

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003058
Centre county:	Dublin 15
Email address:	48woodvale@docservice.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Mary Lucey-Pender
Lead inspector:	Michael Keating
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
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 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: 18 August 2014 09:30 To: 18 August 2014 17:30

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
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of this community based residential centre by the Health Information and Quality Authority (the Authority). The inspection was unannounced and purpose of the inspection was to assess the level of compliance with the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

The designated centre is operated by the Daughters of Charity Services Ltd comprises two community based houses in close proximity to one another in the Clonsilla area of Dublin 15. Each house is home to 6 residents' and both houses were managed by the same person in charge.

A major non compliance was identified under One outcome, Safeguarding and Safety. The specific issues identified related to the monitoring of restrictive practices operating within the centre. Three outcomes were judged to be in moderate non compliance these related to the areas of meaningful social activities provided to residents, the availability of documentation and the evacuation procedures for residents in the case of an emergency. Four of the eight outcomes inspected against were deemed to be fully complaint namely; Healthcare, Medication Management, Workforce and Governance and Management.

Action plans at the end of the report reflect the outcomes not met in line with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 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 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 it was found that person centred plans (PCP) were mainly task orientated and associated with health care or related to one off activities, such as holidays, rather than assessed social needs, interests and capacities. In addition, reviews of the plans did not consider how the impact on the lives of residents had or should have improved.

Each resident had person centred plans contained within their overall care plan. This was referred to as the process used to identify and address residents social needs and preferences. Some strong goals were read by the inspector in some plans, such as supporting a resident through an important transition into day services and a developing a life story book with a resident. However, other goals were read that were more relevant to a different part of the care plan used to identify short and longer term health care needs and goals. Specific health goals read referred to weigh loss, responsible smoking or occupational therapy referral for new shoes. Other goals related to maintaining 'behaviour' again, inappropriate to the identified aim of the person centred plan. While identified as important needs for residents' these were not meeting social needs and activities as outlined under the aim of the person centred planning process.

One off activities such as cinema, shopping trips, mass or walks were provided regularly to residents and these activities were recorded and assessed in relation to the frequency of these activities.

Judgment:

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:

While there were arrangements in place to manage risk and emergency planning, non compliances were identified in relation to the evacuation procedures for residents in the event of fire or other unplanned reason to evacuate.

As referred to previously, the centre was made up of separate houses, each home to six people. Each house had three identified exits identified within their evacuation plans. However, only the main entrance/exit of each premise's was distinguished by way of appropriate signage as required within the Regulations. Emergency lighting was provided in the main hallway, stairs and landing, and sensor lights were operating at the rear exits. In addition, emergency keys were not in place at all exits, break-glass boxes were provided however, not all boxes contained keys. This was particularly relevant as all exits remained locked at all times as detailed within restrictive practices under Outcome 8: Safeguarding and Safety.

There were regular fire drills, with seven drills having taken place within each house during 2014. All fire drill reports identified an issue in one resident refusing to leave the centre during the drills. The resident's individual evacuation plan identified that this had always been the case with this resident. There was a plan in place instructing staff on what to do with this resident in the event of a fire should the resident refuse to evacuate. While there was a plan in place instructing staff to leave her if she refused to evacuate no other attempts have been made (or were documented) to try to find alternative ways to safely evacuate this resident. All staff had received recent training in fire safety and demonstrated an appropriate knowledge and understanding of what to do in the event of a fire.

There was an up to date health and safety statement and risk assessment policy. Risk assessment of the environment and work practices had been undertaken and had been reviewed by the nominee provider and organisations health and safety committee as required. Risk assessments relating to the individual risk in relation to everyday activity were also assessed within each care plan, with a 'Risk V Rights' matrix used to assist staff to consider the balance of rights versus risk appropriately.

Accidents, incidents and near misses were being recorded in detail and a copy of the reports was submitted to the nominee provider. Incidents were being discussed at regular health and safety committee meetings with a view to learning from them and reducing the risk of recurrence.

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:

Generally, there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, there were a number of non compliances identified in the area of restrictive practices.

Staff spoken to were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. Staff were familiar with the organisational policy on the protection of vulnerable adults and were able to refer to it. Staff had been provided with training on the protection of vulnerable adults, and the policy on protecting residents from abuse had been recently updated in line with the revision of the national (HSE) safeguarding policy. Staff said they were aware of the importance of promoting the safety and respect for each resident. The inspector observed staff interacting with residents in a respectful and friendly manner.

