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## A designated centre for people with disabilities operated by Health Service Executive

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0004646
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Deborah Harrington
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power; Carol Maricle
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	18
<b>Number of vacancies on the date of inspection:</b>	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 1 day(s).

**The inspection took place over the following dates and times**

From: 25 May 2016 10:00 To: 25 May 2016 18:30

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

**Background to the inspection**

On 6th November 2015, HIQA applied to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities run by the Health Service Executive (HSE).

This report relates to one of the centres. This was the fourth inspection of this centre. As outlined in the most recent published report for this centre (in July 2015), eight of 18 outcomes were found to be at the level of major non-compliance at that inspection.

**Description of the service**

The centre comprises two houses known as hostels. One hostel is based on the grounds of another designated centre and can accommodate eight residents. The second hostel is located in the community and can accommodate ten residents.

**How we gathered our evidence**

Inspectors spoke with or briefly met 12 residents and a number of relatives over the course of the inspection. Residents told inspectors that staff treated them well and that they liked the staff team. Relatives were happy with the service being provided

to their loved ones and were complimentary of the staff and the persons in charge. Issues raised by relatives related to the inappropriate placement and mix of residents in one of the hostels. Two residents in the same community hostel told inspectors that they were not happy with where and/or with whom they lived.

#### Overall judgment of our findings

Overall, inspectors found that significant improvement had been made in the centre since previous inspections.

A new person in charge had commenced in the centre seven months prior to this inspection and this change had been accompanied by staff changeover and the recruitment of new staff, including social care workers and supports to the staff team in relation to key areas such as care planning, risk assessments and activities for residents. Inspectors found evidence that these combined changes had led to demonstrable improvements in the quality and safety of care and support to residents and in quality of life outcomes for residents. For example, residents' involvement in the wider community had been enhanced, residents' healthcare needs were being met and residents were being supported to express wishes and choices relevant to their individualized needs.

However, five outcomes remained at the level of major non-compliance since the previous inspection:

Under Outcome 5: Social Care Needs, a comprehensive assessment of needs for all residents had not been completed and the centre did not meet the needs of all residents.

Under Outcome 6: Safe and Suitable Premises, the communal space in one of the community hostels was inadequate for the number of residents living in that premises and was contributing to incidents between residents. This was compounded by an inaccessible outdoor area.

Under Outcome 7: Health, Safety and Risk Management, an immediate action plan was issued to the provider in relation to fire safety arrangements in the centre. The provider responded adequately to the identified failings within an acceptable timeframe.

Under Outcome 8: Safeguarding and Safety, there were on-going incidents of behaviours that may challenge between residents and there was a lack of behaviour support services to support residents with behaviours that may challenge.

Under Outcome 12: Medication Management, an unreported medication-related incident had occurred in the centre.

Findings are discussed in the body of this report and required actions to be taken to address any non-compliances are outlined in the action plan at the end of this report.

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

**Outcome 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:**

Overall, improvement had been made in relation to personal planning and supporting residents' goals. However, a comprehensive assessment of residents' health, social and developmental needs had not been completed for any resident in this centre. In addition, improvement was required in relation to review of the personal plan and ensuring that each centre was suitable to meet residents' abilities, wishes and assessed needs.

A comprehensive assessment of residents' health, social and developmental needs had not been completed with multi-disciplinary input that reflected residents' key support requirements. A priority assessment had been identified by the person in charge for one resident and was in the process of being arranged.

A new format of personal plan had been introduced across both centres since the previous inspections and was in the process of implementation. Personal plans reflected information specific to individual residents, their likes and dislikes, who was important in their lives, how they chose to spend their days and how to support residents to communicate, make choices and participate in activities in accordance with their wishes. The personal plan was complemented by documents such as health action plans, a communication profile, end-of-life preferences and risk assessments.

Due to the fact that personal plans were being rolled out, some were more developed than others. For example, the part of the plan that related to community inclusion was completed in detail in one hostel but staff in the other hostel told the inspector that they

were unsure how to complete that part of the plan. However in practice, the person in charge and staff demonstrated that they had made significant efforts to increase residents' participation in the wider community in terms of activities, outings, trips and pursuing residents' interests. However, it was not always clear how the resident participated in the development of their personal plan or how a copy of the personal plan in an accessible format was made available to residents.

