

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Mary's Centre (Telford) Ltd
Centre ID:	ORG-0008476
Centre county:	Dublin 4
Email address:	orla.aver@stmarysblind.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Mary's Centre (Telford) Ltd
Provider Nominee:	Maura Masterson
Person in charge:	Orla Aver
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	2

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 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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
11 March 2014 10:30	11 March 2014 19:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11: Healthcare Needs
Outcome 12: Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first monitoring inspection of this centre. It took place over one day and reviewed 8 of the outcomes required to demonstrate compliance with the legislation and regulations. As part of the monitoring inspection the inspector met with residents and staff members. Inspectors observed practices and reviewed the documentation including care plans, medical records, accident and incident reports, policies procedures and staff files.

This centre is designated as a centre for female adults with sight impairment. The accommodation consists of 10 individual apartments over two storeys and three houses, two of which can accommodate five people and one which can accommodate four people. The facility is situated on the grounds of a large campus which also accommodates a designated centre for older persons also with sight impairment. Both services are managed by the same organisation, and the person in charge manages both. The findings of this inspection indicate that there is a commitment to achieving compliance with the regulations and standards and that there were effective governance structures in place.

There was evidence that residents' healthcare needs were well supported and promptly responded to according to their need and capacities in an environment that promoted their continued independence and choice. Access to allied services including those of particular reference to sight impaired persons was evident. Staffing was adequate and all mandatory training requirements were adhered to.

Policy and training in the protection of vulnerable adults was satisfactory and there was access to advocacy services for the residents.

Some improvements were required in the following areas:

Risk management strategies specific to the nature for the assisted living environments

Complete and detailed documentation of resident healthcare needs pre-admission assessment and review

End-of-life medical records

Arrangements for receipting fee payments

Recruitment of volunteers

Medication management.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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 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

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were policies available which guided practices in the centre in relation to the social care and welfare of residents including the assessment of and management of individual needs. The inspector found evidence of a focused approach to care provision based on the wishes and needs of the residents. The age range of the residents was diverse and the practices were varied in order to support this diverse range. There was evidence that residents were assessed in order to ascertain their capacity to live in either the shared houses where there were additional supports or in the independent apartments. The findings demonstrated a process of supporting independence, development of life skills, strategies to manage sight impairments, maintenance of social relationships and personal preferences according to the diverse needs of the residents. There was evidence from interview and records that residents were actively involved in the identification and assessment of need and the subsequent outcomes which they hoped to achieve. A range of multidisciplinary clinicians were made available including occupational therapy, physiotherapy, sight clinicians and mental health specialists. The intervention of these clinicians was detailed in the records.

A document entitled "My Day My Way" was completed with each resident. These documented residents' preferences and capacities in all areas of daily living, routines and what type of supports were needed in order to achieve this. The plans were suitable to the different range of needs, capacities and life stage. The plans took account of residents' psychosocial needs as well as medical and physical status. There was evidence observed of day-to-day strategies implemented including help with personal care adapted to the identified needs of the residents. The inspector found that there

was sufficient knowledge and understanding by staff of a range of supportive interventions appropriate to the residents to whom the services are available.

Residents confirmed to the inspector that their routines and life choices were supported within this assisted living environment. They were assisted to maintain contacts with their communities, friends and normal social activities. Two residents attended slimming world and one participated in marathons. Another resident explained how staff accompany her shopping and to other events as she cannot undertake these activities entirely independently. The houses and apartments were fully equipped and residents are assisted as required to undertake personal care and laundry. The lift and the laundry facilities in the apartments were adapted for Brail so that those residents who require this method of communication are facilitated. The residents were fully aware of their plans and had full access to them.

There were 6 monthly reviews of progress for each resident and very regular healthcare reviews undertaken. Residents had access to all the services and resources available in the complex, including a large resource room which is used for arts and crafts, group events such as music and the residents' meetings. There were pleasant gardens and seating areas suitably adapted to ensure accessibility for the residents.

However, the documentation currently in use was not cohesive and some instances were not reflective of the care as described by residents and staff. While the plans were reviewed the outcome of the review including any changes were not clearly documented. Pre-admission assessment documentation did not clearly demonstrate the process or outcome.

Where residents' needs with particular reference to age changed significantly and they were seen to require additional nursing or staff support on long term basis the provider and social care leader described a process of reassessment and consultation with the residents. The existence of the designated centre for older persons on the campus and under the same organisational umbrella and criteria for care means residents can at least remain within a familiar environment and maintain the friendships made in the houses and apartments if a transition is required.

