

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dearaglishe
Centre ID:	OSV-0002610
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joanna McMorrow
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
06 December 2016 10:15	06 December 2016 20:00
07 December 2016 08:00	07 December 2016 20:15

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 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 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

The purpose of this unannounced inspection was to monitor the centres' on-going regulatory compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres' for Persons (Children and Adults with Disabilities) Regulations 2013.

Dearaglishe was previously inspected as part of a larger campus based setting, formally Cloonamahon Services. Previous inspections of the Cloonamahon Campus had identified a number of non-compliances resulting in meetings with the provider and the Authority issuing a notice of proposal to cancel and refuse registration of the Cloonamahon Service. Following the notification the provider submitted

representations setting out the improvements which had been made at the service since the last inspection, including the re-configuration of the campus from one designated centre into four. This was the centre's first inspection as a standalone centre, following the re-configuration of services provided at Cloonamahon Services.

How we gathered our evidence:

The inspector met with residents, staff members and the management team during the inspection process. The inspector reviewed practices and documentation to include residents' personal plans, accident and incident reports, policies and procedures, fire management related documents and various risk assessments.

Description of the service:

This service is operated by the Health Service Executive (HSE). Dearaglishe is one of four designated centres which recently underwent re-configuration. Dearaglishe is located on a campus based setting, situated outside Sligo town. The centre can accommodate up to eight residents from 18 years of age onwards. There were three female residents and five male residents residing in the centre at the time of inspection, ranging from 50 to 93 years of age. The centre is a nurse led service, providing care to residents with intellectual disabilities, autistic needs, dual diagnosis of intellectual disability and mental health disorders, dementia care needs and end of life care needs.

The Person in Charge (PIC) had the overall responsibility for the service and is supported in her role by the Provider and Person Participating in Management (PPIM). The PIC works directly within the centre and has oversight of the day- to-day operations. Dearaglishe is located on the ground floor of the main campus building and has spacious communal areas for residents' use. The centre was found to be clean and well maintained at the time of inspection.

Overall judgment of our findings:

Overall, the inspector found that this centre was well managed and provided individualised care to the residents availing of the service. Staff were found to be very respectful of residents and were knowledgeable of each resident's needs. The inspector found the centre provided a calm atmosphere and homely environment for residents. However, aspects of the service delivery were led by routine practices and resources of the service and not by the residents' support needs. Overall, the inspector found the daily practices of the centre did not adequately reflect the ageing profile of the residents residing in the centre, with particular reference to social care needs and mealtime practices.

An immediate action was issued on the first day of inspection due to significant concerns identified regarding the disposal of expired medication and medicinal products within the centre. This immediate action was actioned by the centre and a written response to the immediate action has since been received by Health Information and Quality Authority (HIQA) outlining the actions taken.

The inspection covered 16 outcomes, seven of which were compliant, three substantially complaint, four in moderate non-compliance and two major non-compliances with the regulations. An action plan was issued to the Provider outlining

the areas of non compliance requiring address. These included Residents Rights, Dignity and Consultation, Social Care Needs, Safe and Suitable Premises, Health and Safety and Risk Management, General Welfare and Development, Medication Management, Statement of Purpose, Workforce and Records and Documentation.

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):

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

Findings:

Significant advances had been made by the centre to ensure residents were consulted with and participated in decisions about their care and about the running of the centre. Residents had access to advocacy services. Staff were observed to greet and address residents in a respectful manner. However, not all actions relating to this outcome had been addressed since the last inspection. The inspector found actions remained outstanding in relation to residents' opportunities to engage in activities that best reflected their assessed needs. Upon this inspection, further improvements were identified in relation to complaints management, residents' finances and residents' privacy and dignity.

The inspector found residents were consulted with, both in a formal and non-formal manner. Residents' meetings were held on a regular basis. Minutes of these were reviewed by the inspector and were found to demonstrate residents' participation in the meeting process. A residents' satisfaction survey had been completed at the time of inspection. This captured residents' feedback on various aspects of the service.

