Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Peacehaven Trust
Centre ID:	OSV-0003690
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Peacehaven Trust Limited
Provider Nominee:	Lily (Elizabeth) King
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Michael Keating
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 April 2016 09:30	12 April 2016 20:30
13 April 2016 10:00	13 April 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection.

This was the third inspection of this designated centre. This inspection was completed as a result of the provider submitting an application to register this proposed designated centre.

How we gathered our evidence.

Inspectors visited the designated centre, communicated with all residents, the person

in charge and five staff members. Inspectors observed practices and viewed documentation such as residents' plans, recording logs, policies and procedures and minutes of meetings. Inspectors spent time with eight residents whom outlined their views in relation to the quality of the service provided. Inspectors met with one family member and received five family questionnaires and fifteen residents' questionnaires. All residents met with identified they felt safe and were very happy to live within the designated centre. One resident stated "I wouldn't be here if I was unhappy, as it is my life so I need to like where I live and I do, I love it here".

Description of the Service.

This designated centre is operated by Peacehaven Trust Limited and is based in Greystones County Wicklow. There were 16 residents lived between three houses, on the day of inspection. Two residents were in the process of transitioning into the designated centre. The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors found that the service provided was not in line with the statement of purpose for example, staff numbers were inaccurate and the supports and facilities provided also required updating (Outcome 13). The designated centre aimed to provide a residential setting for adults with a disability where residents are supported and valued within a safe care environment that promoted the health and well being of each resident as outlined in the statement of purpose.

Overall Judgments of our findings.

Overall, inspectors found that residents had a good quality of life within the designated centre. All 18 outcomes were inspected against. For the most part the provider had put appropriate systems in place to ensure the regulations were being met. However, two outcomes remained at major non compliance, these related to the governance and medication management. Significant improvements were required in the area of governance and management to ensure effective monitoring in relation to the overall provision of safety and care delivered within the designated centre. Inspectors found compliance in six of the outcomes. Five outcomes were found to be substantially compliant and five were found to be off moderate non compliance.

Areas of improvement included the management of medication, staff training and the complaints procedures.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan. All proposals outlined and plans agreed will be verified at the next inspection.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were treated with dignity and respect. However, improvements were required in relation to the complaints procedure and consultation with residents.

The designated centre had a complaints policy and procedure in place. Complaints and advocacy services were identified with details on display in the designated centre. The person in charge and the two care managers were designated to manage complaints and the complaints procedure outlined the appeals process. However, it was not clear if there was a nominated person to ensure all complaints were handled appropriately and in line with the organization's procedure. There was no clear timeframes for when complaints would be addressed contained in the document. Residents spoken with by inspectors were very clear who they would speak with should they have a complaint to make.

Limited evidence of residents meetings were available to inspectors across the three houses. One house had one meeting in 2015 and none in 2016, another house had three in 2015 and none in 2016 and the third house had two in 2015 and one in 2016. These meetings included discussions relating to areas such as house issues, residents comments, staff comments and information from the board of management. From speaking with residents inspectors were informed that residents met on a weekly basis. This was to discuss items such as food to go on their grocery list and planned the menu for the week ahead. Residents' preferences and dietary requirements dictated the menu. Inspectors also observed this taking place in one of the houses on the first day of inspection.

Inspectors observed that practices and routines were centred on the residents and their wishes. Inspectors observed staff respecting resident's personal space and speaking to the residents in a respectful manner.

Judgment:
Substantially Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were supported and assisted to communicate in accordance with residents' needs and preferences.

Resident's augmentative and alternative communication needs were identified within their personal planning documentation. Supports needed by residents were put in place such as visual displays for meals, staff rosters and I.S.L (Irish sign language). Inspectors observed all of these interventions within residents' files and also in practice over the two day inspection. Staff were aware of the communication needs of all residents and inspectors observed staff and residents communicating freely through the resident's preferred method.