Staff told inspectors that they were continually working to improve the setting of residents' goals in both centres. Goals were both short and long-term and progress to achieve goals was reviewed by each resident's key worker. An inspector met with a social care worker who was a key worker to one of the residents. The key worker demonstrated a good understanding of the needs and abilities of all residents, in addition to the individual to whom they had been assigned as key-worker. There was some variation between goals in terms of how they contributed to quality of life outcomes for residents with further improvement required to some personal plans. However, it was clear from other personal plans how goals contributed to meeting residents' wishes, preferences and abilities. For example, the option of bee-keeping was being explored for a resident with an interest in nature. Other goals included participating in cookery courses or travelling independently on the bus.

There was evidence that the families of residents were invited to be involved in the review of the residents' person centred planning. The family members with whom inspectors met had some awareness of these meetings and told the inspector that they had been invited to these meetings.

However, there was no system in place that ensured that the review of the personal plan would be multi-disciplinary, as required by the regulations.

In addition, it was not demonstrated that the designated centre was suitable to meet the needs or abilities of all residents. Neither premises was suitable for all residents in terms of age profile, the numbers of residents in the centre and the location of the centre. A resident in one hostel told the inspector that they were not happy with where they were living and they clearly articulated their preferences in terms of where and the age group with whom they wished to live. This information was also included in their personal plan. A second resident told an inspector that they were not happy with everyone with whom they were living. Inspectors found that such unsuitable arrangements as described were manifested in incidents of behaviours that may challenge between residents. This is further discussed under Outcome 8: safeguarding and safety.

During the inspection, inspectors observed that a number of residents at both houses participated in individual and group activities. For example, a resident was observed reading the newspaper (which was in turn outlined as an interest in his/her personal plan), whilst other residents were enjoying visits from family members. Some residents were quite independent and left the house to attend Mass and to attend a large social event organised by the provider on the main campus. Staff were observed being very welcoming to visitors at one of the houses. Staff completed activity sheets for each resident on a daily basis, and whether residents had actively participated in the activity or declined. Pictures and details of activities available to residents were clearly displayed

in a dining area at one of the houses and this contained up-to-date information on events taking place.

**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):**

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

**Findings:**

Specific aspects of this outcome were inspected due to issues identified on inspection.

As previously discussed under Outcomes 5 and 8, the communal space in one of the community hostels was inadequate for the number of residents living in that premises and was contributing to incidents between residents. There was one main living area for 10 residents in that house. Staff had made efforts to offer alternative space by putting a couch in the kitchen area and by supporting residents to participate in different activities during the busiest times of the day. The person in charge was exploring different ways to create more options for residents. The inadequate communal space was compounded by an outdoor area that was not an accessible space. The outdoor area was overgrown in places and was uneven with steps and damaged and missing patio tiles, meaning that it was not an accessible area to all residents. This issue was identified on previous inspections.

Internally, parts of the premises required attention. There were hazards in one of the bedrooms at one of the houses as there were broken tiles around the hearth of a mantelpiece and the trim around this hearth had come away in part. The conditions of some of the walls around both houses was very poor and did not lend itself to a homely appearance. There were holes in a wall in one bedroom and there was cracked paint in various rooms. A communal space in one of the houses was particularly poor in terms of the condition of the wall and its need for painting. The person in charge and nurses told the inspectors that some rooms at the centre were due to be painted, though approval had not been received for all identified works.

Also, the stairs in the centre was steep and possibly not suitable for the age profile of residents in this centre into the future. This was also identified as an issue in the provider's unannounced visits. A long-term plan was in place to close this centre and re-locate to more suitable premises.

**Judgment:**  
Non Compliant - Major

### **Outcome 07: Health and Safety and Risk Management**

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

**Theme:**  
Effective Services

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

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

#### **Findings:**

Overall, there were a number of measures in place to protect the health and safety of residents and staff. However, significant improvement was required in terms of fire safety arrangements in this centre that have been satisfactorily addressed since this inspection.

