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:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002569
Centre county:	Meath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Fiona Monahan
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 February 2016 10:20	10 February 2016 18:30

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

Summary of findings from this inspection

This announced inspection was the first inspection of the centre. Its purpose was to monitor the level of compliance with regulations. The centre comprised of a five bedroom house in a town in County Meath.

Seven Outcomes were inspected and the inspector found evidence of good practice across all outcomes. Some improvements were required with regard to social care needs, fire drill documentation and staff files.

The inspection took place over one day and as part of the inspection process, practices were observed and relevant documentation reviewed such as care plans, health care records, policies and procedures. The inspector also met with and spoke with residents and staff.

Residents had decided to stay at home rather than going to their day services in order to meet the inspector the day of the inspection. The inspector met each resident during the inspection. All residents spoken with told the inspector they really liked their home and had liked the staff that supported them. They said they would go to the person in charge or their key worker if they had a problem or if somebody was not nice to them.

The person in charge and staff members demonstrated their knowledge of the

Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.

There was evidence throughout all Outcomes that residents were receiving a good quality of service. Staff were supportive in assisting residents in making decisions and choices about their lives. Residents had access to an independent advocate and there was a photograph and contact details of their advocate displayed in the kitchen with the advocate's next visit date clearly marked.

Residents, the person in charge and senior management for the centre discussed with the inspector a proposed plan to make alterations to the living space by knocking down a wall that separated the kitchen and the staff office. This would allow a larger dining area for residents in the kitchen and a smaller more compact office space. The works did not have a start date set, but all residents have been informed of the intended works and consulted for their opinion.

Of the seven outcomes assessed, six were found to be compliant or substantially compliant with one moderate non-compliance in Outcome 7; Health & Safety & Risk Management.

The findings to support these judgments are in the body of the report; the action plan with the provider's response in addressing the identified failings is found at the end of the report.

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

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall evidence of good practice was found with regard to meeting the residents social care needs. However, some goals in residents' personal plans had not being addressed adequately. Personal plans were not in an accessible format for residents and some support needs identified did not have adequate care planning in place.

Residents social care needs were assessed using a comprehensive assessment which incorporated a nursing model of assessment whereby residents' activities of daily living were assessed together with a person centred model of assessment which identified residents' goals, wishes and plans.

Each resident was assigned a key worker and scheduled monthly meetings were facilitated. Daily records were maintained of the how residents spent their day. Personal plans contained information about the residents' life, their likes and dislikes, their interests, details of family members and other people who are important in their lives.

There was also evidence of multi-disciplinary assessments and recommendations which were used to develop support plans for residents based on their assessed needs. These were reviewed as required with a scheduled review date of all plans at least annually.

A resident identified as being at risk of developing a pressure ulcer did not have a care plan related to this healthcare risk incorporated into the overall management of a medical condition they had which could predispose them to pressure ulcers.

While there was good evidence to indicate residents' social care support needs were

comprehensively assessed and implemented some goals identified by residents were not being adequately addressed, reviewed or carried out.

One resident, as part of their person centred plan, had identified that they would like to participate in art therapy. However, the action plan for this goal was not adequate and entries indicated that no concerted action had been taken to support the resident in achieving the goal or working towards achieving it.

Residents did not have a copy of their personal plans in an accessible format.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The health and safety of residents, visitors and staff was promoted in the centre and suitable arrangements were in place to for the identification and management of risk and adverse incidents.

There was a Health and Safety Statement in place which was up to date. The risk management policy provided guidance to staff on the identification and management of risk. It contained the matters as set out in regulation 26 of the Care and Welfare Regulations 2013.

A centre specific risk register was in place and up to date. Risks in the centre were identified and given a risk rating for likelihood and severity of impact that was documented against each risk. For each risk control measures were in place to mitigate the risk. For example, a risk assessment had been carried out with regard to temperature of the water throughout the centre thermostatic control valves had been fitted to mitigate the risk of scalds to residents from water that was too hot.