Residents were supported to manage their own finances. Residents' monies were securely stored and transactions were monitored through the use of the centre's own recording system. A sample of residents' finance logs were reviewed by the inspector and a member of staff on duty. Although receipts were in place for transactions, discrepancies were found in the overall total balance documented and the balance available in each resident's account. In one instance, the inspector observed a recent transaction made by a resident was not documented in the resident's finance log. This

recording error did not provide clarity on the exact balance to date in the resident's account. This was brought to the attention of the staff member on duty and was rectified at the time of inspection.

The centre had 'key to me' documents which outlined residents' preferences and wishes. Staff spoken with informed the inspector that these documents guided them on specific resident-centred practices. Staff also stated that care routines in the centre had become more resident focused, and all efforts were being made to ensure residents spent their day as they wished. However, the inspector observed that residents' daily lives were still determined by the routine and resources of the service as opposed to choice and residents' support needs. For example, the inspector noted that daily routines of the centre were structured around the arrival and serving of meals from a centralised kitchen. The inspector observed morning personal care routines being attended to and completed by 9.15am to facilitate the breakfast meal delivery at 9.30am. Staff spoken to informed they are required to be finished certain tasks to facilitate the serving of meals once delivered from the centralised kitchen.

Some residents within the centre had diagnosed cognitive impairments and these residents were observed by the inspector to attend the on-site daycare service. Given the aging profile of some residents, not all residents attended this service daily. Upon a review of residents' daily notes, the inspector noted that non-attendance was attributed to factors such as fatigue and the onset of infections. During the inspection days, the inspector observed occasions where residents did not attend day-service activities as planned. These residents were found to spend a large portion of their day in the communal room. Adequate arrangements were not in place to facilitate alternative age appropriate and meaningful activities for these residents. Staff informed the inspector that efforts are made to provide social engagement to these residents. However, this did not occur in a structured manner and where alternative activities were provided, this was at the discretion of the facilitating staff member.

There was a complaints management process within the centre and staff spoken with were aware of their responsibility in the local management of complaints. There was a nominated person in place to deal with complaints and a photograph of this person was displayed within the centre. The inspector found that a record of all complaints, including details of investigations, the outcome of complaints and any actions taken was maintained. However, gaps in the recording process were found where the complainants' satisfaction level, following the outcome of the complaint, was not routinely recorded.

Staff were found to treat residents with dignity and respect. The inspector observed staff knocking before entering residents' bedrooms and handling residents' possessions with respect. Bedroom doors were found to be closed when in use to maximise residents' privacy. However, the inspector found that the privacy and dignity of residents within shared bedrooms was compromised. Portable bed screens were provided in shared bedrooms, however, these were observed by the inspector to provide inadequate privacy for residents.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

On inspection, the inspector found that the communication needs of residents were met.

Residents within the centre presented with verbal and non-verbal communication needs. Staff were observed to address residents in a courteous manner. Staff spoken to were knowledgeable of each resident's communication needs. Staff were aware of non-verbal cues associated with specific residents and demonstrated a clear understanding of their role in ensuring residents' communication needs were met daily.

Detailed communication passports were available for each resident. These passports clearly outlined the specific verbal and non-verbal communication needs of residents. Daily communication notice boards were in use, displaying staff photographs to inform residents of which staff members were on duty.

Residents were observed to have good access to multi-media devices such as television and radio.

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):

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

Findings:

The centre's admission process considers the wishes, needs and safety of the individual and the safety of other residents currently residing in the centre. A sample of residents' written agreements were reviewed by the inspector. These were found to be signed by a representative on behalf of the resident and outlined a breakdown of additional costs.

No residents had recently been admitted to the centre at the time of inspection.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

All efforts had been made by the Provider to ensure that residents' wellbeing and welfare was maintained. Residents were being prepared for, and supported to, transition back into the community. Significant work had been completed by the staff in the assessment and personal planning of residents' health, social and personal care needs. Upon this inspection, the inspector observed that not all actions had been satisfactorily completed since the last inspection. The inspector found some improvements were still required in relation to the timely review of personal plans following a change in need.

