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:	Damien House Services
Centre ID:	OSV-0002442
Centre county:	Tipperary
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Carol Moore
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	12
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 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:
07 September 2016 09:30	07 September 2016 20:00
08 September 2016 09:00	08 September 2016 17:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre. The registration inspection was undertaken on 28 April 2015 and due to the number of non-compliances a full follow up inspection took place on 8 September 2015. At that time a significant number of critical improvements had been made and the provider was recommended for registration.

How we gathered our evidence:
The inspector met with all residents and communicated directly with four. A number of residents also communicated in their own preferred manner and allowed the inspector to observe their day and have tea with them. Eight residents, had with staff support, completed questionnaires which stated that they were happy with the care provided and could tell staff if anything was wrong. Three relatives also completed questionnaires which were also very positive regarding the care and communication offered to them.

The residents stated that they enjoyed their activities and knowing what they were doing each day. They liked having their own rooms and their own possessions

around them. One resident said he was doing "well" and he wanted HIQA to know that the staff was also doing "well".

The inspector also met with the person in charge, assistant director of nursing and staff, observed practices and reviewed the documentation such as personal plans, medical records, accident logs, policies and procedures and staff files.

Description of the service:
The statement of purpose describes the services and a high support facility which provides care to adult male and females with high moderate to profound intellectual disabilities and significant challenging behaviours.

It is comprised of three units with four residents in two units and the capacity for five in one unit. Two of the units are located on a campus which also houses day services and other care facilities. One unit is located in another village some 15 miles from the main unit. All are in close proximity to local towns and services and had suitable transport available for the residents.

Overall judgement of our findings:
There were six actions required following the previous inspection. The provider had satisfactorily addressed four of these actions. One of the actions was not reviewed on this inspection to the inability to access the data in relation to recruitment information. The systems for review of and auditing of practices and incidents required further development.

The inspector found that there were effective governance systems in place which promoted good outcomes for residents and evidence of planning for the future of the service. The process of reviewing the service and the compatibility of residents needs was commencing following the completion of a full psychological review. This had been secured by the provider as part of the action plan from the registration inspection.

This resulted in positive experiences for residents, the details of which are described in the report. Good practice was found in:
• Resident's access to suitable and meaningful activities according to their preferences which had improved their quality of life (Outcome 5
• Good access to multidisciplinary assessment and healthcare which optimised their opportunities (Outcome 5 &11)
• Safe medicines management practices (outcome 12)
• Suitable numbers and skill mix of staff which ensured resident's care and psychosocial needs were met (outcome 17)

Some improvements were required in the following areas:
• Safeguarding, decision making and monitoring of restrictive practices and behaviour supports (Outcome 8)
• unannounced visits and subsequent reporting on behalf of the provider (Outcome 14)

The actions required to achieve compliance with the Health Act (Care and Support of Residents in Designated Centres (Children and Adults) With Disabilities Regulations 2013 are outlined at the end of this report.

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
From a sample review of 6 residents personal plans and records the inspector found that the social, health and psychological care needs of residents were regularly assessed by staff and relevant clinicians. There was good access to allied health services for assessment and intervention including speech and language, dieticians, physiotherapy, dentistry and optician services.

The process of review by a clinical psychologist which had been commenced by the provider following the initial registration inspection had been concluded. This could be seen to have had a significant positive impact for the residents with clarity regarding their care needs and detailed support plans devised. Regular psychiatric support and review was also evident. The intervention was multifaceted and included ongoing training and development for staff to support the changes being made.

The inspector also reviewed the records of the annual reviews of the residents and found that they were informed by the assessment and progress made and where needs changed the care and support plans were duly altered. Family members were involved in decisions and where feasible for the residents to attend this occurred. However, there was evidence that they were consulted in regard to their personal plans.

There were evidenced based assessment tools used for falls, pressure areas and nutrition. The assessment tools were regularly updated by staff. Resident's personal goals, social preferences, communication needs, personal care needs and preferences were also documented in the plans and these informed the support plans being made. They demonstrated an in depth understanding of the residents based on interactions

with and information gleaned from residents, family members and clinicians. It was evident that goals were being achieved and activities pursued.

