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 Brothers of Charity Services South East
Centre ID:	OSV-0005069
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Johanna Cooney
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
22 March 2016 09:30	22 March 2016 20:00

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 first inspection of the designated centre and the purpose was to monitor ongoing regulatory compliance. The provider has applied for registration. The inspection took place over one day and eight outcomes were inspected against.

The centre is located in the centre of a town within easy access to all amenities and services.

As part of the inspection the inspector met with all residents and three staff members, the person in charge, team leader and regional manager. The inspector spoke with one resident who stated that they were happy living there and enjoyed his various activities but was sometimes afraid due to the behaviours of other residents.

The inspector observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, policies procedures and staff files.

Description of the service:
The centre is comprised of a single story bungalow which accommodates five residents and an adjacent single apartment for one resident. The premises were suitable for its purpose.

It is described in its statement of purpose as designed to provide care for adult residents of moderate to severe intellectual disability and those on the autism spectrum.

Overall judgement of our findings:
The inspector acknowledges that these findings are influenced by the fact that the person in charge had only been appointed in the weeks preceding this inspection and the regional manager was also relatively new to the position. There had been no person in charge of this centre for six months. This inspection found that the provider was not in substantial compliance with the regulations in a number of areas. This resulted in poor experiences and potential risks for residents in some cases, the details of which are described in the report.

Good practice was found in health care and medication management.
The inspector found that there was a lack of effective governance and management systems which had resulted in:
• Risks being identified in health and safety due to poor risk management and fire safety procedures (outcome 8)
• Poor safeguarding measures in behaviour support systems which have resulted in risk and negative impact on residents (outcome 7)
• Poor staff training and supervision to ensure staff can meet the residents' needs which presented risks to residents' welfare and wellbeing (outcome 17 and 14)
• Poor systems for reviewing and updating residents personal plans which impacted on their development (Outcome 5)
• Failure to forward the required notifications to the Authority in relation to incidents of abuse and the absence of the person in charge and failure to have a person in charge for a period of 6 months. resulting in risk of insufficient monitoring Outcome 9 and 14).

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

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:
The inspector reviewed the personal plans, medical records, daily records and multidisciplinary reports of four of the residents and found improvements required in ensuring that annual reviews were taking place, that they were multidisciplinary in focus and that the actions arising out of the reviews and personal plans were implemented. Two of the residents had not been reviewed in a significant time period. The reason for this was explained as being a result of the pressure on staff to manage behaviours in the centre.

There was evidence of multidisciplinary assessments from speech and language dieticians and physiotherapy. The interventions advised by these assessments were available and were implemented by the staff.

Each resident had a personal plan which outlined their individual wishes preferences and goals. These included increased contact with families, access to activities or holidays. In the main these social objectives were achieved.

Some developmental goals had been identified without any plan as to how to achieve them. For example, a resident required training in appropriate safe social interactions. The action identified was to seek a volunteer to address these issues. Another resident had a similar road safety need identified. The action identified was to encourage him to stay safe. These did not demonstrate that the plans were being supported by concrete strategies which would enable the resident to achieve these goals taking their dependency levels into account.

Re-evaluation of needs or addressing changing needs was not always apparent. For example, one resident's sensory assessment had not been reviewed since 2011 and how the associated plan was being implemented was not apparent. A restrictive practice had not been reviewed for a number of years.

The minutes of the annual reviews available did demonstrate that relatives attended and represented the residents. However, the reviews which had taken place focused mainly on behaviour and therefore were not a comprehensive assessment of the personal plans.

There were no communication needs detailed in the support plans available for the residents the majority of whom were non-verbal. It was however apparent to the inspector that the staff were very familiar with and understood the residents means of expression very well.

The resident who lived in the adjacent apartment kept his personal plan with him and was able to tell the inspector what he liked to do and how this was achieved. An assessment had been undertaken to assess his capacity to live independently with staff support.