The person in charge highlighted restrictive practices operating in the centre as notified to the Authority in line with her obligations under the Regulations. There were many types of recording and documentary evidence relating to restrictive practices in individual files. Some of this documentation was confusing and repetitive. For example, 'mood indication' protocols were used to help identify mood changes however, there was no guidance on how to redirect the resident concerned or at what point staff should intervene. This information was contained in separate documents such as the 'PRN (as required medication) Protocol' or the 'Reactive Strategy' but this information was not directly linked and difficult to find. The non compliance in relation to documentation is actioned under Outcome 18; Records and documentation.

While 'protocols' were in place referring to behaviours and levels of anxiety which were reviewed and signed off by relevant clinicians, there was no evidence that these protocols and associated restrictive practices had been reviewed to assess their overall

impact upon the residents' concerned. For example, a number of restrictive practices were operating on individual(s) with the same objective; to prevent or minimise the risk of absconding. These restrictions included locked and alarmed front door(s), use of a stair gate, use of a tracking device placed on the individual and the locking of other exits. However, these restrictions were not considered together, there had been no attempts to reduce or remove restrictions in light of the fact that the identified problem had been alleviated. For example; the protocol for carrying the tracking device stated that this must be placed on the person at all times when awake. However, given that when the resident was in the centre with exits locked and alarmed, there has been no incidence of absconding. In addition, staff stated that in practice, this device was only placed on the resident when he was leaving the premises; this was not reflected within the written protocol.

Other identified restrictive practices documented within the centres' restrictive protocols that had not been assessed as a procedure of last resort and without a plan to reduce or remove them included:

- locked kitchen presses; the identified need at both locations was the danger of uncontrolled eating/drinking however, in both locations, there was open access to the fridge, which had large quantities of food and drink. Staff stated that it did not need to be locked as staff were always present. This contradicts the rationale for locking presses.

- use of monitoring camera; the identified need was the danger of unsupervised seizures, risk of falls and to prevent the resident being disturbed by staff checking upon her throughout the night. However, seizures have been well controlled for some time. Records reviewed by the inspector with a member of staff indicated that this resident had only had two seizures in the past ten months, neither of which occurred during the night. The risk of falls had also reduced significantly, and providing a double bed for the resident was reported as being the main reason for this. There was no record of a fall from bed in more than two years. Finally, staff reported that night staff continued to observe this resident during the night, therefore, the rationale behind this invasive practice had not been considered as part of a review.

- use of sound monitor; the identified need was the danger of unsupervised seizures. The resident concerned had ongoing issues in relation to uncontrolled frequent seizures. However, this resident's bedroom had been moved in previous years to be located beside where waking night staff were based. All staff spoken to, including night staff stated that they hear this resident pre-seizure at all times, as they were very aware of the vocal signals communicated, to alert staff to oncoming seizure activity.

- locked exits; the identified need was the risk of absconding for two residents. These residents lived in this location for almost 5 years and it was reported to the inspector that they had never left or tried to abscond from this residence. This was not reflected in the care planning protocols. In one protocol, it referred to a danger of absconding highlighted in a different living environment.

All restrictive practices had been approved and reviewed by a multi-disciplinary team. However, in all cases documentation relating to restrictive practices did not clearly

demonstrate that the procedures were being reviewed from a safeguarding and quality assurance perspective. They also did not consider the impact upon other residents sufficiently. Plans were often indicative of past behaviours which were no longer recent or relevant. In addition, many bedroom doors had locks which could be locked from the outside and staff carried a key for these locks at all times. There was no evidence to suggest these locks were ever used to restrict personal freedom. However, if these locks were not used or required, they should be removed to reduce the overall perception of a highly restrictive living environment.

There were other common restrictive practices operating for all residents without individual assessment of need. For example the practice of checking all residents on a half hourly basis during the night. The inspector reviewed a number of residents files and noted that these residents slept throughout the night, there was no clear rationale for this practice and the residents personal plans did not provide any reason for this. In one location, staff reported that there were minimal support requirements for all residents throughout the night. Staff did inform the inspector that this was due to be reviewed at a staff meeting later in the week with a view to considering staffing support requirements in light of these circumstances.

Other identified restrictive practices identified through notifications and observed by the inspector had been appropriately assessed and reviewed and were observed by the inspector to be enabling residents to lead more active and inclusive lifestyles. For example, two residents required specialised harnesses to use the transport provided by the service. Consent had been obtained by family (as was the case in all of the restrictive practices referred to) and the inspector observed that in the case of one resident, she consented to wearing this harness, as she was observed putting it on with some assistance and also getting into the bus and wearing it. The identified need was to stop the resident unbuckling the standard seat belt and standing up during transport.

