This will include review of all assessments and plans of care in each individuals care plan. Future planning and changing needs will be identified through this review.

Proposed Timescale: 15/08/2015

Theme: Effective Services

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

Goals were not based on an assessment of residents' needs. As a result, there were no planned goals to address some identifiable needs. In addition, the supports required to

meet goals were not specified.

Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

All goals will be reviewed by the Team involved with the Service Users. This team will include the Person in Charge, staff from the Centre, the Clinical Nurse Manager 3 and relevant members of the Multidisciplinary Team. Each goal or part thereof, will have a named responsible person for actioning the goal within an agreed time frame. Where there are changes required to the goal to aid its achievement these changes will be made in the plan, for example changing needs due to ill health, aging or mobility. The Clinical Nurse Manger 3 will carry out random audits of the personal plans and goals to ensure their effectiveness.

Proposed Timescale: 15/08/2015

Theme: Effective Services

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

The review of the personal plan was not multi-disciplinary, as required by the Regulations. In addition, where MDT input had been sought, there was no link between MDT meetings and the residents' personal plans and the care and support that is delivered to them.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

All service users care plans will be reviewed by the person in charge, the house manager, key worker and with the support and training input from the clinical nurse manager 3. Where an assessment has not already been completed or a change in care needs is identified this assessment will be completed by a registered nurse and a multi disciplinary team member where required, and plans of care set out. The plan of care will have review dates as necessary depending on the service users care needs, and changes in same. The person in charge will monitor and the CNM3 will audit the effectiveness and ensure the completion of these assessments and plans of care, and reviews as recommended. All identified health care needs will have a plan of care in place.

There is a lack of multi disciplinary support to the service users in the centre; the service is currently recruiting for same. In the interim where multi disciplinary support is required, this will be contracted in for an individual.

The Service Human Resources Director, Nominee Provider, Person in Charge and

Clinical Nurse Manager 3 are reviewing staffing in the centre. Service users support needs will be the basis of this review to ensure that appropriate skill mix and safe practices are in place, this process commenced on 20/06/2015. The Clinical Nurse manager 3 with direct responsibility to the centre will monitor and lead healthcare and clinical care needs within the centre.

Proposed Timescale: 15/08/2015

Theme: Effective Services

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

It was not always clear if the identified healthcare need had been followed up following discharge from hospital. In addition a plan of care for the identified healthcare need had not been created following discharge from hospital.

Action Required:

Under Regulation 25 (2) you are required to: On the return of a resident from another designated centre, hospital or other place, take all reasonable actions to obtain all relevant information about the resident from the other designated centre, hospital or other place.

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

The Person in Charge with the support of the Clinical Nurse Manager 3 will ensure when a Service User is discharged from the acute hospital any changes required to their plan of care will be implemented with a named responsible person identified and a review put in place.

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:

There was no written or coordinated plan in place in relation to a resident as they were being cared for in two separate locations.

Action Required:

Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

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

The practice of a service user living by day in one centre and sleeping in another centre at night, even as a temporary arrangement will no longer take place.

Proposed Timescale: 27/04/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There were issues relating to the accessibility and in particular residents being able to get to the upstairs bedrooms.

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:

The Nominee Provider and the Logistic Director will review the premises and will have a plan of alterations as may be required with dates and time frames to meet the changing needs of the service users residing in this centre.

Proposed Timescale: 31/08/2015

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 system was not sufficiently robust as staff did not understand how to complete a risk assessment.

Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

The Clinical Nurse Manager 3 from another part of the Service will support staff in the Centre with on site training in relation to Risk Assessments and will also provide general input on Risk Management to ensure a safe environment for all Service Users. The nominee provider and the Quality and Risk officer have developed a procedure in risk management to support staff in the centre to understand how to complete and recognise the need for a risk assessment.

Proposed Timescale: 24/07/2015

Theme: Effective Services

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

The risk management policy did not meet the requirements of regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

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:

The nominee provider and the Quality and Risk officer have developed a procedure in risk management to support staff in the centre to understand how to complete and recognise the need for a risk assessment and gain a better understanding of serious incidents and adverse events.

The Person in Charge will with the House Parent ensure it is a regular item on the agenda for staff meeting.

Proposed Timescale: 24/07/2015

Theme: Effective Services

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

Each resident had a fire risk assessment mobility status which outlined the help that residents would need in the event of an evacuation. However, this document was unsigned and undated and it was unclear if the information contained in it was valid.

Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

The Person in Charge and the House Manager will review each Service Users risk assessment and their mobility status which will be person centred, dated and reviewed by a named responsible person. The existing document has been reviewed, signed and dated and contains all relevant and valid information.

Proposed Timescale: 17/07/2015

Theme: Effective Services

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

While there was a senior manager on call system for staff to ring if there was an

emergency there weren't clear instructions as to where residents would go if the centre needed to be evacuated.

Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

In the event of the need to evacuate service users from this centre, they would be supported by staff to secure accommodation in a local hotel.

Proposed Timescale: 03/07/2015

Theme: Effective Services

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

The last recorded complete evacuation was in December 2014 with night time staff levels i.e. one staff member on duty with all residents in the house.

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:

The Nominee Provider has directed the Person in Charge and the House Team that evacuation must take place monthly – this must be dated and documented by a responsible person. Random audits will be carried out by the Fire Officer and findings will be an agenda item for team meetings.

Proposed Timescale: 10/07/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was no evidence in behaviour support plans that every effort had been made to identify the cause of residents' behaviour.

Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The Person in charge with the support of the Clinical Nurse Manager 3 will review each Service Users Behaviour Plan. The Multidisciplinary Team members will be involved in this review and behaviour support plans will be developed or changed as required. There will be a review date and a named person responsible.

Proposed Timescale: 20/08/2015

Theme: Safe Services

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

Multi-disciplinary input into behaviour support plans viewed in the centre was limited. Behaviour support plans for residents with behaviour that challenges did not provide adequate guidance for staff. There was no link between the residents' risk assessments relating to behaviour that challenges and the behaviour support plan and risk assessments were inadequate. Also, there was insufficient review of strategies through the personal plan.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

All staff will receive support in relation to the management of behaviours that challenge. This will be delivered by a clinical nurse manager 3 with specialist experience in the area of challenging behaviour, to identify behaviours and develop comprehensive behaviour support plans for service users requiring same, this support will be delivered in August 2015.

It is recognised that Multi Disciplinary input to support plans is limited, and there is actively a recruitment process in place for multi disciplinary team members. Where multi disciplinary team support is needed by any individual service user the nominee provider will ensure funding is made available to source this support. The person in charge will make the referral to the multi disciplinary member.

Proposed Timescale: 12/09/2015

Theme: Safe Services

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

Staff training records indicated that mandatory training in relation to behaviour that challenges was not up-to-date for all staff.

Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Training has been completed for all staff in the centre in relation to behaviour that challenges.

Proposed Timescale: 12/06/2015

Theme: Safe Services

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

Inspectors found that the arrangement in place whereby the centre was being used to provide a day service for a resident not residing in the centre had resulted in the peer-to-peer abusive practices against residents living in the centre. In addition, the organisation's policy to protect residents from financial abuse was not being followed in that all entries were not double-signed.

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:

Since 10/07/2015 the above practice of another service user attending the centre for a day service no longer occurs. The Director of Finance will review the patient private property guidelines with particular attention to the co signing of receipts, this will be reviewed however any change made will continue to ensure safeguarding of service users monies. Audits will be carried out by the Financial Accountant and findings will be shared with the person in charge and will be discussed at staff team meeting

Proposed Timescale: 30/09/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Not all incidents of peer-on-peer abuse had been notified to the Authority, as required by the Regulations.

Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The Nominee Provider has discussed with the person in charge her responsibility in making notification of incidents to the Authority in a timely manner. The nominee provider and the clinical nurse manager 3 met and discussed with the person in charge on 29/06/2015 to discuss all aspects of the service policy on protection and welfare of vulnerable adults, with particular attention given on peer to peer abuse. The person in charge's responsibility in making notification was highlighted by the nominee provider. The clinical nurse manager 3 will support and monitor the person in charge to ensure that incidents are recognised and that notifications are completed.

Proposed Timescale: 30/06/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Not all residents had a formal assessment of their training, educational and personal development goals.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

The policy in relation to access to education and training is now in place. The centre team with the person in charge and the day service areas staff that support each service user will meet to develop a plan for each individual service user's education and training needs. There will be a separate, and designated, section in each care plan to ensure appropriate assessment of education, training and development needs of each service user. Out of each assessment, short, medium and long term goals will be developed with the service user to ensure that residents are afforded every opportunity available to them around education, training and employment.