Residents informed the inspector that they were very happy with the care provided, had choice, independence and support. One resident described the experience as like "finding shelter".

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there was proactive response to the management of risk while maintaining residents' independence. There is a signed and current health and safety statement available. A health and safety committee which was comprised of the provider, person in charge, fire safety consultant and catering section met circa two monthly. A review of the minutes demonstrated that good practice in the identification and management of risk with actions identified and records of completion of the actions were available. The inspector noted that steps from the back doors of the houses were high. This was already identified by the provider and plans to provide a suitable ramp were about to be implemented.

The risk management policy was detailed, contained an evidence-based risk assessment tool and detailed all of the specific requirements of the regulations. A detailed risk register was maintained and actions were identified following any incident to prevent recurrences. The provider concurred however that systems for overall review of risk and learning from incidents had not been fully developed as yet. There was an emergency plan for the complex and a generator available. While this did not cover the individual houses and apartments there was sufficient accommodation in the premises in which the nursing home is located to provide suitable interim accommodation, heat and catering for the residents in such an event. The entire operation is monitored at night by an on site security firm and alarms including fire and personal alarms which residents have are connected to the monitoring system and the security personnel. A review of the incident reports indicated that accidents and incidents were not a significant feature of the service.

The environment in the houses and apartments was suitable for the needs of the residents with good lighting, furnishings placed in positions to prevent risk of falling and items maintained in the correct places to ensure residents could have ease of access and movement. This however did not impinge on the homely and comfortable environment.

Inspectors reviewed the fire safety register and training record and found that fire training and evacuation for all staff was up-to-date with the most recent training having taken place in 2013. A fire evacuation drill takes place regularly and the social care manager maintains records of checks on the fire alarm systems. There were personal plans for each resident's needs in terms of mobility and evacuation posted outside each bedroom door. Staff to whom the inspector spoke confirmed their attendance at fire training and gave clear accounts of their understanding of fire procedures in the event of an outbreak of fire. Additional staffing supports are available should these be required. Fire safety equipment including the fire alarm, fire fighting equipment and emergency lighting were serviced quarterly and annually as required. Evidence of written compliance with the requirements of the local area fire service was not available at this time but will be required for registration. There was a satisfactory risk management strategy for a resident who smokes and staff were able to articulate this.

There was a detailed infection control policy and practices were congruent with the

needs of the residents. Records indicated that manual handling training for staff was undertaken in 2012 and dates were further scheduled for 2014. There was no requirement for specialist equipment such as hoists but all other equipment including heating and the lift were serviced as required. Residents were provided with suitable aids such as rollators to support independence and prevent falls where this was necessary. There were risk assessments utilised for residents pertinent to their needs including falls and management of their environment.

In some instances however, the supporting risk management policies and processes including the procedure for missing residents, and the safety audits were generic to the organisation and did not govern the specific arrangements required for the assisted living environments. In practice staff were able to articulate these distinct procedures. For example, they would ask residents to advise them of their expected return time and they had an agreed procedure for contacting them or their relatives should this not occur. This was not reflected in the policy.

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

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory and demonstrated an awareness of the role of external services and reporting mechanisms in this matter. Staff were able to articulate their understating and responsibility in relation to this. There was also a slow whistle blowing policy in place. Other factors which support the protection of residents included easy access to relevant and accessible advocacy services, the residents' forum meetings, and access to the religious sisters who continue to support residents on a voluntary basis. There were procedural guidelines on the provision of personal care to residents. These were identified in personal care plans although they did not provide specific information to guide practice. Records demonstrated that all staff have received training in the prevention of and response to abuse in 2013 and this is revised annually. Interaction as observed by the inspector was respectful and open.

The social care leader is employed full-time as is the person in charge. It was apparent to the inspector that both people were well known to the residents. The residents informed the inspector that they were very confident of their safety and that staff were very responsive to their needs. The inspector was informed that the nominee of the provider calls regularly and speaks with staff and residents. Residents have full access to all resources and easy access to all staff in the organisation. The inspector was informed that no concerns or allegations of this nature had been raised.

There is a policy on the management of behaviour that is challenging although this is not a feature of the service. The inspector saw no evidence that any restrictive procedures were used including medication and this was confirmed by the social care leader.