An immediate action plan was issued to the representative of the provider in relation to fire safety in both hostels. Fire safety drills did not simulate all likely scenarios and situations, such as night-time conditions or different staffing arrangements. In addition, improvement was required to ensure that documentation arising from fire drills reflected any issues identified during practice fire drills and what action was required to address any identified deficiencies. These failings were compounded by gaps in fire safety training. The representative of the provider responded appropriately to the immediate action plan issued and undertook to ensure that adequate practice fire drills were completed without delay. The person in charge of the centre subsequently provided evidence that this action had been adequately addressed.

A risk register was in place in both centres. Risk assessments had been completed for some key risks including risks related to behaviours that may challenge, choking, mobility-related, absconding, safety awareness, travel and risks of scalds or burns. Inspectors reviewed the risk registers and found that the persons in charge had appropriately escalated risks to the risk register.

The ageing profile of residents and the two-storey structure of the premises had raised concerns at previous inspections regarding residents' safety on the stairs. Inspectors found that all residents sleeping in upstairs bedrooms had been assessed for safety on the stairs by a physiotherapist within the previous six months. Assessments were on file in one hostel but were not available for review in the second hostel at the time of

inspection. The person in charge told the inspector that they had received verbal confirmation from the physiotherapist that assessments had confirmed that all residents sleeping in upstairs bedrooms were currently safe to use the stairs.

**Judgment:**  
Non Compliant - Major

**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):**

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

**Findings:**

Overall, while a positive approach was demonstrated by staff to supporting residents with behaviours that may challenge, significant improvements were required under this outcome. It was not demonstrated that residents were adequately protected from injury and harm by their peers. In addition, the effectiveness of interventions in place were not reviewed by appropriate multi-disciplinary team members.

There were policies and procedures in place in the organisation for the safeguarding of vulnerable adults, in relation to the protection of residents' finances and personal belongings, supporting residents' during intimate care, supporting behaviours that may challenge and restrictive practices.

Staff members and the person in charge were observed to support and interact with residents in an appropriate and warm manner. Staff with whom inspectors spoke demonstrated a good understanding of the prevention, detection and management of abuse and the process to follow in the event that they were concerned about a resident. Staff were aware of who the designated person was and were confident that if they saw a staff member abuse a resident, regardless of the person's post they would report the concern.

Behaviour support plans were in place for residents who required such plans. Behaviour support plans had been developed by the staff team. However, behaviour support plans had not been developed and/or reviewed with appropriate multi-disciplinary inputs. Sample logs of the effectiveness of behaviour support strategies indicated that they

were being implemented with mixed success.

The person in charge demonstrated that he was acting within his own realm of responsibility to support residents in this area. Where one behaviour support plan in particular was not proving to be effective, the person in charge was in the process of organising a multi-disciplinary review for that resident.

However and as previously mentioned under Outcome 5, incident records and conversations with staff and the person in charge in one hostel indicated that residents were not adequately protected from injury and harm by their peers. Causal and contributing factors in one hostel were identified as being as a result of an incompatible mix of residents; the number of residents and; the lack of communal space in that hostel.

This was evidenced by a significant number of incidents between residents in the same hostel. In a four-month period (from 1 Jan 2016 to 30 April 2016), there had been 25 incidents that included hitting, shouting, kicking, slapping, grabbing, pushing and threatening behaviour. Incident records indicated that the incidents were mainly between four residents. One resident described a recent incident to the inspector, whereby s/he was pushed to the ground by another resident and sustained bruising during the fall. A second resident said that they were not happy with being pushed, teased and shouted at by another resident with whom they lived. The person in charge described steps that they were taking to try to manage the situation, including increased staffing during key times of the day when incidents were most likely to occur, engaging residents in different activities and exploring ways of increasing the available communal space in the house. However, the core factors relating to the incompatible mix of residents living in the centre and the number of residents living in the centre were outside of the control of the person in charge and staff team.

Risk assessments had been completed for behaviours of concern and an assessment of how residents demonstrate their distress or other emotions. Staff members were able to articulate to inspectors what residents' key triggers were, how those emotions may manifest themselves and how to respond in order to support residents.

A positive approach to restraint was demonstrated and alternatives were explored to the use of restraint. Inspectors spoke with members of the staff team, who were aware of what to do in the event of an allegation, suspicion or allegation of abuse. There was a designated person within the service to whom any concerns were reported.

Inspectors reviewed a sample of residents' intimate care protocols in both centres and found that they outlined the supports each resident may require while also supporting and promoting independence.