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 inspector was not satisfied that the systems for identifying and managing risks were satisfactory. There were no fire doors or emergency lighting in the centre. While the fire alarm and extinguishers had been serviced annually and quarterly as required all doors required individual keys to exit which were carried by staff. There were no break glass keys or thumb locks available. In the adjacent apartment the resident used his own keys but in the event of his not been able access these he could not exit the apartment.

Fire drills had been held at three monthly intervals and not issues of concern were noted in evacuating the residents. However, only one of the night staff had been involved in a fire drill and this was in 2014. Staff work alone at night and their ability and capacity to respond effectively by the use of regular drills was essential. There were emergency numbers available for staff.

The adjacent apartment was equipped with an emergency alarm which the resident demonstrated to the inspector. He also explained what he would do in the event of the fire alarm going off.

The inspector found that the risk management policy was not implemented in practice. While there was an organisational quality and risk management framework the response to individual incidents was not apparent. In some instances there had had been no response, for example, to assaults on staff.

A number of safety audits of the environment and work practices had been undertaken. While some control measures had been implemented including locked exit doors and additional staffing, emergency procedures for lone workers were not sufficient. Two incidents of assault had taken place at night and staff did not have a panic alarm to gain assistance. A risk assessment for a resident at risk of falls was not comprehensive enough to provide sufficient support.

There was a signed and current health and safety statement available.

The policy on infection control was detailed and staff articulated good practice in relation to this. Staff were observed taking appropriate precautions and using protective equipment including gloves and sanitizers as this was necessary.

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:
The inspector found that systems for the protection of residents including the management of behaviour and the use of restrictive practices were not robust. The policies and procedures for the protection of vulnerable adults was in accordance with the Health Service Executive (HSE) policy to ensure satisfactory screening, implementation of safeguarding plans and adequate review of incidents. A review of incidents with residents indicated that this had not been robustly adhered to.

There were significant improvements required in safeguarding systems for behaviours that challenge and in the management of restrictive practices. There were some behaviour support plans in a place but not all residents who required these had such a plan. Three members of staff including the team leader had not had MAPA (training in the management of challenging behaviours) since 2011.

There was evidence of regular review by psychiatrists and significant input from the psychology department which is internal to the organisation. This included weekly meetings with staff to enable them to implement the behaviour support plans. However, the inspector found that despite this there was a significant number of incidents where other resident's wellbeing, physical and psychological safety had been impacted upon by the behaviour of one resident. The records demonstrated that since 2012 it was acknowledged that the placement might not be suitable for this resident. From the records and from speaking with staff it was also apparent that the behaviour support plans were not being implemented. Staff said that they did not feel they could do so.

In February 2016 it was recommended that staff undertake a review with the behaviour support trainers in order to develop their confidence in working with the resident. This had not occurred. The internal safeguarding team had become involved in October 2015 following complaints made to the social work section by staff on behalf of the other residents. The remaining residents were particularly vulnerable to this behaviour.

Additional staff support had been made available in 2015 and specific plans were made to ensure the resident had external activities each evening and at weekends. This at least lessoned the impact on the other residents. However, during the inspection it was apparent to the inspector that there was considerable tension in the centre when the resident was present.

One resident who could communicate with the inspector stated that he was afraid of the other resident when he shouts or bangs.

Form the records available to the inspector it was apparent that staff have been unable to protect the residents and implement the behaviour support plans. In this instance none of the resident's needs including those of the resident with the presenting behaviours were being met.

There were no safeguarding plans developed for the other residents.
A resident who presented with less overt behaviours that challenge but self harming behaviours had no support plan in place and had not had a review in over twelve months.

Improvements were required in the management of restrictive practices to ensure they were safe, clinically overseen and managed.

The main interventions used were the use of arm splints, the locking of the front door and some chemical restrictions. There were protocols in place for the use of these and for example the arm splints were to be removed when not required. This was documented.