The inspector reviewed the procedure for the management of residents' finances including fee payment and management of monies for residents for whom the provider acts as agent. Residents confirmed that they were confident and satisfied with how their finances were managed. The records demonstrated very clear accounting systems where residents could at any time be given an account of monies including comfort funds. However, there was no standardised system for receipting fee payments where these were directly paid to the account.

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The records available demonstrated that there was regular access to a local GP service by residents who can attend either outside the service or on the campus. The records of these visits and the subsequent outcomes were detailed and demonstrated that resident's health care was prioritised. Staff were observant and responsive to the residents changing healthcare needs. There was evidence of referral and regular consultation with allied services as required by the residents, including occupational therapy, physiotherapy, mental health specialists and sight specialists. Physiotherapy and dietician services were provided free of charge to the residents by the provider. Interventions were documented and there was evidence that these were adhered to. However, some of the assessment documentation was fragmented and did not provide composite information on residents' overall health status including sight impairment.

There was a policy on end-of-life care. The provider outlined that in the event of a resident at end stage of life who wished to remain in the house or apartment this would be supported by nursing staff from the nursing home and access to the nearby hospice services. The residents could, if they so wished, also access a bed in the nursing home at this time. They were familiar with this facility and with the staff who worked there. A discussion had been held with each resident in regard to their wishes for this time including their preferences in relation to resuscitation. Documentary evidence of this process were dated and signed by residents and the GP.

The inspector reviewed the records in relation to a sudden death which had taken place. The records indicated that staff had followed the agreed procedure which included notifying An Garda Síochána. Neither the medical records nor the daily record however contained the required evidence of verification of the death and the records did not outline the events following this in order to ensure completeness. This matter is actioned under Outcome 18 Records and Documentation.

The houses and apartments are furnished with cooking facilities and fridges. Residents may have their meals in either the apartments or their main meal in the dining room at lunch time. If they are unwell this will be brought to them by staff. The inspector saw the mealtime experience and as the dining room is furnished in a cafe style and is shared by staff this was a social and pleasant occasion where the residents can choose where they sit and who with. They can prepare food themselves according to their preferences and capacities. There was evidence of dietary monitoring and communication with relevant specialists. Weights were monitored regularly and any changes were responded to. There was evidence of choice in the timing of meals and the food available appeared to be nutritious and readily available.

Outcome 12. Medication Management

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

Theme:

Health and Development

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There was a centre-specific policy on the management and prescribing of medication which was compliant with guidelines and the legal framework. An assessment was undertaken to ascertain if a resident had the capacity to manage their own medication safely in accordance with the assisted living function of the service. Overall the inspector found that procedures were safe, no transcribing was undertaken by staff, medication

was stored securely and there were documentary arrangements for the management of unused or returned medication.

Some improvements were required in that the administration record did not contain the initials of the person administering the medication and there was no register for controlled medication. The inspector was informed by the social care leader that the procedures were in the process of being altered following an audit by the pharmacist. A revised administration record was being issued which would ensure that the initials were evident, a controlled drugs register was also being procured and a revised system for dispensing would be put in place. The records available indicated that residents' medication was reviewed regularly by the general practitioner and on occasion in consultation with other relevant specialists. Residents were able to discuss their medication and the reasons for their use of this with the inspector. The final result of the pharmacist audit was not yet available.

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

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Overall the inspector found that governance arrangements were satisfactory. The person in charge is suitably qualified, and engaged full-time in the post. On a day-to-day basis the social care leader who is also suitably qualified and experienced in the care of person with sight impairment is responsible for the residents in the houses and apartments and reports directly to the person in charge. The nominee of the provider is also engaged full-time. Staff and residents were clear on the management structure, reporting systems and areas of responsibility.

Although no formal annual review of the safety and quality of the service takes place there was sufficient evidence to demonstrate that the service was well managed and focused on improvements, development and good outcomes for residents.

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

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector was satisfied from observation and records available that the numbers and skill mix of staff were satisfactory for the needs of the current residents and the supported assisted living category of the centre. There is an actual and planned rota. Two staff was available during the day from 8.00 am until 5.00 pm and this is then reduced to one until 8.00 am overnight which is a sleep-over duty. The social care leader is also available during the weekdays. The residents have personal alarms and regular checks are undertaken until late in the evening. Residents expressed their satisfaction with this arrangement and that they were fully aware of the alerting system and had confidence in its effectiveness. The houses and apartments are also protected by alarms and the presence of security on the campus at night. Additional support such as nursing support is available if required from the nursing home. The residents assessed needs do not indicate that full-time nursing care is required.