**Judgment:**  
Non Compliant - Major

## Outcome 11. Healthcare Needs

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

### Theme:

Health and Development

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

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

### Findings:

Inspectors found that residents' healthcare needs were met by access to medical, nursing and allied healthcare and supported by staff.

Residents had access to their own general practitioner (GP) and consultants where required. Residents had access to allied healthcare professionals, including speech and language therapy, occupational therapy, physiotherapy, dietetics and dentistry.

Residents' wound care, nutritional and hydration needs, skin integrity and continence was all promoted and maintained by staff.

Based on a sample of healthcare plans reviewed, residents changing healthcare needs were met. For example, where a resident had fallen, they had been reviewed by the occupational therapist and/or physiotherapist as indicated. Mobility support plans developed by the physiotherapist were being implemented by staff. Where residents had mental health needs, input from the psychiatrist had been sought and a mental health care plan developed. Input from a counselling service was also sought for individual residents.

Based on the sample reviewed on the day of inspection, the required healthcare plans were in place to support residents identified and readily identifiable healthcare needs, for example in relation to their mental health, mobility, circulatory problems, chronic conditions and skin integrity. Some improvements were required to records as they pertained to health and this is addressed under Outcome 18: Records and Documentation.

There was evidence that relevant risks, such as the risk of choking or falls, were monitored and any incident recorded. Input from allied health was sought in relation to preventing related incidents. Input from allied health was also sought to support independence, for example, in relation to travelling independently. Staff members were able to articulate that they were aware of and understood how to implement the recommendations made by allied health professionals.

Breakfast and tea were prepared and served in the houses. A hot meal was prepared in the central kitchen and residents ate that meal in the main dining room on the campus. While this was an institutionalized practice, inspectors observed an example in the community houses where residents were unable or chose not to go to the campus for their meal and the meal was instead delivered to the house.

Where residents had difficulties with swallowing, an assessment had been completed by a speech and language therapist. Where residents had dietary requirements or nutritional needs, assessments had been carried out by a nutritionist and other healthcare professionals as indicated. Weight was monitored and food diaries kept as indicated. Clinical assessments were completed as required in relation to risks of pressure sore development, moving and handling and mental health.

Each resident had an individual 'hospital passport' that contained key information should a resident be admitted to the acute hospital sector. Information contained in the hospital passport was specific to that resident and included information about allergies, their medication, communicating with the resident in relation to healthcare matters and any relevant risks. Information was kept in the kitchen about any dietary requirements or supports around mealtimes.

**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:**

Medicines management practices were examined by a medicines management inspector. This outcome was at the level of major non-compliance due to an unreported medication-related incident that had occurred.

There was a medicines management policy in place. Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. The inspector saw that the pharmacist had undertaken a review of residents' medicines in March 2016. However, it was not demonstrated that the recommendations made by the pharmacist had been discussed with the multidisciplinary team and implemented as appropriate.

A sample of medication prescription and administration records was reviewed. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However, the inspector identified an unreported medication-related incident that had occurred on

23 May 2016 whereby it was recorded that a resident had received 1.8 times the prescribed dose of a medicine. This was immediately brought to the attention to the Clinical Nurse Manager who undertook to investigate the incident identified. In addition, the inspector noted that a time of administration for three medicines was not recorded by the prescriber and the time when these medicines were administered was not recorded by staff. Therefore it could not be confirmed that the medicines had been administered as prescribed.

Residents' medicines were stored securely. Medicines requiring refrigeration were stored appropriately and securely. The inspector saw that the temperature of the refrigerator was checked and documented on a daily basis to ensure the reliability of the refrigerator. Staff with whom the inspector spoke confirmed that medicines requiring additional controls were not in use at the time of inspection.

Staff outlined the manner in which medications which are out-of-date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail. However, the inspector noted that the date of opening was not recorded for a medicine that was to be disposed of 28 days after opening. Therefore, staff could not confirm when this medicine was no longer to be used.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records.

The inspector saw and confirmed with staff that no resident was managing his/her own medicines at the time of the inspection. Members of the management team outlined that the tool to be used to support a risk assessment for this practice was under review to meet the requirements of the regulations.