The outcomes included additional review or assessment, access to medical care, choices in day to day activities and social activities. Examples of this were a recent sourcing of a sensory assessment for a resident, access to an additional premises to allow a resident more time quiet away from the group and significantly improved access to external activities and day care pertinent and suitable to the need and capacities of the residents. The improvements also enabled residents whose access had been limited and curtailed due to the need for significant staff support and security measures to have a much improved quality of life.

They did activities such as swimming, bowling, shopping, long walks, pottery; art and gentle exercise for stress reduction. One unit had hens which some residents enjoyed feeding. Some did basic typing training or money management. This process was supported by the detailed pictorial charts used individually to reduce anxiety levels, strict adherence to the plans and staffing availability to ensure the one to one or two to one supports necessary was available.

Some residents explained their routines to the inspector and showed the inspector their individual charts. They said they enjoyed their activities and the skills they learned were very important to them. Residents had short overnight holiday breaks with staff during the summer.

Where sections of the environment had previously been quite stark, primarily due to safety concerns these had been significantly improved albeit still within a secure environment. A resident had been enabled to take part in painting a mural and also in safely laminating personal photos for the walls of the accommodation. This was a significant change and the resident was able to show this work to the inspector.
A full-time HSE psychology service had been assigned to the service just prior to the inspection to continue the interventions which had commenced.

It is expected that the ongoing review in conjunction with the psychiatric service will enable future development and planning for each of the residents. As a result of these findings and continued changes the inspector was satisfied that the provider was making sufficient arrangements to ensure that the complex and diverse needs of the residents could be met.

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:
The action from the previous inspection required a more timely response to incidents and adequate incident management and reporting systems. This had been partially but not fully resolved. Records seen found that staff were detailing the incidents more effectively and reporting and response systems were prompt. All incidents were reviewed by the local management team which included the clinical nurse behaviour specialist and in some cases by the clinical risk manager. Strategies had been identified in response such as, additional staffing, falls management strategies or medical review.

The documentation and development of pertinent individual risk assessment and management plans was not consistent. While there were individual and very detailed risk assessments and management plans undertaken for a number of pertinent issues such as road safety or choking some issues identified such as self harm or absconding did not have management plans in place.

In addition, a resident prescribed emergency medicine did not have access to this medicine when outside of the unit. While there had been no occasion when the medicine was needed, in any circumstances for which it was prescribed, this was not a safe arrangement.

The risk register while detailed, did not provide the framework for the subsequent management of risk identified. The inspector acknowledges however that the staffing level and the environment by its nature do help to mitigate such risks.

Good practice continued in the quarterly and annual servicing of the required safety equipment and fire doors were installed. Daily and weekly checks on the alarms and exits were documented.

Fire drills had been undertaken regularly at various times with no untoward issues identified. Staff had received training in fire safety. It would not be recommended that deep sleep fire drills take place in this centre due to the medical and mental health needs of the resident. The inspector was informed that it was planned to do either a very early morning or late evening event on order to simulate night time systems and staffing levels. There were suitable and pertinent personal evacuation plans available for the residents.

Staff carried personal safety alarms at all times in one unit which were also monitored and serviced.

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):
No actions were required from the previous inspection.

Findings:
There were no actions required from the previous inspection. However, on this occasion there were some improvements required in the documentation of and review of safeguarding and challenging behaviour plans and restrictive practices.

Where safeguarding plans were required by virtue of incidents of peer to peer assault the inspector found that they were generic and did not outline the actual steps implemented by the person in charge such as one to one staffing, changes to routines and increased activities to avoid points of conflict. The inspector was satisfied that these measures were implemented.

There were a number of incidents of peer to peer physical abuse reported. From a review of a number of such incidents it was apparent that in some instances there had been a significant reduction in these. In others there appeared to be an increase in incidents but this data was not sufficiently analysed.