Residents had access to television, radio and wireless internet connection within the designated centre. Some residents also used the aid of technology to communicate with family members such as visual telephoning family members living in another country.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that families and friends were encouraged to get involved in the lives of residents in accordance with resident's preferences.

Staff outlined how they facilitated residents to maintain contact with their families. This included access to telephones, transport home or visits by family members. Family members and friends were also invited to events in the designated centre including, significant life events such as birthday parties.

Residents showed inspectors pictures and memory books of life events including family members and friends.

Regular contact with family members was evident between staff and their relatives in accordance with residents' wishes. Staff assisted in the planning of holidays for both family members and residents with staff available to support the resident during holidays if required.

Visitors were welcomed within the designated centre and residents were building relationships among the local community including neighbours.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspectors found that the admission and discharge process required significant improvement. The details contained in residents' contracts of care provision were not as outlined within the regulations.

Fees paid by residents were unclear to inspectors, as residents within the same designated centre had different amounts specified within the resident's contract of care provision. The amounts ranged from €115 to €138 per week for that same level of service provision.

There were policies and procedures in place for the admission, transfer and discharge of residents. The process was also described in the statement of purpose. Inspectors found that this was not fully adhered to in relation to admissions. For example, inspectors viewed evidence of a resident transitioning into the designated centre without an effective plan in place.

The criteria for admissions contained within the statement of purpose and the admissions policy in the designated centre did not reflect the current practice for example, residents must have a day placement or a job was identified within both documents.

Some resident's had written contracts in place and inspectors noted that these were signed where possible by the resident and the resident's representative and representatives of the designated centre.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Inspectors found resident's wellbeing and welfare was maintained and each resident has the opportunity to participate in meaningful activities that were appropriate to their interests and preferences. Improvements were required in relation to transition plans.

Inspectors were informed that one resident was in the process of transitioning into the designated centre. From the information available the resident was not supported adequately. Assessments completed identified that the resident required a high level of support. The staffing levels in the designated centre had not been adjusted accordingly to reflect the needs of the resident. Inspectors were unable to see evidence of a detailed transition plan to guide members of staff effectively to provide consistent person-centre service delivery.

Each resident had a personal plan, this identified the assessed needs of the residents and reflected their interests and capacities. These plans were completed in collaboration with each resident.

Inspectors viewed a sample of eight plans and found them to be comprehensive. Each resident was assigned a keyworker who completed personal plan reviews in consultation with the resident and monitored progress against the agreed goals. Inspectors found that the personal plans contained important information about the residents' lives, likes, dislikes, interests, family members and other people who were important to the residents. Some residents had written the information into their own plans including things I enjoy doing, what I what to change in my life and what I want to stay the same in my life.

A number of residents informed inspectors what was in their personal plan and other residents went through the detail contained within their personal plan through providing the document to inspectors.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
Inspectors found the designated centre was suitable and safe for the number and needs of residents.

The designated centre consisted of three community houses within a 1.5 mile radius. One house consisted of a two story detached house, this was home to five residents. The second house was a dormer bungalow with an attic conversation and this house was home to six residents. The third house was a semi detached house and was home to five residents with a self contained apartment for one resident with a separate entrance. All residents had their own bedroom and these were individualised in accordance with the preference of the residents.

Residents within each house provided inspectors with a tour of their house and

identified different areas of the house they were involved in for example, laundry and cookery. Residents showed inspectors personal items such as sporting memorabilia and musical belongings these were displayed within their home.

Inspectors found the designated centre meet the requirements of schedule 6 of the regulations. For example, the designated centre was suitably heated, had suitable kitchen and laundry facilities while adequate private and communal accommodation was available.

Judgment:
Compliant

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:
Inspectors found the designated centre required improvements to ensure it was suitable and safe for the number and needs of residents. Improvements were required in the areas of personal emergency evacuation plans (PEEPs) and learning from accidents and incidents.