The inspector reviewed the personal records for three staff and two volunteers and found that the provider was in substantial compliance with this regulation. Three references, An Garda Síochána vetting, photographic identification, CV evidence of fitness, copies of qualifications and registration with professional bodies and verification of information was available. The provider has recently commenced using a pro-forma reference request form which is detailed and helps to support safe recruitment practices. Volunteers are also vetted by An Garda Síochána appropriate to their role. They are also supervised and provided with training to support their role.

The staff were trained in a range of suitable and varied disciplines including FETAC level 5, social work or social care. Mandatory training requirements, detailed under outcomes 7 and 8, were found to be compliant. Other training for staff has included falls prevention, activities for persons with dementia and medication management training. Training for 2014 is scheduled and includes CPR. There was planned rotation of staff between the Designated Centre for Older Persons and the assisted living section to ensure that staff were familiar with both services and the residents. The inspector did not find evidence that this rotation occurred at a level which would compromise the residents care however.

The inspector saw records of a comprehensive induction for new staff and an annual and focused supervision system is implemented. Team meetings were held monthly with smaller meetings held weekly to promote consistency of care. There was knowledge and understanding of the standards and regulatory requirements evident. Communication as observed was respectful and comfortable between the staff and residents. Staff spoken with demonstrated an understanding of the particular needs of each individual resident and the type of support needed.

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

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

This inspection did not examine in detail the full records and documentation required by the Regulations. While some of those examined such as the staff records and training schedules and the residents' guide were very comprehensive, some improvements were required in relation to the maintenance of comprehensive pre-admission and ongoing assessment including healthcare, personal plans for residents and records in relation to verification of death. In addition policies including end-of-life care were not specific in relation to the assisted living environment.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Mary's Centre (Telford) Ltd
Centre ID:	ORG-0008476
Date of Inspection:	11 March 2014
Date of response:	10 April 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

Pre-admission and ongoing assessment documentation and personal plans did not comprehensively reflect the needs of the residents.

Action Required:

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

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

In relation to all new applicants we will document and insert into the personal care

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

plans the pre-admission risk assessment for the Assisted Living Service. As part of the pre-admission assessment a system will be put in place to record the details of the pre-admission interview and assessment details of home visits in the applicants' own home environment. Our objective in the assessment is to determine that St. Mary's have the resources and capabilities to put in place supports to meet the identified needs of potential residents.

Proposed Timescale: 14/04/2014

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:

Risk management processes including the procedure for missing residents, and safety audits were not specific to the assisted living environment.

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

We are currently reviewing the Risk Management Policies for the whole Centre to ensure they are inclusive of the Assisted Living Services.

Proposed Timescale: 09/06/2014

Theme: Effective Services

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

There was no system implemented for the investigation and learning from incidents or adverse events.

Action Required:

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

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

At the monthly staff meetings we have commenced a formal review of serious incidents/ adverse events and near misses. The Social Care Manager ensures a record of the incident report is maintained in the resident's care plan and monitors for any trends.

Incidents for the whole Centre are reviewed and trends are discussed at bi-monthly Quality and Safety Meetings.

Proposed Timescale: 03/04/2014

Outcome 14: Governance and Management
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Theme: Leadership, Governance and Management

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

No annual review of the quality and safety of care was undertaken.

Action Required:

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

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

The quality and safety of care and support in the Assisted Living Service will be reviewed at the next Quality and Safety Committee meeting. The CEO will prepare an Annual Report based this review.

Proposed Timescale: 29/04/2014

Outcome 18: Records and documentation
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Theme: Use of Information

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

Some policies required amendment to ensure they were centre-specific to the assisted living environment.

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:

We are currently reviewing the Centre's policies and procedures to ensure they are inclusive of the Assisted Living Service and the Standards for the Residential Services for People with Disabilities.

Proposed Timescale: 09/06/2014

Theme: Use of Information

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

Records in relation to residents were not cohesive and comprehensive as required by Schedule 3.

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:

We are currently reviewing the layout and content of all personal care plans to ensure they are more cohesive and comprehensive to comply with Schedule 3.

Proposed Timescale: 30/06/2014