**Judgment:**  
Non Compliant - Major

#### **Outcome 14: Governance and Management**

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

**Theme:**  
Leadership, Governance and Management

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

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

**Findings:**

Overall, it was demonstrated that there were significant improvements to the governance and management of the centre since previous inspection, as evidenced by the improved level of compliance throughout this report.

A new person in charge had commenced in the centre seven months prior to this inspection. The person in charge was suitably qualified and experienced to fulfil the role of person in charge, was full time and was nominated as the person in charge of this centre only. The person in charge did also provide cross-cover for the person in charge of another designated centre during periods of leave (that centre comprises three houses and can accommodate 18 residents). The person in charge was supported in his role by a CNM1, who visited the centre daily, a CNM2 (who also worked in another designated centre) and a night supervisor.

The person in charge demonstrated that they knew residents, their needs and abilities well. Inspectors met with a number of staff and relatives who spoke positively of the person in charge and the changes that had taken place over the previous few months. The commencement of the new person in charge in the centre had been accompanied by staff changeover and the recruitment of new staff, including social care workers and supports to the staff team in relation to key areas such as care planning, risk assessments and activities for residents. Inspectors found evidence that these combined changes had led to demonstrable improvements in the quality and safety of care and support to residents and in quality of life outcomes for residents. For example, residents' involvement in the wider community had been enhanced, residents' healthcare needs were being met and residents were being supported to express wishes and choices relevant to their individualized needs.

Audits viewed included audits of unit meetings, safety and risk, incident analysis and learning from incident analysis and medication management. In relation to medicines management audits, inspectors saw that internal and external audits had been undertaken to review and monitor safe medicines management practices in the centre. The clinical nurse manager undertook a monthly audit and the pharmacist had completed an audit in March 2016 against the Authority's National Standards for Residential Services for Children and Adults with Disabilities. The monthly audit was limited in scope and did not cover all aspects of the medicines management cycle including ordering, receipt, disposal, monitoring and staff training. The audit undertaken by the pharmacist was comprehensive and a number of pertinent actions had emanated from the audit. However, it could not be demonstrated that the actions had been implemented.

HIQA required the provider to carry out two unannounced visits within the previous six months and submit reports on the safety and quality of care and support provided in the centre, as part of an escalation process.

An inspector reviewed the two audits that had been completed in December 2015 and February 2016 and found that actions were traced and tracked for completion between the two audits. For example, the auditors tracked whether the range of activities available to residents were increasing, whether personal plans were up to date, whether occupational therapy assessments had been arranged and whether specific works to the premises had been completed. The inspector followed up on a sample of actions from the most recent audit and found that they had been completed. A number of key issues were identified during the audit, including in relation to the unsuitability of the premises and that residents had identified that they wished to live elsewhere.

However, some further improvement was required to demonstrate that such audits adequately assessed the quality and safety of care and support being provided in the centre. For example, a number of key failings identified on this inspection had not been identified such as, the need for a formal system of staff supervision and appraisal, inadequate fire safety drills, the lack of communal space in the centre, the lack of behaviour support input to the centre or the lack of multi-disciplinary review of the personal plan. Finally, while the audit referenced that an audit of incidents had been completed in the centre and it referenced peer-on-peer inappropriate interactions in the centre, there was no analysis of this audit or plan to address or improve this significant issue.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Overall, improvements had been implemented since the previous inspection in order to support residents' needs and abilities and promote community inclusion. Improvements were required in relation to the implementation of a formal system for staff appraisal, staff training and ensuring effective procedures were in place that included checking and recording of information required as part of the recruitment process.

There was a planned staff roster in place. However, improvement was required to the staff rota as it did not always indicate the hours that each staff member was scheduled to work. Residents received continuity of care from a core staff team however on the day of the inspection one of the houses had three staff scheduled to work but all were either out sick, taking unexpected annual leave or on leave. This meant that there were two relief staff member working that shift with a third staff member called in from annual leave to join them later that day. The person in charge was supernumery to the roster and was based in a separate office at one of the hostels.

A number of relief staff were available to the person in charge in the event of staff sickness and inspectors met a relief staff at one of the houses. Despite this house not being their usual place of work, they had a good understanding of how the centre operated and the needs of the residents. A relief staff member showed an inspector a 'welcome' information folder that was particular to each house and gave staff an insight into how the centre operated and the needs of each of the residents. The staff member said that she used this folder as a guide when she came on shift.