Another risk identified was the risk of slipping on the wooden decking at the rear of the centre. Risk control measures had been implemented whereby a gridded cover had been fitted over the timber decking to reduce the likelihood of residents, visitors or staff slipping and falling.

Records of accidents and incidents were maintained and up to date. Of the sample of accidents/incidents recorded they were detailed with a risk analysis carried out and

corrective action taken where and where required.

There were adequate infection control measures in place given the purpose of the centre and the needs of residents living there. There was adequate hand washing facilities throughout. Paper hand towels were available in all bathrooms/toilets of the centre. Alcohol hand gel was also in supply in the centre.

Residents' manual handling needs had been identified and manual handling plans were in place for residents that required them. All staff had received manual handling training with refresher training available.

All staff had attended fire safety training in 2015. The fire alarm system and fire fighting equipment had been serviced February 2016. There were up to date records of checks carried out on the emergency lighting system in the centre, electrical equipment and fire exits to ensure they were unobstructed at all times.

Fire exits in the centre were clearly signed. The inspector observed that all exit doors had keys in the locks for security purposes for the centre. Fire compliant spare key containers were located beside each door. While these were appropriate and ensured a key was available at all times the inspector was not assured that residents in the centre would have the dexterity to break the glass of the units to retrieve a key during an emergency evacuation.

The assistant director of nursing, who acted as a person participating in management of the centre, informed the inspector that it was the intention of the organisation to replace the key lock system in each fire escape door with a thumb turn locking system which would negate the necessity for use of a key and ensure residents could open fire exit doors easily during an evacuation.

Each resident in the centre had a personal evacuation emergency plan which set out the supports each resident required to safely evacuate the centre. Fire drills had been carried out regularly in the centre in 2015.

Fire drills documentation included the date the drill took place, the staff that participated and the names of the residents. However, the documented fire drills did not provide any other information. This was not adequate as they did not provide information about the effectiveness of residents' personal evacuation plans or if any issue had arose during a fire drill that would bring about changes to evacuation procedures for the centre or residents' individual plans being changed.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness,

understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were measures were in place to protect residents from being harmed or experiencing abuse. A restraint free environment was promoted in the centre and supports were in place for residents that may display behaviours that challenge due to mental health deterioration, for example.

There was an organisational policy in place on the prevention, detection and response to abuse and staff received training in safe guarding of vulnerable adults. During the inspection adult safeguarding staff training was being carried out. The person in charge ensured staff were rostered to staff could attend. Senior management responsible for the centre also attended the training on the day of inspection. Staff spoken with had knowledge of what constituted abuse and described appropriate actions they would take if they witness abuse or an allegation of abuse was disclosed to them, including who to report it to. A designated person had been nominated by the organisation to whom allegations of abuse were referred to.

Residents spoken with said they felt safe in the centre and that they could talk to any staff member or the person in charge at any time if they had any concerns. An independent advocate was available to residents at any time and was scheduled to meet with residents 19 February 2016.

Intimate care support plans were documented and maintained in residents' personal plans. These outlined the supports residents required in relation to their personal hygiene and continence management, for example.

A restraint-free environment was promoted. There was a policy in place for the provision of behavioural support and for the use of restrictive procedures. All staff had received training in the management of behaviours that challenge.

No restrictive practice was used in the centre and there were minimal issues with regard to challenging behaviour also. Residents were supported to access mental health services as required.

There were no allegations of abuse under investigation at the time of inspection. The person in charge was aware of their responsibility to notify the Chief Inspector of any allegation of abuse that might occur in the centre.

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

Findings:
Resident's health needs were met to a good standard. Residents had access to GP services and there was evidence to show appropriate treatment and therapies were in place to address their health issues.

Residents had received assessments, recommendations and interventions to meet their needs from allied health professionals such as physiotherapy, dietician, occupational therapy and speech and language therapy (SALT). Allied health professional recommendations, reviews, recommendations and support plans were maintained in residents' personal plans and informed supports in place for them.