Some residents were in the process of transitioning back into the community at the time of inspection. The inspector observed that multi-disciplinary input had been sought to aid in the planning of the residents' transition plans. The provider had identified various additional supports required by the resident, and these were outlined within the residents' transition plans.

Residents' personal goals were observed to have action plans in place which outlined the nature of each goal, the person responsible to support the resident and the timeframe for review. These action plans were observed to consider goals surrounding community participation, leisure and fun, family, friends and relationships. There was a routine three monthly review of these plans in operation, however, the inspector found that the

centre had not completed some reviews in line with their own timeframe.

The inspector reviewed personal plans for residents residing in the centre at the time of inspection. These were found to be reviewed on a regular basis and provided clear guidance to staff on the daily care and support to be provided to residents. 'Key to me' documents had been completed for all residents and were found to reflect residents' personal plans. Personal plans were observed to incorporate multi-disciplinary input where required. However, the inspector found that personal plans for residents with cognitive impairments had not been updated to reflect recommendations provided by a clinical specialist.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The location, design and layout of the centre was suitable and met residents' individual and collective needs in a homely manner. The centre was found to be clean, suitably decorated and well-maintained at the time of inspection.

Refurbishment works had recently been undertaken at the centre. The entrance to the centre was found to now have a partitioning wall in place. The addition of this wall ensured residents' bedrooms were no longer opening onto the main entrance corridor of the centre. Bedrooms were found to be suitably decorated and provided adequate floor space for residents' use. Following on from feedback received from a recent resident and relative survey, an additional front door has been installed at the centre. The centre's kitchen area was found to provide dining space for all residents. There was a large communal room where residents could watch television and interact with staff. This room had a nurses station incorporated within which enabled staff supervision of residents.

An unused church was adjacent to the centre and was accessible from the main communal room. This unused church was observed to store surplus equipment such as beds and furnishings. The inspector found that this room was also used to store

frequently used equipment such as wheelchairs, hoists and oxygen cylinders. The unused church was found to provide a unclean environment for the storage of this equipment. The inspector observed that there was no clear storage segregation of unused and used equipment within the unused church. This impeded staff to safely and easily access frequently used equipment from this storage area. Inadequate storage arrangements were also in place for the suitable storage of sharps boxes in the centre. Sharps boxes were observed stored on the floor within the staff toilet.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Overall, the health and safety of residents, visitors and staff was promoted and protected. The centre had made improvements in relation to fire precautions, however, actions remained outstanding from the previous inspection in relation to fire training and the display of fire procedures. Additional improvements were identified upon this inspection in relation to risk and infection control management.

The centre had systems in place for the assessment of resident and organisational specific risks. The centre had an organisational specific risk register which was observed to be reviewed on a regular basis by the PIC. This register outlined various risk categories specific to the centre and informed on the current risk rating of each risk category. The register also detailed the current controls in place to mitigate risks, further controls that were required and those responsible for responding to the risks identified. A preliminary risk screening assessment process was in place for each resident. This system was observed to provide staff with an overview of risks specific to each resident. The system further indicated to staff the likelihood of these risks occurring and what control measures were in place. The inspector found that where resident specific risks were identified through this process, this prompted staff to complete a more comprehensive risk assessment.

The inspector found improvements had been made in relation to the fire precautions at the centre. Designated fire points for fire equipment were allocated throughout the centre. Fire equipment was observed to be serviced on an annual basis. The provision of magnetic closers and intumescent strips had been made to fire doors within the centre. However, further improvements were required in relation to fire precautions. The

inspector found that not all fire escape routes were accessible at the time of inspection. For example, a staff member identified a fire escape within the communal room, however, the inspector observed this escape route was blocked by a couch. The inspector also found that where the kitchen door was open, this impeded access to the fire door located in the adjoining hallway. Fire plans were displayed in the centre, however the inspector observed that not all identified fire exits had adequate signage in place. The provider informed the inspector that planned works were scheduled for the completion of these works by 8 December 2016. The provider was requested to provide confirmation of all works completed to the inspector following this date.