Inspectors viewed the accidents and incidents logs for the designated centre and found a clear system of recording. Inspectors could not find arrangements for learning from, serious incidents or adverse events involving residents within the designated centre, this was also identified at the previous inspection.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced by an external company on a regular basis. Staff also completed checks on the exits, alarm panels and equipment. One resident identified they were not satisfied with having emergency lighting in place in their home. The resident visits the homes of friends and family members and they are not required to have emergency lighting in place.

Fire drills had taken place and records recorded the time taken to evacuate and issues identified. Some residents did not have a PEEPs in place. However, from the sample of plans inspectors viewed were found to be concise and informative and included information on mobility, awareness and support needed.

The designated centre had an organizational risk management policy in place this

included the specific risks identified in regulation 26. The designated centre had a risk register which recorded a number of risks in the service and the controls in place to address these. Risks identified included slips trips and falls, chemicals and the use of electrical equipment.

There were individual risk assessments for residents in place these included fire, falls, self injury, swallowing and epilepsy.

The designated centre had a health and safety statement this outlined the responsibilities of the various post-holders within the organization. The statement referenced a wide range of policies and procedures and guided staff in their work practices. There was a policy in relation to the unexpected absence of a resident. The designated centre had an emergency evacuation plan in place for a number of various events such as fire, adverse weather conditions, flooding, power failure and possible gas leakage. The plan identified specific alternative accommodation to be provided in the case that residents could not return to the designated centre.

There were procedures in place for the prevention and control of infection and inspectors found that all areas were clean and hygienic. There were adequate hand-washing facilities within the designated centre.

Inspectors viewed a sample of staff training records and found training was completed in people moving and handling and fire.

Inspectors found that the designated centre vehicles were appropriately taxed, insured and had a National Car Testing (N.C.T) certificate.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors found measures were in place to protect residents from being harmed or

suffering abuse. Improvements were required in relation to the oversight of resident's finances.

Inspectors reviewed a sample of financial records and found the system required improvement in relation to the auditing of residents' finances. Inspectors were unable to see a list of resident's personal possessions owned by residents as outlined in the regulations.

Inspectors found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. From speaking with residents they knew who to speak to should concerns arise. Residents were also able to identify the procedure to follow if an allegation of abuse arose.

There was a policy on and procedures in place for the prevention, detection and response to abuse which staff members were aware off. Staff members spoken with by inspectors were knowledgeable in relation to the management of an allegation of abuse and outlined the procedures to be followed should such an allegation arise.

Restrictive practices were appropriately reviewed and recorded.

There was a policy in place for providing intimate care.

Judgment:
Substantially Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Inspectors found that some incidents were not appropriately notified to the Chief Inspector as outlined within the regulations. This was discussed with the person in charge and these were subsequently provided to the Authority.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:
Health and Development

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

Findings:
Inspectors found that the general welfare and development needs of resident's were promoted. Residents were afforded opportunities for new experiences, social participation, education, training and employment.

Both residents and staff members outlined how support was provided to residents to pursue a variety of interests including, computers, cooking and art classes such as mosaic classes. Resident's also engaged in community activities such as, the church activities, music events and holidays.

Inspectors viewed residents' profiles and these contained relevant information in relation to activities residents participated in.

Residents were also facilitated to partake in employment within a local hotel and another resident was employed within a local supermarket. Both residents discussed this with inspectors and identified the enjoyment they attained from working in both places. Other residents underwent a job coach programme within their dayservice including working in a television studio and another resident spent time in the Dáil Eireann (Government offices) with An Taoiseach (head of the Irish government).

Inspectors viewed evidence where resident's were supported through significant life experiences including the death of a family member. Residents were offered the choice to participate in a bereavement programme and staff members assisted with visits to the graveyard and to the church.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors found each resident was supported to achieve the best possible health.

Inspector found that resident's health needs were reviewed with appropriate input from multidisciplinary practitioners including physiotherapy, dental, cardiac nurses and dieticians.

Inspectors determined resident's had access to a general practitioner (GP) and viewed evidence of reviews taking place regularly.

Inspectors found the practices within the designated centre met residents' nutritional needs to an acceptable standard.