Based on observations, a review of the roster and these inspection findings, it was demonstrated that staff numbers were appropriate to meeting the number and needs and abilities of residents. Changes to the staff team had taken place since previous inspections, including an increase in social care workers in some parts of the centres, in order to promote a social care approach and increase the variety and type of activities for residents. Staff demonstrated that they were constantly exploring opportunities for residents in the community, including residents who were retired.

A sample of staff files was reviewed against the requirements of Schedule 2 of the regulations and gaps were found in staff files. For example, gaps were found in relation to employment history, job descriptions, hours of work, commencement dates and in one file, a reference from a staff member's most recent employer was not on file.

There was evidence of effective induction procedures in line with the policy. Staff who had commenced working in the centre in the previous few months told the inspector that they had received a comprehensive induction to the centre. Staff told the inspector that while a changeover of staff in late 2015 had been unsettling for some residents, residents had been supported through this period. A core staff team currently provided continuity for residents.

The inspectors viewed a sample of personnel files and found that most of the documents were in place however, one of the three files viewed did not have a reference from a recent employer. Two of the three files viewed did not have a copy of the staff member's job description. As a result, not all of requirements of Schedule 2 of the Regulations in relation to staff documentation were met.

Weekly staff team meetings took place and minutes were kept of those meetings. Inspectors reviewed a sample of minutes that included a review of areas relevant to residents' support requirements, including a review of activities, opportunities to increase social inclusion, intimate support plans, findings of audits, residents' meetings, discussion of how to manage complaints, review of incidents and the use of near miss incidents as opportunities of learning. Staff told the inspector that they could add to the

agenda if they wished to do so.

However, a formal supervision system was not in place in the centre to facilitate staff to raise any concerns and to support, develop and manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

Staff training records indicated that there were gaps in mandatory training and training relevant to their role. Gaps were found in relation to safeguarding, fire safety and fire evacuation, positive behaviour support, hand hygiene and manual handling. For example, three staff required training in relation to safeguarding, eight staff required training in fire evacuation, six staff required training in fire safety and one staff required training in positive behaviour support.

However, a detailed staff training schedule was available for review that demonstrated that training gaps were in the process of being addressed.

**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):**

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

**Findings:**

Specific aspects of this outcome were inspected as they arose over the course of the inspection.

The medicines management policy required review as it did not adequately detail the requirements in relation to recording medicines administration and self-administration. It was outlined to an inspector that the policy had been reviewed, was in draft form and was awaiting implementation.

As mentioned under Outcome 11, some improvements were required to records as they pertained to health. While recording sheets were in place, it was not always clear when this sheet was to be used any by whom. Some of the records view appeared to show only the nurses recording information while other records viewed appeared to be written by staff other than nurses. In addition, the reason for completing records was not always clear, for example, the reason for recording complaints of a headache by a resident.

**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:***

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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0004646
<b>Date of Inspection:</b>	25 May 2016
<b>Date of response:</b>	28 June 2016

### 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 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, social and developmental needs had not been completed.

One priority assessment had been identified by the person in charge and was in the process of being arranged. Dates for two aspects to this assessment were required (a

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

multi-disciplinary assessment to inform current support requirements and a comprehensive assessment of needs to inform a transition plan).

**1. 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:**

A comprehensive assessment of residents' health, social and developmental needs will be completed for all residents by 20/07/2016. To complement this process a multi disciplinary review of each resident's personal plans will also be completed.

**Proposed Timescale:** 30/09/2016

**Theme:** Effective Services

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

As detailed in the findings, personal plans required further development to reflect residents' needs, abilities, wishes and preferences.

**2. Action Required:**

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

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

Personal plans which reflect each resident's individual needs, abilities, wishes and preferences will be fully completed for all residents.

**Proposed Timescale:** 31/08/2016

**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 how the resident participated in the development of their personal plan or how a copy of the personal plan in an accessible format was made available to residents.

**3. Action Required:**

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

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

Every resident has been involved in the development of their personal plan. Clear evidence of their involvement will be documented in their personal plan. Each resident will have an accessible format available to them.

**Proposed Timescale:** 30/09/2016

**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.

**4. 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:**

Multi-disciplinary team annual review of each residents' personal plans will be completed.