Records of fire drills were available on the day of inspection. Staff spoken to informed the inspector of their involvement in fire drills and demonstrated clear knowledge on how to evacuate residents from the centre. Personal Emergency Evacuation Plans (PEEPs) were in place for residents and these guided staff on how to evacuate each resident in the event of a fire. However, these evacuation plans were found to lack guidance to staff, on the evacuation procedures for residents with specific neurological conditions, who were in use of emergency medications. Arrangements were in place for the provision of staff training in fire management, however, the inspector found not all staff had received fire training at the time of inspection.

The centre had a health and safety statement in place, however, this statement was found to be out of date. Although the statement did allow for the identification of those responsible for various health and safety activities, the statement had not been updated to reflect where new appointments had been made.

While there were policies and procedures in place to guide on infection control management, the inspector found improvements were required in relation to laundry and linen management. A colour coded laundry system was in place for the segregation of contaminated linen. Although staff spoken with were knowledgeable of this segregation system, the inspector found non-compliance with this practice. On the day of inspection, the inspector observed the preparation of general and contaminated laundry in a non-segregated manner. This was brought to the attention of laundry staff and the PIC on the day of inspection. The inspector also found there were inadequate dirty sluice arrangements in place for commodes. One bedroom, within the centre, had en-suite facilities, which the inspector observed being used by staff to dispose of commode contents in use by another resident. The inspector also observed this en-suite was used to store two commodes for the duration of the inspection. Staff spoken with informed the inspector that this en-suite facility was regularly used for this purpose given its close proximity to other residents' bedrooms.

The centre had a smoking policy in place which identified that a smoking area would not be provided on the campus. However, the inspector found that residents were facilitated to smoke within the unused church adjacent to the communal room. On the first day of inspection, the inspector observed residents accessing this room unsupervised. This was brought to the attention of the PIC who put alternative arrangements in place to facilitate residents who wished to smoke.

Judgment:

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Measures to protect residents from being harmed or suffering abuse were in place. Efforts were made by the centre to identify and alleviate the underlying causes of behaviour that is challenging for each resident. The rights of residents were protected in the use of restrictive procedures and the use of restrictive procedures was carefully monitored by the centre.

There were safeguarding plans in place at the time of inspection. The inspector found that the centre was supported in the development of these plans through multi-disciplinary involvement. Staff spoken with were knowledgeable in the purpose and function of these plans and could clearly demonstrate to the inspector an understanding of their role in the protection of vulnerable residents. The person in charge had ensured that all staff had received up-to-date safeguarding training.

A sample of residents' behavioural support plans were reviewed by the inspector. These were found to provide clear guidance on residents' behaviour types, specific triggers and on various proactive and reactive de-escalation techniques. The centre had systems in place to appropriately manage behaviours that challenge. The inspector observed the use of ABC behavioural records to aid the centre in the trending of residents' behaviours. These records were reviewed as required by the centre's behavioural support therapist. Where required, the behavioural therapist completed a functional analysis questionnaire which provided recommendations to the centre on how to manage the assessed behaviours that challenge. Staff were knowledgeable in the management of behaviours that challenge and had received up-to-date training.

Restrictive practices were in place at the time of inspection. The use of restrictive practices was found to be reviewed on a regular basis. The inspector observed staff at the centre had completed restrictive practice reduction programmes as part of residents' personal planning processes. Guidance documents were in place for the use of restrictive practices and these were found by the inspector to provide guidance on the use of the restrictive practice for the shortest duration necessary. The involvement of

the Human Rights Committee had been sought by the centre for restrictive practices.

Judgment:

Compliant

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

On the day of inspection, inspectors found that the PIC had maintained a record of all notifications submitted to HIQA. The PIC demonstrated a detailed knowledge of the notifiable incidents, which were noted by the inspector to have been submitted to HIQA within the specified timeframes.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

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

Findings:

The inspector found that efforts had been made for some residents to access opportunities for skill development, with particular emphasis on residents who were preparing to transition back into the community. However, it was not routine practice within the centre, to ensure all residents were supported to access age appropriate opportunities for education, training and employment.