Care plans were developed from a health assessment completed on each resident and this identified healthcare needs such as, epilepsy.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that residents were not protected by the policies and procedures for medication management in the designated centre. Improvements were required in relation staff training, p.r.n. (a medicine only taken as the need arises) medication and administration records.

Improvements were required in the following areas:

- provisional prescriptions were being used for some residents. These did not contain sufficient information for example, the date the medication was prescribed and the prescribers signature was blank

- short term medication was not administrated when prescribed, inspectors viewed four days within the administration record which was blank

- some p.r.n. did not have the maximum dosage identified for a 24 hour period

- p.r.n. protocols were not evident for all p.r.n medications

- p.r.n. medication plan did not contain the same information as the prescription for example, the prescription identified longer that 5 minutes where the plan stated longer than 10 minutes

- practice in relation to medication administration was not completed in accordance with the medication policy. For example, one and a half hours was identified as the timeframe to administer medications however, staff members informed inspectors the time frame was two hours

- stock control for loose medication not contained within medication dispensed dosage system was not evident

- medication was past the expiry date for a number of medications for example, May 2012, January 2012, September 2014 and October 2014

- no staff members had received training in the administration of emergency medication, this was prescribed on October 2015.

Inspectors viewed medication errors and while these were being recorded, in some instances there was no evidence of this system bringing about learning to avoid future occurrences.

Inspectors viewed medication plans these were signed by residents and contained essential person-centred information pertaining to the preferences of each resident for example, how I like to take my medication. However, some medication plans were not dated and signed.

Some residents were very knowledge about the medication they were taking. One resident maintained their own administration as this resident self medicated. The resident presented some of the records to inspectors, all records presented by the resident where maintained to an excellent standard. However, no locked storage was provided for the resident to store their medication.

There was a policy in place within the designated centre dated July 2015 however, practices within the designated centre were not reflective of the document for example, the administration of emergency medication.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in

the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found the statement of purpose did not met the requirement of the regulations.

Amendments were required in relation to the following:

- admission criteria including emergency admissions
- facilities provided
- support needs
- staffing levels
- complaints procedures
- resident's individualised personal plan.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found the overall governance and management structure in place within the designated centre required significant improvements. Areas identified in the previous two inspections were not followed through for example, the completion on an annual review. Inspectors also found improvements were required in the areas of unannounced visits, auditing and review of practices across all aspects of care provision.

Inspectors found that the designated centre did not have suitable management systems in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. This was evident through the findings of this inspection. The person in charge was also the CEO (Chief Executive Officer) and provider therefore, due to the responsibilities associated with each position. This individual was unable to ensure the effective governance, operational management and administration of the designated centre. During the second day of inspection the person in charge identified that the chair person of the board had resigned since January and a temporary chairperson had been appointed.

An annual review of the quality and safety of care in the designated centre had not taken place despite this been highlighted in the previous inspection.

The person in charge conducted visits to each house once every month however these visits focused on food and the cleanliness of the houses. These visits did not focuses on the safety and quality of care and support provided across the designated centre and no report was generated on a six monthly bases.

Inspectors found there was lack of oversight and trending of accidents incidents and medication errors. While there was a system of recording in place records were not collated to bring about any future learning among team members in order to mitigate future risks. No audits were available within the designated centre for inspectors to view in relation to practices and oversight of service delivery.

Inspectors found that there was a clear reporting structure in place. The person in charge met with the two care managers, inspectors viewed minutes of these meetings and noted that areas pertaining to the organizational management of the designated centre were discussed. During the course of the inspection residents were able to identify who the person in charge was and inspectors observed residents visiting the house where the office was located in order to met with the person in charge during the course of the inspection.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
Inspectors found that the designated centre was not resourced to ensure the delivery of care and support in accordance with the assessed needs of the residents.

Inspectors viewed documentation in relation to a resident transitioning into the designated centre however, no changes were made to the staffing levels to assist in this process.

The person in charge, CEO and provider did not have sufficient resources to discharge all aspects of their role. This was evident though the lack of audits and outstanding actions from the previous inspection. This is further discussed under Outcome 14.

Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found appropriate staff numbers and skill mix present to meet the assessed needs of residents and the safe delivery of services. Improvements were required in relation to staff training and supervision of staff members.

Records of staff training were maintained however, some mandatory training was not up-to-date. This was also an action in the previous inspection for in the areas of safe guarding and medication management training. While all staff required training in the administration of emergency medication.

Supervisory meetings or performance appraisals were not taking place with all members of staff on a regular basis. Some staff had not had a supervision meeting since February 2014.

Three staff files were viewed as part of this inspection and were found to contain all of the requirements of schedule 2 of the regulations.

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:
Inspectors found the documentation required by the regulations to be maintained in the designated centre required improvements in relation to schedule 5 of the regulations.

Inspectors found schedule 5 policies were not maintained in accordance to the

regulations as no implementation or review date specified within some policies. The access to education, training and development was not present in the designated centre. This was already identified in the previous inspection. Residents personal, property, finances and possessions policy did not contain sufficient details to guide staff. For example, the steps outlined within the policy did not identify effective oversight or residents' finances as the policy stated "all transactions are checked periodically and audited annually".

Records and documents that were viewed were in accordance with schedules 3 as listed in the regulations were viewed.

Records and documents that were viewed were in accordance with schedules 4 as listed in the regulations were in place.

Inspectors found systems were in place to ensure that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Inspectors read the residents guide and found that it provided detail in relation to all of the required areas. This document included a summary of the services and facilities to be provided, arrangements for resident's involvement in the designated centre and a summary of the complaints procedure.

Inspectors reviewed documentation submitted as part of the application to register, and determined that there was an up to date insurance policy in place for this proposed designated centre valid up until the 15 January 2017.

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:

Karina O'Sullivan
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[1]

Centre name:	A designated centre for people with disabilities operated by Peacehaven Trust Limited
Centre ID:	OSV-0003690
Date of Inspection:	12 April 2016
Date of response:	

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
House meetings involving residents were not being conducted regularly.

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

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

Please state the actions you have taken or are planning to take:
Monthly House Meetings for Residents have now been put in place and a different member of staff has been assigned responsibility for each of the 3 houses.

Providers Update:
House Meetings Occurred as follows:
AW: 28th March 2017; 17th Oct 2016; 6th April 2016
BH: 19th June 2017; 25th May 2017; 13th April 2017; 23rd March 2017; 26th February 2017; 11th January 2017; 30th Nov 2016; 29th Aug 2016; 21st April 2016;
LH 23rd February 2017; 22nd June 2017-06-22
For AW and LH full monthly meetings have not occurred, as Peacehaven Trust stated. A schedule for house meetings has now been established for all houses; for the first Tuesday in every month in AW; First Thursday in every month for BH & LH.

Proposed Timescale: 08/08/2016 22/06/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear who was the person nominated in the designated centre other that the nominated person in regulation 34(2)(a) to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

2. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
An Additional person has been contracted as Director of Services. The structure of Nominated Persons is now: Two Care Managers- Administration Manager –Director of Services.

Providers Update:
In addition to the above revised structure, (May 2016) the Complaints Policy has been revised, May 2017. An external Monitor has been appointed – who is Mr Clive Evans – Chair of the Board. The Monitor is to review complaints on a quarterly basis. First external monitoring report due July 2017 for the 1st & 2nd quarters 2017.

Proposed Timescale: 08/08/2016 31/07/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Some residents did not have written contracts in place within the designated centre.

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

Please state the actions you have taken or are planning to take:
The Contract for one Resident was not filed in the correct place at the time of Inspection. The Contract was filed on the evening of the 13th. April immediately following the inspection.

Providers Update:
Each resident has a Contract of Care and also Resident's Agreement Handbook. Since May 2017 a Resident's Guide had been introduced. The Tenancy Policy is due for review; whereby it is anticipated that the Resident's Agreement and Handbook will be redefined as a 'Tenancy Agreement'. Therefore each resident will have a clear 'Contract of Care', 'Resident's Guide' and a 'Tenancy Agreement'.