These interventions had been reviewed by the rights committee but not by the multidisciplinary team. The records showed that they were not however used indiscriminately. From a review of Pro-re-nata (as required) medication that was prescribed for the management of behaviours it was apparent that this was not overused and was carefully monitored by the psychiatric service.

However, on one occasion staff had decided to leave a key hanging by a door so that a resident could be locked into his room if behaviours escalated. The human rights committee refused to sanction this although it was not actually used on any occasion. This action and the decision was recorded on an incident report form. There was no immediate response from management either to sanction the decision or provide an alternative until the decision of the rights committee was issued.

The use of a physical restraint was recorded on an incident report. There was no detail as to what this restraint entailed and no protocol as to what level of intervention was permitted and in what circumstances.

These findings do not demonstrate that management were directing the care delivered and the imposition of restrictions in accordance with national policy, and all staff were not trained in such interventions. At the feedback meeting the regional manager and person in charge stated that they were actively making plans to accommodate one resident in another service.

Judgment:
Non Compliant - Major

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

Findings:
A review of the accident and incident logs, resident's records demonstrated that the provider failed to notify the Authority of a number of significant events including a number of incidents which constituted physical and psychological abuse of residents due to the behaviour of other residents. The latter were not defined as incidents.

One notification had been forwarded in March 2016 which was a cumulative notice of a number of incidents affecting a number of residents and was not satisfactory.
The use of a restrictive procedures including chemical restraint had not been notified on a quarterly basis as required.

Judgment:
Non Compliant - Moderate

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:
The inspector found evidence that resident's healthcare needs were well supported with some small improvements required. A small number of general practitioners (GPs) were responsible for the healthcare of residents and records and interviews indicates that there was frequent and timely access to this service.

There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, mental health specialists, dieticians and physiotherapy, psychiatry of old age and geriatricians.

The residents overall did not have complex clinical care needs and one who did was very familiar with his medication and his symptom management.

The inspector saw evidence of health promotion and monitoring with regular tests and interventions to manage health issues and specific issues such as, diabetes. There were protocols in place for the management of epilepsy and emergency medication. This was available although had not been required for some time.

There was evidence that families were kept fully informed and involved in regards to any external medical appointments and regularly attended with the residents. The inspector was informed that if a resident was admitted to acute services staff were made available to remain with them to ensure their needs were understood and there was detailed passport available in this event.

Residents' nutritional needs were being addressed and monitored. There was documentary evidence of advice from dieticians and speech and language therapists available and staff were knowledgeable on the residents' dietary needs. The inspector observed that they received the correct consistency of food and fluids.

Staff were also aware of resident's preferences and they had choices for meals with pictorial images used. Resident's weights were monitored regularly. However the meal times as observed, due primarily to the tension in the centre was not a social occasion.

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:
The policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for medication were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medication.

There was good communication noted with the dispensing pharmacists who had undertaken one audit of medication. No other audits of medication were available. One error was noted and this had been addressed appropriately. The inspector was informed that only staff who had undergone medication management training were administering medication and competency was assessed following the training. The training records confirmed this training had taken place.

The inspector saw evidence that medication was reviewed regularly by both the residents GPs and the prescribing psychiatric service. A capacity assessment had been undertaken on one resident to partially self-administer medication.

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

Findings:
The inspector was not satisfied that the governance arrangements were effective to ensure the safe delivery of care in their current configuration.

The person in charge had only been appointed to the post in the weeks prior to the inspection. She was also the service manager in the area and had responsibility for four residential services and a day service. She had been in the service manager post since September 2015. The regional manager had been in post in a temporary capacity since November 2015 and in a permanent capacity since 29 February 2016. Staff informed the inspector that the service manager /person in charge was supportive and responsive to them. However, the findings in Outcome 8 Safeguarding and Outcome 7 Health and Safety indicate that there has not been effective overseeing or monitoring of practice and systems available to the centre for some time.

There were senior regional staff meetings at six weekly intervals and the information is shared via the team leader in the house.