Residents in the centre were of an ageing population, some of whom presented with cognitive impairments. The inspector found that while these residents had opportunities for social engagement, these were limited in scope in terms of skill development.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The inspector found that each resident was supported to achieve and enjoy the best possible health. Residents' healthcare needs were met in line with their personal plans and through timely access to healthcare services. Residents had access to allied healthcare services which reflected their varied healthcare needs. Improvements had been made by the centre to facilitate residents in choosing snack time options. However, improvements were still required to ensure residents were facilitated to prepare and cook their own meals.

The centre had a comprehensive assessment and care planning system in place. Residents' needs were observed to be reviewed on a regular basis and personal plans had clear guidelines in place on the management of these needs. Areas of good practice were observed in the management of skin integrity within the centre. Where residents had a history of pressure ulcers or were identified as being at high risk of developing pressure areas, the inspector observed that staff had appropriately risk assessed these residents. Skin integrity plans were in place for residents, where required, and were found to provide clear instruction to staff on the skin care required by the resident. Re-positioning schedules were in place to support residents identified with skin integrity needs and the inspector observed staff adhering to this schedule during the inspection.

The inspector found residents had timely access to various allied health professionals such as nutritional specialists, behavioural specialists and cognitive specialists. Residents had access to a General Practitioner (GP) service and a record of all correspondences from these health professionals was maintained by the centre. The previous inspection findings identified deficits in the monitoring of residents' weights. A sample of residents' weight recordings were reviewed by the inspector and these were found to be consistently recorded on a monthly basis.

Some residents required modified diets and thickening aids for drinks at the time of

inspection. Staff spoken with were knowledgeable of their role in supporting residents' modified diets. Staff demonstrated understanding of the preparation of drinks for residents requiring thickening aids. The inspector observed staff assisting residents at mealtimes. Residents were observed to dine both in the main dining room and in the main communal room. The centre had provided a dining table in the main communal room to facilitate this dining arrangement. Staff informed the inspector that this dining arrangement supported residents with behaviours that challenge. Staff informed the inspector that this arrangement provided a much more therapeutic dining experience for all residents.

There was a system in place for the recording of residents' food choices. A food preference listing was in place for all residents and outlined residents' preferred snacks of choice. Residents' snack choices were obtained from the kitchen store, depending on stock availability. Residents' preferred snacks were stored in the centre, however the availability of these snacks was dependant on the stock availability from the main centralised kitchen. Residents' meals were provided to the centre from a centralised kitchen located on the main campus. Residents' meal choices were recorded each morning and sent to the centralised kitchen. These meals were delivered to the centre at set times each day. Staff informed the inspector that where residents wished to order meals other than those provided on the daily menu, this was accommodated by the centralised kitchen. Staff spoken with informed that arrangements would be put in place to enable residents to be involved in the preparation of their own main meals, should they wish to do so.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

Although improvements had been made to the medication management system, the inspector observed improvements were still required in relation to the legibility of prescription sheets. Further areas for improvement were identified in relation to the assessment of residents' capacity to take responsibility for their own medication, prescribing of crushed medications and disposal of expired medicinal products.

Staff spoken with were knowledgeable of their responsibility to report all medication

errors using the centre's incident reporting system. Staff demonstrated a clear understanding of medication related incidents which required reporting. A sample of medication administration records were reviewed by the inspector and no gaps in the documentation of medication administration were found.

Medication profiles were in place for each resident. These profiles provided information to staff on residents' preferred medication management routines. For example, where residents preferred to take their medication with certain drinks, this was identified on the medication profile. Medication profiles were observed by the inspector to also inform staff where residents required crushed medications. However, upon review of prescription sheets for these residents, the inspector found that these medications were not prescribed in crushed format by the prescribing medical practitioner.

Previous inspection findings had identified prescription sheets were not always legible. The centre had not successfully completed this previous action as similar findings were also found on this inspection. A sample of prescription sheets were reviewed by the inspector and these were noted to contain prescriptions which were not clearly written.

No residents were responsible for their own medications at the time of the inspection. A risk assessment and assessment of capacity had been completed for residents who were undergoing planned transition into the community. However, the routine practice of completing capacity assessments to encourage residents to take responsibility for their own medications was not in place. The inspector also found these risk assessments were completed only where residents indicated they wished to take responsibility for their own medication.