Proposed Timescale: 13/04/2016 31/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some resident's assessed needs were not met within the transition process.

4. Action Required:
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

Please state the actions you have taken or are planning to take:
The Action Required has been noted and care will be taken in future to ensure that a greater assessment of needs is made before entering into a transition process with prospective residents. This will ensure that the process will only commence in circumstances where the required level of staffing can be provided for the person.

Providers Update:
Each resident has an assessment of need, which is updated on a yearly basis. The referral procedure requires an assessment of need and a transition plan, and is governed by the admissions policy (Last reviewed March 2015).

Proposed Timescale: 08/08/2016

Theme: Effective Services

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

The rational for different fees charged to residents was unclear.

5. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
Fees will be reviewed and brought in line by 1st. September 2016.

Providers Update:
Peacehaven Trust has two models of service provision; A) Standard Residential Support and Care, B) Semi-Independent Residential Support and Care. These two models charge different amounts. Residents within each model are each charged the same amount, consistent with similar models of other service providers.

Proposed Timescale: 01/09/2016

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:
Transition plans were not in place for a resident undergoing the process to effectively guide staff in the delivery of care and support.

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

Please state the actions you have taken or are planning to take:
Discussions have taken place in this regard and documentation is to be completed by end of July

Providers Update:
The resident referred too did not complete transition. However another referral was received. For that person an effective transition plan was also not established. The person has had an assessment of need.
Whilst the service is now at capacity, the new PIC will ensure that any subsequent new admissions, and potential discharges have effective transition plans, and that the admission policy is reviewed to reflect this necessity.

Proposed Timescale: 31/07/2016 31/07/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Learning from, serious incidents or adverse events involving residents were not evident within the designated centre.

7. 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:
A 'Learning Log' has been introduced which will be overseen by the Care Manager and Director of Services

Providers Update:
Learning Logs have been used on five occasions since introduction. The new PIC is reviewing the incident report form system to ensure that actions and learning outcomes occur systematically, and are transferred into residents plans where applicable, Trust procedures where applicable but also into every day practice.

Proposed Timescale: 08/08/2016 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements for evacuating all residents in the designated centre were not evident.

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:
Current arrangements are being reviewed and staff and residents will be updated with changes.

Providers Update:
Both Personal Evacuation Egress Plans, and Emergency Plans have been revised to ensure adequate response to emergency alarms.

Proposed Timescale: 15/08/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Oversight of residents' finances in the form of auditing accounts was not evident within the designated centre.

9. 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:
A weekly check of Residents finances is now in place

Providers Update:
Since the appointment of Michael Williams as Director Of Services, Resident's Finance auditing has moved to monthly checks within the standard monthly monitoring process. Any actions arising are communicated to keyworkers and all staff.

Proposed Timescale: 08/08/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The chief inspector was not notified that no incidences took place in the designated centre within a six- month period.

10. Action Required:
Under Regulation 31 (4) you are required to: Where no incidents which require to be notified have taken place, notify the chief inspector of this fact on a six- monthly basis.

Please state the actions you have taken or are planning to take:
Dates for returns has been noted and diarized.

Providers Update:
Both 3-day notifications and also quarterly notifications (NF39) are being sent in as required. Therefore six monthly nil return forms are unlikely to be required.

Proposed Timescale: 08/08/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Chief inspector was not notified within 3 working days of an injury to a resident requiring immediate medical or hospital treatment.

11. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector

within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
It has been noted that any injury requiring hospital treatment should be notified

Providers Update:
All 3 day notifications are now bring sent to the authority. (And if required also to HSE/ Safeguarding Team etc.).

Proposed Timescale: 08/08/2016

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:
Some out of date medicines were stored in the designated centre since 2012.

12. 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:
Out of date medicines were removed immediately and returned to the pharmacy for disposal. Further training and review of our policies will ensure that the various aspects of our policies and procedures are in fact adhered to.