There had been one unannounced inspection undertaken on behalf of the provider in 2015. Some issues had been identified but there was no evidence of follow up on this or that it was reflective of the resident's experience. For example, it did not reflect the significant behaviour issues being presented at the time.

No annual report was available. However, a synopsis of information and a template for presenting such a report to the residents had been devised.

A supervision schedule was available for some but not for all staff. A review of a sample of these records did not demonstrate that it was focused on residents care or professional development for staff in meeting the resident's needs at this current time.

There were meetings held with residents and in late 2015 they had been supported by staff to make a complaint. However, there was no evidence provided to the inspector that any system for assessing their own or their relatives views on the quality of their care was implemented.

There were no audits on medication since may 2015 and audits of incidents or accidents which would further inform quality assurance systems were not undertaken. These issues were discussed with the regional manger and person in charge at the feedback meeting. They acknowledged the difficulties in the governance structures and also that current workload of the person in charge may not support effective delivery of care across four residential units.

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

Findings:
The inspector found that there were insufficient staff available at times and that the skill mix was not satisfactory to meet the needs of all of the residents. The staff were observed and found to be very understanding and supportive of residents' primary, health and social care needs. However, they were not sufficiently trained to support residents with challenging or complex behaviours and the skill mix had not been reviewed as this became apparent. The inspector found that the provider had been responsive to changing demands and added some additional staff at evenings and weekends. However, from 19:00hrs only two staff were available. Given the presenting behaviours and the impact on other residents this required review.

The residents had been assessed as not requiring fulltime nursing care. The staff were social care or FETAC qualified.

There was a centre-specific policy on recruitment and selection of staff. A sample review of four personnel files found that while they were mainly in order and contained the correct information, Garda Síochána vetting had not been sourced for a staff that had left the providers employee for a period of years and returned. A number of staff had been with the service for some time.

There was an induction programme in place but only one afternoon of protected supernumery training time was provided. This would not be sufficient to ensure that the residents' individual and primary care needs were understood. For example, four of the residents had swallow care plans and specific personal care needs which staff needed to be very familiar with.

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:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services South East
Centre ID:	OSV-0005069
Date of Inspection:	22 March 2016
Date of response:	12 April 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of residents' personal plans had not been reviewed annually.

[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 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
All personal plans will be reviewed and updated by 11th May 2016

Proposed Timescale: 11/05/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews were not multidisciplinary.

2. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
All personal plans will be reviewed and updated by 11th May 2016 and will incorporate multi-disciplinary input.

Proposed Timescale: 11/05/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of personal plans were not sufficiently detailed to achieve the goals outlined for the resident.

3. Action Required:
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
All personal plans will be reviewed and updated by 11th May 2016 and will be sufficiently detailed to achieve the goals outlined

Proposed Timescale: 11/05/2016

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:
There was an insufficient response to risks identified including individual incidents of assault, emergency support for lone workers at night and residents at risk of falls.

4. 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:
The identified risks have been reassessed and new management plans are in place to address the response to these risks including the following;
- Individual presenting with risky behaviour transferring to a more suitable residence from the 13/04/2016
- Provision of a monitored personal alarm for lone workers from 20/04/2016
- A risk assessment and management plan for the individual at risk of falls will be revised to address the identified short comings by 15/04/2016

Proposed Timescale: 20/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Exit doors did not have easily accessible keys by which to leave the building.

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:
Break glass key box to be installed beside each exit door by 15/04/2016.

Proposed Timescale: 15/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no emergency lighting in the centre.

6. 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:
Emergency lighting will be installed by 15/04/2016

Proposed Timescale: 15/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no fire doors which would contain the spread of fire.

7. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Fire doors will be installed by the 29/04/2016

Proposed Timescale: 29/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Night staff who worked alone did not have regular practice in evacuation procedures.

8. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A schedule is in place to ensure that all night staff have an opportunity to participate in evacuation procedures during night time hours to incorporate deep drills to commence 29/04/2016.