On the first day of inspection, the inspector found that expired medicinal products were being stored in the centre. An immediate action was issued requiring the PIC to ensure that all expired medicinal products were removed from the centre. The immediate action further required that robust stock control measures would be introduced, to ensure that in future, no expired medical devices or medications would be available and used within the centre.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose for the centre which was accessible at the time of inspection.

Upon review by the inspector, it was found that the statement of purpose did not accurately describe the service available to residents. The inspector found that the following information was required;

- Omission of any reference to other named centres other than the intended designated centre, Dearaglishe.
- Ensure all rooms within the centre are outlined with their size and primary function.
- Ensure clarity in the transport arrangements for the centre.
- Ensure the whole time equivalents (WTE) for the centre are reflective of the current management structure.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The quality of care and experience of the residents was monitored on an on-going basis. Revised management structures were in place to support quality care services for residents. The inspector found this new management structure provided clear lines of authority and accountability within the centre.

An annual review of the service was completed at the time of inspection. This was completed by the provider and an action plan was in place, to mitigate areas of non-compliance identified within the report. Six monthly audits were also completed within the centre and findings were also actioned. Each action plan was found to outline the staff responsible for the completion of actions, estimated close out dates and the current status of the action.

The PIC had recently been appointed to the centre. She demonstrated clear knowledge

of the centre, the needs of residents and of her responsibility to meet the regulations. The PIC was supported by the PPIM who deputised in the absence of the PIC. The PIC was present in the centre on a full time basis and was engaged in the governance, operational management and administration of the centre. The provider visited the centre on a regular basis and provided support to the PIC as required.

The inspector observed that staff meetings were held on a regular basis within the centre. Staff spoken with informed the inspector that they were fully supported in their roles by the new management structure and were familiar with the new lines of authority.

Judgment:

Compliant

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The PIC was supported in her role by the PPIM who deputised in the PICs absence as required.

At the time of inspection, the PIC had not been absent from her role for more than 28 days since her appointment.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

There were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of the service. Residents received continuity of care and staff were supported by the management team. However, some gaps in staff training were identified. Further gaps were observed in accordance with Schedule 2 in relation to staff documentation.

There was a planned and actual rota in place, which matched the staff on duty at the time of inspection. The inspector observed that an hourly supervision system was in operation to ensure residents were appropriately supervised by staff at all times. Contingency plans were in place within the organisation to cover staff annual leave and sick leave. The centre was not using agency staffing at the time of inspection. Arrangements for staff supervision had commenced prior to the inspection date. The staff supervision programme was being led by the PIC who had schedules in place to ensure all staff were supervised on a regular basis.

The inspector reviewed the staff training records for the centre. Staff were provided training in the areas of behaviours that challenge, safeguarding and hand hygiene. Upon review, the inspector observed that not all staff had received up to date training on manual handling. A sample of staff files were also reviewed by inspector. The inspector found that not all documents required under Schedule 2 of the regulations were contained within staff files.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The inspector found that records, required by the regulations, were maintained in the centre. However, some policies within the centre were found to require review.

During the course of the inspection a range of documents such as the residents' guide, risk register, medical records, staff recruitment files and health care documentation were viewed and were found to be satisfactory. All records requested during the inspection were made readily available to the inspector. Records were found to be neat, clear and orderly.

The inspector reviewed the centre's policies and procedures and found:

- The policy on recruitment, selection and Garda vetting detailed the Garda vetting procedures but did not include procedures on the selection and recruitment of staff.
- The risk management and emergency planning policy was due for a review on 1 September 2016 and had not been updated.
- The procedure for the management and escalation of serious incidents was due for review on 1 June 2016 and had not been updated.
- The guidance on the administration on Buccal Midazolam had no implementation date, or date of review, and did not detail where this guidance had been ratified.
- Your Service, Your Say guidance on the management of complaints for staff was not centre specific and had been developed in 2008. This had not been subject to further review or updated since it had been developed.
- The CCTV policy did not have an approval date

