

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | A designated centre for people with disabilities operated by Redwood Extended Care Facility Ltd |
| Centre ID: | OSV-0002437 |
| Centre county: | Co. Dublin |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Redwood Extended Care Facility Ltd |
| Provider Nominee: | Corinne Pearson |
| Lead inspector: | Catherine Rose Connolly Gargan |
| Support inspector(s): | Jillian Connolly; |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 10 |
| 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: 26 May 2014 10:00 To: 26 May 2014 16:30

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |

Summary of findings from this inspection

The centre is governed by Redwood Extended Care Facility Ltd and operates seven days a week to provide a service for a maximum of ten male and female residents on the autistic disability spectrum. The Statement of Purpose describes an emphasis by the service on promoting 'consistency, structure and routine to ensure predictability for these residents in the service.

This was the first inspection of this centre and was announced in advance. As part of the inspection, inspectors engaged with staff and residents, reviewed relevant documentation including personal plans, clinical files, policy and procedure documents, risk management and fire safety procedures. The inspectors met with the provider and person in charge at the beginning of the inspection and a clinical nurse manager was present throughout the day to facilitate the inspection. Inspectors also met with the chef and the catering manager on the day of inspection.

Staff were knowledgeable about the residents likes and dislikes, their life history and their day to day routine. Inspectors observed respectful and positive interactions between residents and staff. Systems were in place and described to enable staff support residents appropriately and safely and assist them through episodes of challenging behaviour. While there was satisfactory evidence that residents' needs were generally met, significant improvements were required in relation to the development and implementation of policies and procedures relevant to the services provided and resident profile in order to guide staff, govern practice and ensure

residents are suitably and sufficiently supported in accordance with national policy and best practice.

Risk management required improvement to ensure all internal and external risks were identified and had adequate controls in place to mitigate these risks. Policies to inform the management of areas of risk to residents including, leaving the centre unaccompanied, aggression and violence, management of behaviour that challenge and self-harm were either not adequate or not available.

Fire safety management was not of an adequate standard to assure the safe evacuation of residents in the event of a fire in the centre, particularly in the areas of ensuring safe evacuation of residents and fire drill procedures. This area required review to ensure current actual and potential obstructions were reviewed.

Other areas for improvement included, but were not limited to the premises and privacy and dignity. The action plan at the end of the report identifies actions which the provider and person in charge will need to take to come into compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.

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 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

A rights review committee comprising of staff and multidisciplinary team members involved with residents, external professionals and family/residents representatives was described as in place to review and inform decisions in relation to residents care and welfare. Inspectors were advised that advocacy services were available to assist residents for specific issues on a sessional basis. The provider advised that the National Advocacy Service (NAS) is used to ensure independence within advocacy in line with best practice rather than the service employing an advocate. This may not robustly support residents to make choices in that their designated advocate may not be adequately familiar to them and vice versa.

Staff were observed by inspectors to interact and engage with residents in a respectful and appropriate manner. Residents had been informed of the inspection taking place and were afforded a choice to meet inspectors which some chose to do. Staff told inspectors of residents communicated preference and choices regarding engaging in the inspection process which was respected.

A complaints process was in place and was displayed on the wall behind a reception counter in the entrance lobby. It was not readily accessible. Inspectors did not review the complaints log on this inspection.

Closed Circuit Television (CCTV) was in place on corridors and in the portocabin activity area. Notices informing of CCTV recording were displayed however one notice was on a wall which the door opened against and as such may not be clearly visible. Peep-holes were located in all residents' doors. Inspectors were told that they were seldom used however, there was no evidence that they were closed off when not required. In addition there was no documented process to assess, monitor and support their use

whilst minimising any impact on the privacy and dignity of individual residents.

Whilst inspectors were satisfied that residents could mostly exercise choice and control, For example some bedroom doors were key-code locked and one resident used a fob which she kept on her person to open her door. Limitations on freedom aimed to protect some residents were applied to all residents, for example high railings and locked doors to parts of the centre. There was limited documentation to demonstrate that the impact of limitations imposed on one resident did not negatively impact on the freedom of others.