Supervision of external visits had been required and implemented for a resident's safety. However, the inspector could not ascertain from records or interviews how or in what forum the decision had been made to remove the supervisory requirements which was contrary to some recommendations seen.

There was evidence that the level of restrictive practices had decreased in some instances and this was a direct response to the guided interventions of the external clinician. Staff acknowledged the benefit of this to their practice. For example, an internal apartment door which had previously been locked as single separation for regular periods of time was used only on one occasion since January 2016 and for the minimal length of time. While the kitchen door was locked in one unit it was opened with staff supervision and residents had full access under supervision. One resident had his own key to the kitchen.

However, there was a lack of definitive oversight and review of the restrictive practices in particular individual incidents. Physical interventions were used on a number of occasions with the details clearly outlined and staff trained to an appropriate standard to undertake this. All such measures had appropriate risk assessment and rationales in

place. From a review of the use of p.r.n (administered as required) medicines for the management of behaviours it was apparent that there had been an increase on the previous quarter.

The behaviour support plans and systems of monitoring of behaviours were intended to act as preventative strategies and provide clarity as to the severity and outcome of the behaviour and interventions. However, some instances of challenging behaviours were not being recorded and in some instances the strategies used to divert the behaviour were not defined prior to an intervention. This could negate the value of the detailed data required by the clinician and impact on the best outcome for the resident.

A rights committee had recently been formed which included legal expertise and representatives of the residents and well as multidisciplinary personnel. The terms of reference had been agreed and it was proposed to review all restrictions.

The inspector acknowledges that no instances of inappropriate conduct in relation to restrictive practices were found.

However, no substantive audits or reviews were undertaken to critically ascertain the current scale and overall impact of the restrictive practices, safeguarding strategies and behaviour support plans and effectiveness.

The CCTV camera remained in place but with strict guidelines as to its usage and the rational remained valid in this instance.

The psychology intervention for the assessment and development of behaviour support plans had been completed. This was found to be an individualised and carefully planned intervention which had resulted in strategies including the clarity of routines, access to increased activities and staff support. One resident told the inspector about the deep breathing exercises and role play which had helped him manage his anxiety.

Staff had received training and further training was planned in safeguarding of vulnerable adults. The designated person who was the PIC was scheduled to undertake this training in the management of such allegations and the assistant director of nursing had already done so.

The inspector found that the person in charge had acted promptly and appropriately on review of an incident of potentially abusive behaviours. Staff could articulate the types of situations which could be considered abusive. There were personal intimate care guidelines available for the residents.

Judgment:
Non Compliant - Moderate

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:
From review of the accident and incident log the inspector was satisfied that the person in charge had complied with the requirement to forward the required notifications to HIQA and had been diligent in providing follow up information.

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:
There were no actions required from the previous inspection and the inspector was satisfied that the residents continued to receive a good standard of healthcare. There was very good access to both general practitioners (GP) services and a range of allied health services appropriate to the residents needs. Residents confirmed that they can attend their GPs. In response to the previous report the records of these visits were now detailed in a discreet format for ease of retrieval.

There was a document entitled titled the "OK health check" which was a comprehensive review of health related needs and progression which was completed by staff as part of the annual healthcare review. Records of all medical appointments and outcomes were maintained.

There was evidence of referral to and consultation with allied services as required by the residents needs, including neurology, occupational therapy, physiotherapy and mental health specialists, cardiac, dentistry and opticians. Where regular and specific reviews were required due for example to medication these were seen to be attended to

promptly. Appropriate vaccinations were provided to help maintain the residents' health. There were evidenced based assessment tools used to determine dependency levels, nutrition and skin care needs. Any health care issues identified such as dietary needs, dental care, stoma care were supported by detailed care plans and staff were knowledgeable on these plans.

Identified risk of pressure areas were well managed and carefully monitored with prompt access to external advice if required and specialist equipment and additional nutritional supports were seen to be available and used. Where required detailed fluid and food intake records were maintained and monitored by staff.