There will be training for all staff in the centre to support them in the development process of suitable programmes for each service user in the centre.

Proposed Timescale: 12/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan to direct care.

In addition, while there was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required, the recording and follow up care planning required improvement.

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:

All service users care plans will be reviewed by the person in charge, the house manager, key worker and with the support and training input from the clinical nurse manager 3 . Where an assessment has not already been completed or a change in care needs is identified this assessment will be completed by a registered nurse and a multi disciplinary team member where required, and plans of care set out. The plan of care will have review dates as necessary depending on the service users care needs, and changes in same. The person in charge will monitor and the CNM3 will audit the effectiveness and ensure the completion of these assessments and plans of care, and reviews as recommended. All identified health care needs will have a plan of care in place.

Proposed Timescale: 15/08/2015

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:

Medication prescription records contained the signature of the nurse who transcribed the record. However, additional controls, such as an independent verification, were not implemented to safeguard this practice.

Action Required:

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

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

All transcribed kardexs will be proof read and signed by two nurses, and the service policy will be ammended to reflect this.

Proposed Timescale: 31/07/2015

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 meet the requirements set out by Schedule 1 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 Clinical Nurse Manager 3 with the Person in Charge and House Manager will review the statement of purpose and make the necessary changes to meet the requirements set out by schedule 1 of the regulations.

Proposed Timescale: 24/07/2015

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:

All documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 had not been provided. The registration fee was outstanding as were certificates of planning compliance and fire compliance.

Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

The nominee provider will ensure that the registration fee is submitted for this centre. The nominee provider will discuss the outstanding planning and fire compliance documents with the Director of Logistics and forward same to the authority.

Proposed Timescale: 20/08/2015

Theme: Leadership, Governance and Management

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

the following respect:

The person in charge managed four designated centres; this arrangement did not ensure the effective governance, operational management and administration of the designated centres concerned.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The person in charge of the centre has a direct link for mentorship and support with the newly appointed clinical nurse manager 3. The recruitment process has commenced in the service to appoint an additional clinical nurse manager 2 post. This post will be a person in charge, and one area of responsibility will be removed from this centres person in charge.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

While an annual review of the centre had been completed, it was not demonstrated that the annual review contributed satisfactorily to improving the quality and safety of care delivered in the centre.

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:

The service Quality and Risk officers, the nominee provider, the Director of Nursing and the ACEO will review the annual audit document and make changes to ensure that it contributes to improve the quality and safety of service delivery.

Proposed Timescale: 12/09/2015

Theme: Leadership, Governance and Management

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

While an unannounced visit to the designated centre had been completed, it was not demonstrated such visits contributed satisfactorily to improving the quality and safety of

care delivered in the centre.

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:

All actions will be completed in a timely fashion. The Nominee Provider and Person in Charge will review the reports and make responsible persons for completing the actions in specific timeframes. The Nominee Provider has detailed the importance of following up on actions outlined and seeking advice and support where necessary. The service Quality and Risk officers, the nominee provider, the Director of Nursing and the ACEO will review the unannounced visit audit document and make changes to ensure that it contributes to improve the quality and safety of service delivery.

Proposed Timescale: 12/09/2015

Theme: Leadership, Governance and Management

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

The annual review of the quality and safety of care and support in the designated centre did not provide for consultation with residents and their representatives.

Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

A copy of the annual review will made available to all families and service user representatives by the person in charge. The nominee provider will include consultations with the service users, their families and representatives in review of the quality and safety of care in the centre in future reviews.

Proposed Timescale: 31/08/2015

Theme: Leadership, Governance and Management

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

A copy of the annual review of the quality and safety of care and support in the designated centre had not been made available to residents.

Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

The Person in Charge supported by the Clinical Nurse Manager will ensure the House Manager and Staff will provide information from the annual review of the Quality and Safety Report to Service Users in a format that Service Users understand. A copy of the annual review will be made available to all families and service user representatives by the person in charge.

Proposed Timescale: 31/08/2015**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The deputising arrangements in the event of the absence of the person in charge for 28 days or more had not been formalised.

The house manager was part-time in this centre (17.5 hours per week) with no allocated supernumerary hours and it was not demonstrated that this arrangement was satisfactory to meet the residents' needs.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The link clinical nurse manager 3 will be the named person in charge for the centre in the event that the person in charge is absent for 28 days or more.