The inspector reviewed the directory of residents and found that this did not include all the required information as detailed in schedule 3 of the regulations and the guidance available to providers, from HIQA, on the contents of the directory of residents.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anne Marie Byrne
Inspector of Social Services

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 Health Service Executive
Centre ID:	OSV-0002610
Date of Inspection:	06 and 07 December 2016
Date of response:	23 January 2017

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 ensure in the provision of adequate bed screening within shared bedrooms to ensure residents' privacy and dignity was respected.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

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:

Provider's response: All shared bedrooms will be fitted with curtains ensuring privacy and dignity is maintained at all times. Portable bed screens will be removed from each double bedroom

Person Responsible-PIC

Proposed Timescale: 10/02/2017

Theme: Individualised Supports and Care

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

The provider failed to ensure residents daily life was led by their choice and support needs as opposed to routine practices.

2. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

Provider's response: The provider will ensure that each resident has the freedom to exercise control in their daily lives.

A total review of the daily activities of the residents will take place to reflect residents choices as opposed to routine practices.

Activities will not be dictated by mealtimes and more choice will be offered so residents can take control of their daily life

Person Responsible -PIC

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

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

The provider failed to ensure that adequate recording arrangements were in place to monitor residents' finances.

3. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Provider's response: Financial competency self assessment will be completed for all residents to assess capacity to control their finance.

A trial is to commence for one resident to open her own post office account and manage her finances with the assistance of her keyworker.

All staff will adhere to the HSE financial policies with regard to client monies and report any irregularities immediately.

Person Responsible - PIC

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

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

The provider failed to ensure that residents were provided with alternative activities and supports in accordance with their assessed needs.

4. Action Required:

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

Provider's response: Based on the assessed needs of each resident in the designated centre a full review of daily activities has commenced.

We will use evidence based therapeutic activities for people who have significant communication impairment, primarily as a result of Alzheimer's or other dementias. The Sonas programme will be introduced which involves cognitive, sensory and social stimulation. The aim is to activate each residents potential for communication, thereby enhancing their quality of life.

Two staff have been trained and another two staff members will be trained commencing 17th February, in the Sonas programme.

We also have liaised with the Alzheimer's day centre in our area and have introduced unit based activities to enhance the quality of life for each resident.

Proposed Timescale: 31/03/2017

Theme: Individualised Supports and Care

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

The provider failed to ensure a record was maintained of whether or not the complainant was satisfied following the outcome of the complaint.

5. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Provider's response: The provider will monitor the complainants satisfaction level by devising a questionnaire to record their satisfaction following the outcome of a complaint, this will be done in conjunction with the HSE complaints officer.

Person Responsible-PIC

Proposed Timescale: 31/01/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

The provider failed to ensure that each personal plan was amended in accordance with any changes recommended following a review.

6. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

Provider's response: Each personal plan will be reviewed every 3 months or sooner if necessary. All recommendations following reviews with clinical specialists will be acted on as required.

Person Responsible -PIC

Proposed Timescale: 03/02/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The provider failed to ensure adequate storage arrangements were in place for the suitable storage of:

- Hoists

- Oxygen therapy
- Wheelchairs
- Sharps Boxes

7. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

Provider's response: The provider will provide adequate storage for frequently used equipment. A new partitioned room will be built to store this equipment and will be segregated from unused equipment.

Sharp boxes will be stored in the locked office and placed in the sharps box holder off the floor. Oxygen will be risk assessed and checked weekly and stored appropriately in a secure stand.

Person Responsible-PIC

Proposed Timescale: 31/03/2017

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 provider failed to effectively assess the risk of fire in relation to residents smoking in the designated centre.

8. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Provider's response The provider has reviewed the smoking policy and a new designated smoking area will be assigned to the designated centre to meet residents needs

Person Responsible - Registered Provider

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

the following respect:

The provider failed to ensure residents were protected through adequate and consistent infection control procedures in relation to:

- adequate arrangements for the storage of commodes
- adequate disposal arrangements following the use of commodes
- adequate preparation of general and contaminated laundry

9. Action Required:

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

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

Provider's response: An area is being converted to provide a sluice area to store commodes and have adequate disposal arrangements following the use of commodes. This area will also have adequate storage of general and contaminated laundry. Advice will be sought from the infection control officer regarding this conversion to ensure prevention and control of healthcare associated infections.