There were strategies in place to encourage healthy eating, diets and health promotion with staff supporting residents on food choices.

Staff prepared all meals with support from residents where this was feasible. As observed and from records seen these were varied and nutritious. The residents were supported to make choices each day. Some residents did the grocery shopping with staff. A number required specialised and modified meals and the details of these were available and they were seen to be adhered to.

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:
The inspector found there was a detailed medicines management policy in place to guide practice which staff adhered to. Nursing staff administered and managed all medicines.

There were identified systems for the receipt and return of medicines with weekly audits undertaken. Medicines were stored safely and prescriptions and administration records were seen to be dated, signed and with maximum doses of p.r.n. (administered as required) outlined.

Residents were assessed as not having the capacity to self self-administer medication. A review of the administration practices of medicines was undertaken and any issues identified were seen to be addressed. No errors were reported at this time. Medicines

were regularly reviewed and monitored by the prescribing clinicians.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There was evidence of a defined management structure and accountable systems in place. However, an effective auditing system had not been developed which would support the monitoring of the service across a range of factors. This was especially pertinent to the use of restrictive practices, use of p.r.n medication incidents of peer to peer assault.

The person in charge had returned from statutory leave at the time of this inspection. The assistant director of nursing who is also suitably qualified and experienced had deputised during this planned absence as well as supporting two other centres on behalf of the provider. The arrangements were satisfactory and all of the required notifications had been made to HIQA.

Arrangements for communication and reporting were evident with records of regular and substantive meetings at local and regional level. The systems were seen to effective with detailed action plans made and monitored to address all of the issues identified in the previous report along with current issues.

The charges made in 2015 with the allocation of a clinical nurse manager to each of the individual units with responsibilities and revised hours of work had been maintained so that there was direct line management and out of hours support to the units.

This ensured that each unit had a manager with responsibility for direct overseeing and direction of care. It also ensured that the outlying unit had the regular presence of a senior manager to oversee care practice and support staff. Staff informed the inspector that this had made a significant difference to their support and access to management. There was also a CNM assigned each weekend with responsibility for management.

The inspector found that the action plans from the providers own annual report of 2015 had been addressed in detail. However there had been no unannounced visit in the centre since then. This was explained as being due to a misunderstanding as to the date and timing of the last visit. However, there was sufficient evidence that despite this the nominee was knowledgeable on the residents and maintained direct reporting and oversight of practices.

The additional staffing resources had been maintained and the contracted external psychology interventions had also been maintained. A date for the unannounced visit was scheduled for September 2016.

Some audits had been undertaken and accident and incidents were reviewed as they occurred. However, the data collated including the use of chemical restraints, medication, incidents of restrictive practices and peer to peer abusive interactions was not analysed to identify time frames, trends or changes which would inform practices.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
There were two actions required from the previous inspection and the inspector was satisfied that the provider had addressed these. Additional nursing staff had been allocated to the outlying unit to meet the ongoing nursing or medicines requirements of the residents. There was a nurse rostered daily in this unit.

The staffing ratio included the provision of one to one supports for some residents which ensured that resident's activities, routines and behaviour support plans could be adhered to. These had been impacted on by staffing levels at the previous inspection.

There were two waking night staff in each unit at night and between three, four and five staff in each of the units daily depending on the needs and dependency levels of the residents. Some agency staff were still required although a core group were nominated

to support better continuity of care. There was an arrangement between the person in charge and the agency to ensure all of the required documents were available.

Adherence to mandatory training requirements in safeguarding and manual handling was also required at the previous inspection. These were both actioned and any deficits were found to be already scheduled.

It was noted at a point during the year the staffing levels in one unit had been reduced at weekends. However, due to the needs of the residents, the requirements for travel at weekends to facilitate home visits and a review of incidents the person in charge and the provider had acted promptly to restore the levels on Sundays. The person in charge informed inspector that this ratio would be kept under review for the Saturday schedules.

There was an on-call system in place for staff which they said was effective.