There was also a wide range of nursing health assessments completed which assessed residents' needs and identify health care risks. Some examples included, falls risk assessments, nutritional risk and pressure ulcer risks

Residents' nutrition needs were well managed. There was adequate space for food preparation and storage of fresh and frozen produce in the centre. Cupboards had plentiful condiments, grains, pulses and cereals to ensure food was wholesome and nutritious. Colour coded chopping boards were in use to ensure raw meat and fresh vegetables were not chopped using the same board, for example, as a measure to reduce food contamination.

Residents' nutritional health was monitored regularly by staff supporting them. Residents had monthly weights taken from which their body mass index was calculate and this in turn was used as part of a nutritional risk assessment which identified if a resident was at risk or might require referral to a dietician, for example.

There were plans in place for all residents to attend a dietician privately as the public waiting list was long. The person in charge was in the process of making referrals for residents to be reviewed. One resident had already been availing of private dietician services which were found to meet their needs and informed the residents nutritional health plan.

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

Findings:
There were safe medication management practices in place. Staff were trained in safe administration of medication practices and administration records of medications were up to date and well maintained. However, some storage of medication procedures were not adequate. There were no documented temperature checks of the refrigerator that stored medications

Written operational policies were in place to guide staff practice in relation to the ordering, prescribing, storing and administration of medicines to the resident.

Medications were stored in a locked cupboard in the staff room and keys to the cupboard were stored in a container that required a code to open it. Residents' medications came in blister pack systems from their pharmacist and the person in charge informed the inspector that this system had reduced the number of medication errors occurring. PRN (as required) medications were also stored in the cupboard. All residents had individualised clearly labelled containers in which their blister pack and PRN medications were stored.

The inspector viewed a random sample of residents' medication records and found that they contained all of the required information. Systems were in place for reviewing stock of medications which ensured they were regularly checked, documented and audited by the person in charge.

Medications were, in the most part, appropriately stored. However, the temperature of the medication fridge was not monitored. There were no documented checks of the temperature to ensure medications stored in it were so at the correct temperature.

No residents were prescribed any controlled medications which required additional controls at the time of inspection. However, there were policies and procedures in place for the management of such medications in the event that they were required.

Medication management audits were carried out by the person in charge to ensure compliance with the centre. Corrective actions were taken where appropriate.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Effective management systems were in place to support and promote the delivery of safe, quality care services. The quality of care and experience of the residents was monitored on an ongoing basis through comprehensive auditing systems which had recently been introduced.
The inspector reviewed a sample of audits carried out and found the system to be comprehensive and effective in improving the standard of care and support received by residents through consistent review of practice and procedures.

Each month the person in charge carried out an audit of practices and procedures in the centre with a view to evaluating their own compliance with the standards and regulations as set out by the Authority. After each monthly audit the person in charge submitted them to the assistant director of nursing for review and feedback. This ensured all levels within the governance and management structures of the centre were informed of practices and actions required to improve services.

An annual review was also part of the auditing system for the centre whereby the person in charge, for example, examined the centre's compliance against the regulations and identified what percentage of compliance they had reached for the year. The annual review also identified actions that would be required to improve practice and standards in the centre.

In addition residents'/families feedback on their satisfaction with the service they received had been completed for 2015 and required actions were being addressed. The resident/family feedback questionnaires had identified some residents would like to have the opportunity to go to Mass each Sunday, they wished to establish and develop positive relationships with their families and wanted to plan a positive mental health week. Changes to the layout of the centre were also part of the feedback. There had been positive feedback to the suggested enlarging the kitchen of the centre by knocking

down a wall that separated the kitchen and staff room. This would result in a larger dining area for residents.

There was a clearly defined management structure that identified the lines of authority and accountability. The centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service. He was knowledgeable about the requirements of the Regulations and Standards.

Since commencing in his role in September 2015 he had gotten to know the residents well and had implemented a number of improvements in the centre. For example, he had introduced a system of formal staff supervision which had had begun to implement.

He was supported in his role by an assistant director of nursing and staff that had worked in the centre for a number of years and was very knowledgeable of the residents. There were suitable on call systems in place to support staff working in the centre in the absence of the person in charge, at night time and weekends also.