Detailed intimate care policy was revised in April 2014, and all residents' had comprehensive competency assessments in place relating to all areas of personal and intimate care, which provided clear guidance to staff, to ensure a consistent and individualised approach was provided to all residents.

Judgment:

Non Compliant - Major

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 that residents were supported to access health care services relevant to their needs. The inspector reviewed the health care plans for five residents and found that they had access to a community based general practitioner (GP). Health care plans identified short term and longer term health care needs as well as considering emerging future need. For example, emergent needs identified included the need for annual assessments for residents identified as at risk of dementia due to age and disability related factors. General health care assessments and referrals read by the inspector and related to short and long term needs included, dental care, psychology support, occupational therapy, phlebotomy, speech and language therapy, dietician and ophthalmology.

More specific health assessments were also identified with appropriate supports and referrals provided relating to thyroid issues, epilepsy and diabetic management.

Weekly menu were chosen by residents and individual choice of main meals were identified in a pictorial format. Residents were supported to be involved in meal preparation and also in shopping for ingredients. There was an ample supply of fresh and frozen food, and residents could have snacks at any time, which they were observed doing.

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:

Overall the inspector found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by qualified nursing staff.

The receipt of medication was being recorded and medication was being stored in a locked press within the kitchen(s) areas. The prescribing and administration of all medication was in compliance with the Regulations and in line with best practice guidelines. Drug errors were recorded and reported using the organisation accidents and incident sheets and reporting mechanism. A monthly 'MPARS' audit was carried out by the person in charge to assess the effectiveness of the MPARS system which is the

system for prescribing and administering of medication.

The drug error and auditing assessments had identified an issue in relation to an extra tablet left in stock, after all of the medication should have been administered. A new counting system was since implemented to ensure that the correct numbers of tablets were left after the each administration of this particular drug. This reflected the fact that varying doses of this drug were administered to a particular resident at different times throughout the day, and therefore, the numbers of tablets to meet that dose greatly differed. The pharmacist was also consulted for support with this, and now provides all medications monthly, but in separate weekly doses, making the counting of medication more manageable.

In addition, the pharmacist also provided blister packed medication to residents who go to their family homes on a regular basis to stay (for example, a number of residents go home every weekend) for the duration of their stay, which assists the residents and their family to administer the medication more safely.

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:

Not all components of this outcome could be assessed during this inspection as the inspection was unannounced there was no opportunity to meet with the person in charge. In addition, the nominee provider was on annual leave, but was represented by two other clinical nurse managers (CNM3) who were recognised persons participating in management (PPIM's).

There was a clearly identified management structure in place and staff were familiar with the reporting mechanisms. Staff were supported by duty clinical nurse managers (CNM's) at all times by phone for advice and support as required. The CNM's referred to had a good knowledge of all residents and of issues discussed during the feedback provided at the end of the inspection.

The roster(s) identify a staff nurse as in charge at all times and the inspector met with two of these persons in charge during the inspection. They were knowledgeable in relation to the needs of residents, and were also clearly well known to residents' as was clearly observed during interactions between them.

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:

Not all components of this outcome were considered as part of this inspection. Staff files, held centrally in the organisations central services were not reviewed on this inspection, and will be reviewed as part of the subsequent registration process. The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with vulnerable adults.

The inspector met with seven staff on the day of inspection, all of the staff held appropriate qualification as nursing or social care workers. All staff were knowledgeable in relation to the supports required for all residents. All staff also engaged very well in the inspection process and were well informed on the requirements of the Authority.

Staff had been provided with all mandatory training, including refresher training in fire safety and safeguarding vulnerable adults in recent months. Staff were appropriately supervised in their role and spoke about the support received from the person in charge as well as the service manager(s). Regular staff meeting had taken place and these meeting were all recorded.

Residents were provided with staff support on a 24-hour basis in both locations. This includes the use of waking and sleepover staff. It was highlighted that the need for waking staff in one location was under review as there was limited support required for residents at night time. Staff in this location, could not recall the last time they were needed by residents during the night. They also stated that this was to be reviewed at an upcoming staff meeting, set for later during the same week as the inspection.

Judgment: Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
This only component of this outcome considered as part of this monitoring inspection related to the documentation contained within care plans of residents. Issues in relation to the protocols relating to behavioural support and restrictive practices were detailed previously under Outcome 8; Safeguarding and Safety.

Overall the documentation referred to was difficult to retrieve and was not sufficiently organised to ensure residents were receiving a consistent approach from staff. When questioned, staff could explain the appropriate responses agreed however, this was not always written down, or staff struggled to find the associated documentation.