**Proposed Timescale:** 30/09/2016

**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 communal space in one of the community hostels was inadequate for the number of residents living in that premises and was contributing to incidents between residents.

The stairs in the centre was steep and possibly not suitable for the age profile of residents in this centre.

**5. 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:**

In line with National decongregation policy, both hostels will be closed by March 31st 2018 and alternative accommodation will be sourced that meets each resident's needs and preferences.

**Proposed Timescale:** 31/03/2018

**Theme:** Effective Services

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

Ten residents shared shower facilities on the first floor at one of the centres. It was not clear why an additional bathroom located on the first floor was locked.

**6. Action Required:**

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

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

The bathroom is no longer locked and is accessible to all residents. There are two showers rooms accessible to all residents.

**Proposed Timescale:** 20/06/2016

**Theme:** Effective Services

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

Parts of the centre required repair internally. The outdoor area was overgrown in places and was uneven with steps and damaged and missing patio tiles, meaning that it was not an accessible area to all residents.

**7. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

In line with National decongregation policy, both hostels will be closed by March 31st 2018 and alternative accommodation will be sourced that meets each resident's needs and preferences.

The internal parts of the house that need repainting will be completed. The large grounds of the house contain a small seated area at the entrance, a large garden to side and the front of the house. Access to the green house will be addressed and the area with uneven steps to the north side of the house will be fenced off as it is not used by residents.

**Proposed Timescale:** 31/03/2018

## 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:**

It was not demonstrated that fire drills as completed, considered all likely scenarios and conditions. In particular, night-time conditions and actual staffing arrangements in place (both day and night) and recorded findings and any actions required.

### **8. 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:**

A separate night time and day time fire evacuation was completed in both hostels following the inspection in May 2016. A schedule of Fire Evacuations is now in place for each hostels, all issues identified from each fire evacuation will be documented and reviewed to ensure learning takes place.

**Proposed Timescale:** 24/06/2016

## 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:**

Behaviour support plans had been developed by the staff team, however, input from a behaviour support specialist had not been provided for a number of plans reviewed. Sample logs of the effectiveness of behaviour support strategies indicated that they were being implemented with mixed success.

### **9. 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:**

All behaviour support plans will be reviewed with clinical nurse specialist in behaviours of concern. Staff have received training in positive behaviour support and the management of potential and actual aggression. All incidents of behaviour of concern are analysed to identify potential triggers and enable learning to take place. This learning is used to strengthen the behaviour support plans and their implementation.

**Proposed Timescale:** 31/07/2016

**Theme:** Safe Services

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

Incident records and conversations with staff and the person in charge indicated that further improvement was required to protect residents from injury and harm by their peers due to:

An incompatible mix of residents living in the centre;

The number of residents living in the centre;

The lack of communal space in the centre.

**10. 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:**

It is acknowledged that the buildings are unsuitable for all residents. In line with National decongregation policy, both hostels will be closed by March 31st 2018 and alternative accommodation will be sourced that meets each resident's needs and preferences.

All incidents of behaviour of concern that impacts on other residents are analysed to identify potential triggers and enable learning to take place. This learning is used to strengthen the behaviour support plans and safeguarding plans for each resident. The analysis of these incidents has indicated that an identified 90 minute period, each day from Monday to Friday has had 40% of the total incidents of behaviour of concern that impacts on other residents.

Potential triggers were identified and a structured support plan is now in place to support 2 residents to engage in activities in their local community which they enjoy at this time, they now return to their home after 17:30hr when a number of the identified triggers are reduced.

This support plan has resulted in a reduction of further occurrences of behaviours that challenge which may impact on other residents. Incidents of behaviours of concern will continue to be monitored and analysed.

**Proposed Timescale:** 31/03/2018

**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:**

It could not be demonstrated that recommendations made by the pharmacist had been discussed with the multidisciplinary team and implemented as appropriate.

**11. Action Required:**

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

Recommendations made by the pharmacist will be discussed with multi disciplinary team and will be implemented, as appropriate. This will be documented in each resident's notes, as required.

**Proposed Timescale:** 31/07/2016

**Theme:** Health and Development

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

The inspector identified an unreported medication related incident that had occurred on 23 May 2016 whereby it was recorded that a resident had received 1.8 times the prescribed dose of a medicine.