Proposed Timescale: 29/04/2016

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:** Staff did not have up to date training in the management of behaviour that challenges and were unable to implement the behaviour support plans. **9. Action Required:** Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques. **Please state the actions you have taken or are planning to take:** All staff are scheduled to attend training in the management on behaviour that challenges on the 11/05/16.
Proposed Timescale: 11/05/2016
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Physical restraints were implemented without multidisciplinary sanction or adequate guidance for staff. **10. Action Required:** Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice. **Please state the actions you have taken or are planning to take:** A behavioural support plan is in place outlining the physical interventions for this individual.
Proposed Timescale: 22/04/2016
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Residents were not protected from psychological and physical abusive behaviours. Preventative actions were not taken in a timely manner when incident occurred. **11. 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:
The individual presenting with challenging behaviours has transferred to another residential placement since 13/04/16.

A meeting is scheduled with the staff team for the 26/04/2016 to address their timely response to abusive interactions and to identify any additional training needs arising.

Proposed Timescale: 26/04/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notification of incidents of abusive behaviours were not forwarded to the Authority.

12. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
All future incidents will be forwarded to the Authority.

Proposed Timescale: 22/04/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Restrictive procedures were not notified to the Chief Inspector.

13. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
All restrictive procedures will be notified to the Chief Inspector from Q1 2016.

Proposed Timescale: 28/03/2016

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:
Management systems were not sufficient to ensure the safe and effective delivery of service as outlined in the findings of the report.

14. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Person in Charge will implement a system of monitoring to ensure that the service provided is;
1. Safe – review medication audits, risk register, complaints log, accidents/incidents log fortnightly, monthly reviews of personal finances, plan and review fire drills, carry out quarterly health and safety audits, and plan and review medication management system audits bi-annually
2. Appropriate to needs - meet monthly with each staff team to review the needs of the individual residents and the supports provided, escalate referrals to health and allied health professionals as appropriate and amend staff support levels accordingly in consultation with the Team Leader. Schedule annual reviews with multi-disciplinary personnel for each person.
3. Consistent - carry out staff supervision sessions and meet with the staff team monthly to review their practices in supporting the residents. Review the residents' support plans and records on a monthly basis to ensure that staff practice is in line with the individual's support needs.
4. Monitored – report on the above on a monthly basis to the Register Provider and plan for any improvements, and review and measure these on an ongoing monthly basis.

Proposed Timescale: 12/05/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review to reflect or monitor the quality and safety of care.

15. 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:
Annual review for 2015 will be completed by the 29/04/2016

Proposed Timescale: 29/04/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No unannounced visit had taken place in nine months.

16. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
The registered provider put a schedule in place to carry out six monthly unannounced visits with the first occurring on 13/05/2016. A written report on the safety and quality of care provided will be prepared and an action plan put in place to address any concerns.

Proposed Timescale: 13/05/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for supervision and support of staff were not sufficient to ensure they could deliver the required by residents.

17. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Person in Charge will implement a system of supervision and support to staff that will ensure the delivery of safe and quality services;
1. Meet monthly with the staff team to review the needs of the individual residents and the supports provided, escalate referrals to health and allied health professionals as appropriate and amend staff support levels accordingly in consultation with the Team Leader.
2. Schedule staff supervision sessions to review their practices in supporting the residents.
3. Report on the above on a monthly basis to the Registered Provider and plan for any improvements, and review and measure these on an ongoing monthly basis.

Proposed Timescale: 12/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of staff available in the evenings and the skill mix was not satisfactory to deliver the care and support required for the residents.

18. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
On review of the service it has been identified that the needs of one individual are not being met and alternative residential placement has been sourced. Transfer has taken place on 13/04/16.

A review of each individual's support needs will be undertaken by the Team Leader by the 22/04/2016 and any additional staffing resources required will be identified and put in place by 29/04/2016 or escalated as required.

Proposed Timescale: 29/04/2016