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:

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003058
Date of Inspection:	18 August 2014
Date of response:	04 September 2014

Requirements

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The review of personal plans did not provide an assessment of the effectiveness of the plan in enhancing the life of the resident.

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 PCP goals of twelve (12) residents will be reviewed with clear outcomes developed based on independent skills/ choices .The care plan assessment will provides us with

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

information to develop these goals . There will be a continuous review of this process.

Proposed Timescale: 30/11/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A comprehensive assessment of the social care needs of each resident was not available in order to determine the effectiveness of any plan to ensure residents were participating in meaningful activities, appropriate to his or her interests and preferences.

Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A comprehensive assessment based on care plan assessment of the social care needs of each service – users will be completed with clear outcomes developed based on independent skills/choices.

Proposed Timescale: 30/11/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Alternative methods were not explored to encourage the safe and independent evacuation of one resident.

Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

- A referral has been made to the Psychology Department for one resident to develop strategy for evacuation during fire. 30/08/14.
- The Health and Safety Manager has been consulted re other strategies to be investigated to ensure the safety of the resident in the event of a fire. 1/9/14
- The local fire station has been consulted for advised. 30/8/14
- Consult with Morris Johnson & Partners Fire Consultants in relation to the safety of the service user and the options available to ensure her safety in the event of a fire.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

The identified exits points were not all clearly identified through with appropriate signage to assist with evacuating all residents.

Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

Seek a Consultation and report from Fire Consultants Morris Johnson & Partners re : use of signage in community house .

Proposed Timescale: 30/09/2014

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:

Restrictive protocols and behavioural support plans did not identify how the intervention had alleviated the identified problem.

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:

- Re – arrange documentation so that protocols and interventions will be together on file.
- The following actions have been taken already in relation to restrictive practice :
 - 1.) Use of a monitoring camera has been discontinued. A risk assessment has been completed for nightly checks and frequency of checks is reduced based on care needs . Date : 30/8/14
 - 2.) An MDT has been arranged for review of the used of the sound monitor and a risk assessment will be completed by : 20/10/14
 - 3.) An alternative device to alert staff has been requested from maintenance and this will replace the lock exit in the front of the house. Date : 30/9/14
 - 4.) All door locks on the outside of bedroom doors has been removed from bedrooms and one service – user has had locked fitted on her bedroom door which she is independently uses. She requested this herself. Date : 22/8/14
 - 5.) Checking of service – users at night – all residents will have a risk assessment completed and frequency of night checks reduced based on care /identified needs . One

house completed (1/9/14/) and four service – users no longer have nightly checks. The risk assessments for the second house will be completed by date : 15/9/14

6.) Locking and alarming of front door / using the stair gate / use of tracking device – an MDT meeting is arranged on October 6th 2014 for review of all these restrictive practices for this individual with a view to reviewing and reducing these practices.

7.) Locking of kitchen presses – kitchen will be unlocked for a trial period of two weeks and documentation of the outcome of the trial period will be completed. An MDT has been arranged on 22/9/14 with a view to reducing the restrictive practice.

There will be clear documentation in relation to remaining restrictive practices as to whether they are alleviating the problem .If not, they will be reviewed in a timely manner. MDTs have been arranged to review all restrictive practices.

Proposed Timescale: 30/11/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Restrictive protocols did not highlight the practice as a procedure of last resort, for the shortest time frame possible. There was no plan in place to reduce or remove the restrictions.

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:

All restrictive practices will be reviewed a minimum of annually by the MDT.
A note will be made if there is no reduction and why. Evidence of less restrictive practices used will also be noted.

Proposed Timescale: 30/11/2014

Theme: Safe Services

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

Interventions were not regularly reviewed from the perspective of improving the lives of residents and the quality assurance of restrictive procedures was poor in relation to ensuring the practice was being used in line with the identified assessed need.

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:

An Unannounced Safety and Quality of Care (Regulationn23(2) visit by the nominee provider and PPIM in July had highlighted the need to review the night checks, locked presses. The PIC is in the process of organising MDT meetings to review all restrictive practices in the designated centre.

Proposed Timescale: 30/11/2014

Outcome 18: Records and documentation

Theme: Use of Information

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

The behavioural and restrictive guidelines were not being adequately maintained in order to direct care provision in the documentation of residents protocols in order to guide practice effectively.

Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The behavioural and restrictive guidelines will be reviewed and set out in a way that guides practice effectively.

This will include a note of other less restrictive practices tried, review dates, effectiveness of restrictions and plans to reduce the restriction. All this information will be filed together.

This will be in accordance with Regulations 21 (1) (b)

Proposed Timescale: 30/10/2014