Judgment:
Compliant

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

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The centre had a staff team who worked to ensure that the needs of residents were met.

Residents appeared comfortable in the company of the person in charge and staff. Interactions appeared relaxed with a genuine rapport evident between residents and staff. During the inspection, the inspector observed staff carrying out supports and practices with residents and found that they were supportive and appropriate.

Staff training viewed confirmed all staff had completed up-to-date mandatory training. A continuous training programme had been implemented and records were maintained. Some areas of training staff had completed were medication management, nutritional

risk assessment, hand hygiene and management of behaviours that challenge.

There were suitable arrangements in place to ensure staff received formal supervision and support on a regular basis. As mentioned in Outcome 14; the person in charge had begun formal supervision meetings with staff working in the centre. The purpose of the meetings was to improve practice and accountability of staff within the centre.

A sample of staff files were reviewed as part of the inspection. However, they did not meet fully with the matters as set out in Schedule 2 of the Regulations. One staff member's employment history did not have enough information including a satisfactory history of any gaps in employment. In another staff file reviewed there were no details and/or documentary evidence of any relevant qualifications or accredited training of the person. However, they were indicated as having completed all mandatory training as per the training matrix for the centre.

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:

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002569
Date of Inspection:	10 February 2016
Date of response:	24 March 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident identified as being at risk of developing a pressure ulcer did not have a care plan related to this healthcare risk incorporated into the overall management of a medical condition they had which could predispose them to pressure ulcers.

1. Action Required:

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

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Comprehensive Care Plan now in place regarding Resident predisposed to pressure ulcers. March 2016.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While there was good evidence to indicate residents social care support needs were comprehensively assessed and implemented some goals identified by residents were not being adequately addressed, reviewed or carried out.

2. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
All Residents are supported to review their respective goals to ensure they are meaningful, realistic, measurable and achievable and within an agreed timeframe.
The person in charge accepts the findings of the inspector and has and will ensure the progress of achieving goals will be monitored on a regular basis in liaison residents, families, keyworkers and with mdt staff as appropriate.

Proposed Timescale: Completed and Continuous ongoing review.

Proposed Timescale: 24/03/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have a copy of their personal plans in an accessible format.

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

Please state the actions you have taken or are planning to take:
The person in charge has commenced work with each resident to support them to develop accessible person centred plans. Relevant support from members of the

multidisciplinary team will be sought where required.

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documented fire drills failed to provide information with regards to the effectiveness of residents' personal evacuation plans during the drill or if any issue had arose that could result in the evacuation procedures or residents individual plans being changed.

4. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Fire Drill recording sheets now developed and in place. The recording sheets will provide the following: Names of Residents and Staff taking part in drill, Day or Night Drill, The length of time taken to evacuate, any difficulties arising during drill and any actions or review required following drill. PEEPs will also reflect any input required following fire drills

Proposed Timescale: 29/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All exit doors had keys in the locks for security purposes for the centre. Fire compliant spare key containers were located beside each door. While these were appropriate and ensured a key was available at all time the inspector was not assured that residents in the centre may have the dexterity to break the glass of the units to retrieve a key during an emergency evacuation.

5. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Thumb Locks have been purchased and will be fitted to all external exit doors as agreed with all Residents and the PIC will ensure all residents receive demonstration on use of Thumb Locks.

Proposed Timescale: 30/04/2016

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:
The temperature of the medication fridge was not monitored. There were no documented checks of the temperature to ensure medications stored in it were so at the correct temperature.

6. 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:
The Temperature of the Medication Fridge is now being recorded and documented on a daily basis.

Proposed Timescale: 10/02/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A sample of staff files were reviewed as part of the inspection. However, they did not meet fully with the matters as set out in Schedule 2 of the Regulations.

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

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that all matters as set out in Schedule 2 of the Regulations will be maintained in respect of all staff employed in the designated centre.

Proposed Timescale: 30/04/2016