Training in the management of aggression and violence had been undertaken and further was scheduled as per the centres policy. Staff in this centre undergo the advanced training due to the needs of the residents.

Other training provided to staff included the management of sharps, CPR, which included the management of emergencies including choking. The specific training which had commenced via the contracted psychologist in 2015 in relation to the management of individual resident's psychosocial well-being and behavioural support had continued. Staff said this was extremely useful to them and this was seen to have a beneficial impact. The inspector was informed that sign language and further disability awareness training was planned.

Team meetings had taken place at circa three /four monthly intervals in each unit. The records showed that they included structured and detailed reviews of the residents. At the time of the inspection these were being rescheduled to monthly in order to improve the process.

The inspector was unable to access personal files at this inspection.

A staff supervision system had been introduced in 2015 but due to industrial relations issues this had not been progressed However, systems for day to day oversight and support of staff were evident.

Staff were was observed to be knowledgeable on the needs of the residents, the care practices they were implementing and respectful to the residents.

Judgment:
Non Compliant - Moderate

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:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Damien House Services
Centre ID:	OSV-0002442
Date of Inspection:	07 September 2016
Date of response:	03 October 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 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:
Some risk identified did not have clear control measures in place including risk of self harm, absconding or access to emergency medicine.

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

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

Please state the actions you have taken or are planning to take:
1. Update the Residents' Risk Registers to include control measures specific to the risk of absconding, self harm and access to emergency medication. Review Risk Registers regarding the specific risks listed above by 15.10.16
2. Conduct a wider review of the Residents Risk registers. Review the wider Residents Risk Register by 04.11.16
3. Review the Risk management and Emergency Planning Policy to incorporate a review of incidents at monthly meetings and a review of the Residents Risk Management plans following quarterly Care Plan reviews. Review policy by 04.11.16 with ongoing implementation.

Proposed Timescale: 04/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems for oversight and review of some of the restrictive practices used were not sufficiently robust.

2. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
1. Included as part of the terms of reference of the Rights Review Committee is oversight of the process of putting a restriction in place. The Terms of Reference of the Rights Review Committee will be finalised and agreed by 02.12.16
2. Monthly Incident reviews include reviewing the use of any Restrictive Interventions. Ongoing incident reviews take place at Unit, Local Management and Regional Management level
3. The Restrictive Intervention Policy will include a 6 monthly audit of Restrictive Intervention prescribing and usage. Restrictive Intervention Policy review will be completed by 18.11.16

Proposed Timescale: 02/12/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient review of some incidents of peer abuse and oversight of decision making in regard to safeguarding of residents.

Some safeguarding plans were generic and did not provide adequate levels of guidance.

3. 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:
1. As part of ongoing monthly incident review the peer to peer incidents are reviewed. Ongoing
2. Safeguarding Plans for all Residents will be reviewed individually and updated in line with incidents that have occurred and learning from reviewing these incidents. Initial reviews to be completed and all plans updated by 28.10.16. Each plan will then be reviewed as incidents occur.

Proposed Timescale: 28/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a failure to undertake an unannounced visit to the centre at six monthly intervals to review the quality and safety of care.

4. 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:
An unannounced inspection was completed on 28.09.16

Proposed Timescale: 28/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems including the collation and analysis of relevant data were not sufficient to effectively monitor the service.

5. 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:
Management systems have been reviewed with the aim of making changes to ensure sufficient analysis which will inform effective planning and service delivery. First report to be submitted from the Person In Charge to the Provider Nominee by 14.10.16

Proposed Timescale: 14/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Formal supervision systems were not implemented for staff as required by the Regulations.

6. 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:
Currently Management and Unions are working on finalising a policy for formal supervision. Following the finalisation of the policy staff training on the policy will be provided and supervision will take place in line with the policy. Managers provide informal supervision to staff at present. Formal supervision of staff to commence from 01.03.17 or sooner as Unions and Management work collaboratively on finalising the policy.

Proposed Timescale: 01/03/2017