Providers Update:
Out of date medications should be 'discovered' by staff on duty, and replaced as soon as possible. The Director of Services doubles checks all medications on a monthly basis. Medicines that are out of date are moved to separate storage, awaiting a monthly 'return to pharmacy' trip. Such medicines are logged and receipted by pharmacy as returned.

Proposed Timescale: 08/08/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Short term medication was not administrated when prescribed

p.r.n. medication did not have the maximum dosage identified for a 24 hour period

p.r.n. protocol not evident for all p.r.n. medications

p.r.n. medication plan did not contain the same information as the prescription.

13. 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:
Issues around p.r.n. dosage, protocol and matching of prescriptions to medication plans and been discussed and addressed. A final oversight will take place by the 31/7/16

Providers Update:
Each resident has a comprehensive medication system. The main document a prescription sheet details the difference between Daily Required; PRN and other non-prescribed medication. In addition, a separate section gives full supplementary information on each medication and resident preferences concerning them for daily required and another separate section gives full supplementary information on each medication and resident preferences concerning them for PRN. Administration of PRN is recorded and signed for.

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:
Medication administration practices within the designated centre were not reflective of the policy in place.

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

Please state the actions you have taken or are planning to take:
Staff have been through the process of being Clinically Assessed in their administration practices and delivery.
Our medications policy & procedures continue to be to the forefront of weekly staff meetings.

Providers Update:
All staff now train in medications management; and then follow all procedure and practice as identified. Errors are notified to management. Staff identified as responsible for an error also need to complete a follow-up report explaining the cause. Staff review

medicine errors weekly in staff meetings. Management review errors on a monthly basis at least.

Proposed Timescale: 08/08/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medication risk assessments were undated.

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

Please state the actions you have taken or are planning to take:
The importance of dating documentation in all areas of medication has been stressed to staff & forms part of on-going communication and training. Each resident's wishes is taken into account in the handling and administration of medications.

Providers Update:
Self-assessments questionnaires are completed and in place for those residents who wish to self-administer. Such questionnaires allow for an assessed opinion of competency of the resident, which is on each resident's file (of those that wish to self medicate).

Proposed Timescale: 08/08/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Provisional prescriptions were being used for some residents, these did not contain sufficient details

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

Please state the actions you have taken or are planning to take:
This issue has been addressed and provisional prescriptions are no longer in place

Providers Update:
Each new Prescription Sheet is signed by the medical authority responsible for the prescribing of the medication. NO provisional prescriptions are allowed.

Proposed Timescale: 08/08/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Stock control for all medication was not evident within the designated centre.

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

Please state the actions you have taken or are planning to take:
A weekly stock control has now been put in place

Providers Update:
Monthly stock control occurs; the last Sunday of each month. This aspect of medication management is under review along with the Medication Management Policy to ensure that stock control is as robust and effective as it ought to be.

Proposed Timescale: 08/08/2016 30/06/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain accurate information in relation to the areas set out in schedule 1

18. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
An amended copy of the Statement of Purpose was submitted after the Inspection and further review of the document will be carried out by mid-September

Providers Update:
The Statement of Purpose has been comprehensively reviewed. It is available in both accessible and word templates.

Proposed Timescale: 15/09/2016

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 person in charge held other roles within the designated centre which impacted on effectively executing the requirements of a person in charge role.

19. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
An additional person has been contracted as Director of Services. This will divide roles and provide an additional PIC.

Peacehaven Trust Ltd has begun the process of coming under the umbrella of the Social Witness arm of the Presbyterian Church of Ireland (PCI) which is a registered charity based in Belfast. This will provide a wider and more effective governance and operational management.
Proposed Timescale: 1st. September 2016 to January 2017

Providers Update:
Whilst the take over by PCI is still on going (Due to clarification on granted funds by Wicklow CC; and approval by HSE for transfer of SLA) a new full time Director of Services is now appointed. This person will hold the post of PIC, and also Provider Nominee until take over is complete. Until then the Chair of the current Board provides active supervision of the Director of Services.