The nominee provider has instructed the person in charge and the house manager, with the support of the clinical nurse manager 3, to review the roster for the centre. Part of this review is to determine if supernumerary hours can be facilitated within present resources for the house manager, if not the nominee provider will ensure additional support to the centre to allow supernumerary hours for the house manager.

Proposed Timescale: 31/07/2015**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not demonstrated that the arrangements and supports in place for the provider nominee to govern this centre and 14 other centres in this service were adequate to

ensure that the service provided was appropriate to the residents' needs, safe, consistent and effectively monitored.

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:

Since inspection the members of the executive team have scheduled weekly meetings with the nominee provider to discuss the designated centre and actions necessary to meet registration standards.

Since inspection the nominee provider and the Director of Nursing have designated times every week where identified areas for support in the centres are addressed.

The nominee provider and the Director of Logistics have weekly meetings and house visits to plan the necessary developments within centres.

The CEO is working with the nominee provider in identifying gaps in service delivery, and seeking funding to put the necessary supports in place, currently the organisation is in the recruitment process for nursing staff, clinical nurse manager 2 and multidisciplinary team members.

The nominee provider has put in place a new management structure to support the centre. This new management structure now includes clinical nurse manager 3 x2 posts. These clinical nurse managers provide the input and support necessary to ensure good practice and ensure all service users' needs are met to a high standard.

Supervision for persons in charge is provided on an on going basis directly by the clinical nurse manager 3, the nominee provider schedules meetings with the person in charge, but also meets with the person in charge on a regular basis and is contactable to them for advise at all times. The clinical nurse manager 3 supports the person in charge and goals are set with the house managers to ensure that the centre achieves and maintains the standards that are necessary for service users to reach their full potential.

Proposed Timescale: 29/06/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

The facilities did not reflect the Statement of Purpose as appropriate accommodation / environment had not been provided for all 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:

The Nominee Provider and the Logistic Director will review the premises and will have a plan of alterations as may be required with dates and time frames to meet the changing needs of the service users residing in this centre.

An assessment of each service users needs will be completed by the person in charge the house team and members of the multidisciplinary team facilitated by the clinical nurse manager 3. The Director of Logistics and the Nominee Provider will review these recommendations and develop a time bound plan to address the changing needs of the service users.

Proposed Timescale: 31/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

It was not demonstrated that staff had the required skills and qualifications to meet the 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:

The Nominee Provider and Director of Human Resources and Clinical Nurse Manager 3 along with the Person in Charge are undertaking a review of the staffing to the Centre this commenced on 20/06/2015. The organisation is currently in the recruitment process for nurse, nursing supports will be allocated to this centre on recruitment to meet the changing needs of service users. The Nominee Provider and ACEO have a plan and funding in place to provide Fetac Level 5 training to staff of the Centre over the coming academic year commencing September 2015.

Rostering of staff will be reviewed to ensure that both Service Users and staff are safe in the Centre at all times.

Recruitment is ongoing, to displace all agency staff from the centre.

Proposed Timescale: 30/09/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The admissions policy did not take account of the need to protect residents from abuse

by other service users.

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:

The nominee provider will refer this to the chairperson of the Admission and Discharge committee, who will coordinate a review of the policy to ensure residents are safe from peer to peer abuse.

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

There was a residents' guide available in the centre but it did not include the terms and conditions relating to residency.

Action Required:

Under Regulation 20 (2) (a) you are required to: Ensure that the guide prepared in respect of the designated centre includes a summary of the services and facilities provided.

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

The Person in Charge with the House Manager and clinical nurse manager 3 and Team will review the residents guide and ensure it includes all relevant information for each Service User with particular attention to the conditions of their residency in the Centre.

Proposed Timescale: 20/08/2015

Theme: Use of Information

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

In some healthcare files reviews of residents' healthcare needs by consultant specialists were filed in plastic pockets at the back of the healthcare record and could not be seen. This system did not adequately ensure that relevant healthcare information was available to plan care for residents.

Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The person in charge and house manager will ensure that all records including consultant's notes will be stored in the relevant section of the service users file, and not in poly pockets. All records and documentation relating to care will be accessible by all staff supporting service users of the centre.

Proposed Timescale: 31/07/2015