A time of administration for three medicines was not recorded by the prescriber and the time when these medicines were administered was not recorded by staff.

**12. 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:**

The present medication audit tool used is to be reviewed to ensure it is more comprehensive. Learning from both internal and external audits will be communicated to all relevant members of the multi disciplinary team to ensure improvements are implemented in a timely and consistent manner. All nurses who administer medication will complete an approved medication management course through HSEland online.

**Proposed Timescale:** 31/07/2016

**Theme:** Health and Development

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

The date of opening was not recorded for a medicine that was to be disposed of 28 days after opening.

**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:**

A standard label will be available in all areas which will be used when required on opening a medicine to clearly identify the disposal date.

**Proposed Timescale:** 31/07/2016

**Theme:** Health and Development

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

No resident was managing his/her own medicines at the time of the inspection and a tool to be used to support a risk assessment for this practice was not implemented.

**14. 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:**

The present risk assessment to support the practice of a resident managing their own medication has been identified as not being sufficiently robust. Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated medicines management policy will be distributed to all staff by 22/08/16. A series of information sessions will be facilitated by the policy review group and completed by 30/09/16. Updated policy will include appropriate and suitable practices relating to resident managing his/her own 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. A new risk assessment will be completed for each resident to explore how they can be supported to manage their own medication.

**Proposed Timescale:** 30/10/2016

## Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

The monthly medicines management audit was limited in scope and did not cover all aspects of the medicines management cycle.

It could not be demonstrated that the actions emanating from an external medicines management audit had been implemented.

**15. 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:**

The medication audit will be reviewed to ensure it covers all aspects of the medicines management cycle. Learning from both internal and external audits will be communicated to all staff to ensure improvements are implemented in a timely and consistent manner.

**Proposed Timescale:** 31/08/2016

**Theme:** Leadership, Governance and Management

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

Some further improvement to the unannounced provider visits were required to ensure follow through of identified failings and review of all key aspects of the safety and quality of care and support being provided to residents in the centre.

**16. 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:**

Unannounced provider visits structure will be reviewed to ensure a more robust and comprehensive report, action plan and review of follow up on the safety and quality of care and support provided in the centre.

**Proposed Timescale:** 02/09/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

A planned and actual staff rota was not maintained, showing staff on duty at any time during the day and night.

**17. Action Required:**

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The layout of the present staff rota will be reviewed to ensure a planned and actual staff rota is maintained which will show staff on duty during the day and night shifts.

**Proposed Timescale:** 30/08/2016

**Theme:** Responsive Workforce

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

A formal supervision system was not in place to facilitate staff to raise any concerns and to support, develop and manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

**18. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Structured staff supervision has commenced and will be completed for all staff.

**Proposed Timescale:** 31/08/2016

**Theme:** Responsive Workforce

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

Staff training records indicated that there were gaps in mandatory training and training relevant to their role.

**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:**

A robust schedule of staff training is on-going in the centre since 01/01/2016.  
An updated analysis of current staff training needs will be completed by 01/09/16.  
A schedule of training dates will be developed by 15/09/16 to address any deficits identified.

**Proposed Timescale:** 15/09/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

An updated medicines management policy was in draft form and was awaiting implementation.

**20. 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:**

Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include 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. Updated medicines management policy will be distributed to all staff by 22/08/16. A series of information sessions will be facilitated by the policy review group and completed by 30/09/16. Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include 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 appropriately to the resident for whom it is prescribed and to no other resident. Updated medicines management policy will be distributed to all staff by 22/08/16. A series of information sessions will be facilitated by the policy review group and completed by 30/09/16.

**Proposed Timescale:** 30/09/2016

**Theme:** Use of Information

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

Improvements were required to records as they pertained to health. While recording sheets were in place, it was not always clear when this sheet was to be used any by whom. Some of the records view appeared to show only the nurses recording information while other records viewed appeared to be written by staff other than nurses. In addition, the reason for completing records was not always clear, for example, the reason for recording complaints of a headache by a resident.

**21. 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 layout of support plans pertaining to health will be reviewed. Staff information sessions will be facilitated to ensure health support plans are developed, implemented and reviewed in a consistent and effective manner.

**Proposed Timescale:** 30/09/2016