Proposed Timescale: 31/01/2017 Time scale unpredictable.

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of oversight and monitoring of care provision and support within the designated centre.

20. 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:
Monitoring visits occurred in May in one house and June in a second house and the

third house is scheduled for July visit.
PCI will undertake these unannounced visits from 1st. Sep.16

Providers Update:
Since the appointment of new Director, unannounced monitoring visits have occurred in all houses (once each – June 2017). A monitoring visit will occur in each house monthly, by Director of Services. PCI also will conduct unannounced Monitoring Visits.

Proposed Timescale: 08/08/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unannounced visits to the designated centre at least once every six months resulting in a written report on the safety and quality of care and support provided in the designated centre was not available.

21. 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:
Monitoring visits occurred in May in one house and June in the second house and the third house is house scheduled for July visit.
PCI will undertake these unannounced visits from 1st. Sep.16

Providers Update:
Since the appointment of new Director, unannounced monitoring visits have occurred in all houses (once each – June 2017). A monitoring visit will occur in each house monthly, by Director of Services. PCI also will conduct unannounced Monitoring Visits. At six monthly intervals, a more detailed monitoring visit will occur, and be reported on – in writing.

Proposed Timescale: 08/08/2016

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 and support in the designated centre was completed.

22. 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 support of PCI will provide additional personnel to carry out & document reviews and checks in our houses. This will ensure that care and support is in accordance with standards.

Providers Update:
An annual report commenting on the quality and safety of care has drafted for 2016. It will be submitted to the authority by 30/06/0217

Proposed Timescale: 01/09/2016

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre was not sufficiently resourced to ensure the effective delivery of care and support when residents were transitioning into the designated centre.

23. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The level of service we can provide for residents has been reviewed and we have noted this for future planning of Residents to be transitioned.

Providers Update:
IN March 2017 interviews were held to complete the workforce within the Trust. Appointment have been made, and the Trust is fully staffed at present.

Proposed Timescale: 08/08/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff required mandatory training while all staff required training in administration of emergency medication.

24. 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:
Ten staff attended the training on 14th July and those who weren't able to attend then will attend the repeat training in August.

Providers Update:
All staff continue with mandatory training. Several gaps existed when the new PIC commenced; most notably Occupational 1st Aid. All staff have received a CPR course and will complete first Aid by end of August 2017. Gaps in Medication Management; Safeguarding Vulnerable Adults and Fire Safety are also being closed as fast as possible. A new Traing Policy has been written; and new procedures put in place to effective guide the PIC in this process.

Proposed Timescale: 01/09/2016 31.08.2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence of effective supervision among staff within the designated centre.

25. 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:
The Supervision Log is to be monitored regularly/quarterly to check for omissions due to holidays, illness, etc & ensure that sessions are re-scheduled.
An arrangement has also been made to provide additional time for the Supervisor to carry out supervision as required.
Managers attend external supervision & have also had internal supervision in May and in June

Providers Update:
Supervision is taking place with social care staff on a regular basis. A record of all supervision is maintained. Care Managers (and Admin) are supervised by the Director of Services. The Director of Services is supervised by the Chair of the Board.

Proposed Timescale: 08/08/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All schedule 5 policies were not available within the designated centre while others

required more details to guide staff effectively for example, residents' finances.

26. Action Required:
Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

Please state the actions you have taken or are planning to take:
Policies are currently under review with the expectation to be completed no later the mid-September

Providers Update:
19 of the 21 policies and procedures as set out in schedule 5 apply to Peacehaven Trust. (It has neither children or CCTV). Of the 19 policies that should be in place 1 is not – Communication with residents. This will be written and in place by end of June 2017. There are 11 policies which are set for review by maximum age (Created and last reviewed in 2014), and are on a schedule for revision. The new PIC aims to have all policies pertinent to the schedule 5 reviewed and fully operational by end of October 2017.

Proposed Timescale: 15/09/2016 31/10/2017