Person Responsible-PIC

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

The provider failed to ensure all staff had received fire training.

10. Action Required:

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

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

Provider's response: All staff have received fire training. This will be repeated yearly. Fire display plans will be changed to correspond with the fire panel for easier room identification. Fire register book will be stored in the designated centre and will include weekly checks on fire doors, fire equipment and lighting. Peep plans will be reviewed for all residents

Person Responsible-PIC

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

The provider failed to ensure all staff were aware of the arrangements for the evacuation of residents in use of emergency medication in the event of a fire.

11. 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:

Provider's response: All peep plans have been updated to include emergency medication for residents in the event of a fire.

Person Responsible-PIC

Proposed Timescale: 23/01/2017

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:

The provider failed to ensure residents were supported to access age appropriate opportunities for education, training and employment.

12. 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:

Provider's response: Residents will be referred to the adult referral committee to access age appropriate opportunities for education training and employment where appropriate

Person Responsible-PIC

Proposed Timescale: 10/02/2017

Outcome 12. Medication Management

Theme: Health and Development

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

The provider failed to ensure appropriate and suitable practices were in place to ensure

out of date medical products were stored in a secure manner segregated from other medical products.

13. Action Required:

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

Provider's response : All out of date medication is returned and stored in line with medication management policy.

All staff nurses working in the centre have been advised to complete their medication management course on HSEland and submit their certificate to their PIC by 31/1/2017. Medication checklist in place in the designated centre.

Medication audit recently completed and recommendations to be put in place

Person Responsible-PIC

Proposed Timescale: 31/01/2017

Theme: Health and Development

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

The provider failed to ensure adequate arrangements were in place for the prescribing of crushed medications.

14. 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:

Provider's response: All staff nurses have been advised to complete the online medication management course on HSEland and submit their certificate by 31/1/2017

-All residents requiring medications to be administered in a preferred method will have this documented on their prescription sheet and individual care plan

Person Responsible-PIC

Proposed Timescale: 31/01/2017

Theme: Health and Development

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

The provider failed to ensure a risk assessment and assessment of capacity had been completed to encourage residents to take responsibility for their own medication.

15. Action Required:

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

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

Provider's response: All residents in the designated centre will have a medication, management and care assessment undertaken to assess the capacity to self medicate in accordance with their wishes and preferences

Person Responsible-PIC

Proposed Timescale: 10/02/2017

Theme: Health and Development

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

The provider failed to ensure prescription sheets were available in a legible format.

16. Action Required:

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

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

Provider's response: A review of prescription sheets has been undertaken, all prescription sheets will be written in a legible format

All staff nurses working in the designated centre will complete the medication management course on HSELand and submit their certificate by 31/1/2017

Stock control checklist is in place and procedures in place in line with the policy for the returning of excess stock if necessary

Person Responsible-PIC

Proposed Timescale: 08/02/2017

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 provider failed to ensure there was 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.

17. 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:

Provider's response: The statement of purpose will be updated to include all requirements set out in Schedule 1 of the Health Care Act 2007

Person Responsible-PIC

Proposed Timescale: 10/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider failed to ensure that identification was maintained for all staff in accordance with Schedule 2.

18. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Provider's response: All staff files will be updated to include all information outlined in Schedule 2. A index page will be included in each file outlining the relevant documentation necessary for each file .

Person Responsible-PIC

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

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

The provider failed to ensure all staff had received training in manual handling

19. Action Required:

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

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

Provider's response: All staff will have up to date and refresher training in Manual Handling ,staff will achieve this by completing online training on HSEland and attending a practical session to complete training .

Person Responsible-PIC

Proposed Timescale: 28/02/2017

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 provider failed to ensure policies and procedures were reviewed within a three yearly basis.

20. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

Provider's response :A comprehensive review of all policies and procedures under Schedule 5 will be undertaken and all policies will be reviewed as necessary to meet requirement

Person Responsible-Registered provider

Proposed Timescale: 30/06/2017