The privacy of residents who did not wish to use window curtains was respected by use of vision obstruction darken glass. This prevented vision from the outside in whilst not obstructing view out for each resident. One resident did not have a shower curtain fitted in her en-suite to ensure her privacy needs were met.

Judgment:
Non Compliant - Minor

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:

Each resident had a personal support plan. Residents had their personal goals outlined however; there was inadequate documented evidence to enable evaluation of each resident's progress with achieving same. While a goal tracker folder was in use, daily progress notes were not informative as goals were not always commented on. Inspectors found that a communication profile completed for each resident was not consistently used as a basis to make affirmative judgements regarding progress for example, there was much use of 'appeared to' to describe the outcomes of social experiences and interactions for some residents. However, Inspectors did observe some good examples in practice where residents were supported to engage in activities that reflected their capabilities and interests and were incorporated into their personal support and behavioural management plans. For example, one resident successfully maintained a placement for one hour each morning in a charity shop and on completion

of the hour the resident was treated to refreshments in the charity shop restaurant. Another resident was supported to manage time spent on a laptop by signing a contract of agreement specifying the hours of his engagement with this activity.

Inspectors observed that family contact and spending time with family in their homes was of great importance to most residents. Many residents went home to their families care at weekends. There was evidence of service support to establish and maintain this contact and inspectors saw the process where one resident was recently supported to visit his family in their home for the first time.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Overall, the centre location, design and layout of the centre was suitable for its purpose and it met residents' individual and collective needs in a comfortable and homely way. While the access from the centre grounds is restricted by secured fencing, residents were observed to move around freely in their accommodation. A large part of the centre was not accessible to residents unless accompanied by staff and included, the centre office, laundry, kitchen and staff accommodation. This area of the building was secured by a key code lock.

The centre is a single storey building in a rural location that caters for up to ten residents. Most of the exterior and one side of the perimeter had a high metal fence surround with a large chain and lock securing access gates in addition to an adjacent pedestrian key coded gate. Outdoor facilities included a large surfaced yard inside the fence with a portocabin available for use as an activity centre that also contained some gym equipment and toilet facilities. Limited car parking space was available outside the fence in addition to a well maintained raised front garden at the level of the house. Residents had access to a well maintained enclosed garden accessible from the dining room to one side of the house. Male and female residents occupied this centre and resident bedroom accommodation was located on ground level throughout. All bedrooms had en-suite facilities.

Maintenance personnel were available and inspectors were told they were responsive to requests as required. Residents had access to an internal activity room that contained a swing and ball pool among other equipment. Flooring was covered with padded mats to protect residents using equipment in this room from injury. When some equipment was in place, the room was locked as the current resident population in the centre required staff supervision in this area, inspectors were told.

Residents also had access to a large comfortable sitting room and a dining room which was accessible to an enclosed garden through sliding patio doors. The house was warm and comfortable. Heating and lighting was available in the external portocabin facility if required. There was evidence that where possible staff had assisted residents to personalise their bedrooms.

Windows in bedrooms outside of the external area enclosed by secure fencing were locked, two bedrooms smelled of urine. There was evidence that the smell of urine was recognised as an issue and two residents' furniture was reviewed and adapted as a solution to same. There was no evidence available of a strategy to ventilate these or other rooms with locked windows. In addition one internal room without windows also smelled heavily of urine.

The surface of a radiator in one en-suite was rusted and one of two curtains was missing from a window in one resident's bedroom. The provider advised new curtains were on order.

Judgment:
Non Compliant - Minor

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 systems in place for health, safety and risk management in the centre, improvements were required assure the safety of residents and others and to meet the requirements of the Regulations. Risk management procedures to protect residents and others were described by staff and management, however, a risk management policy to inform the measures and actions to be taken to control risks that were of significance to protect the well-being of the resident population in the centre including; the unexpected absence of a resident, accidental injury to residents, visitors or staff, aggression and violence, and self harm were either not adequate or not completed.

Although the premises were not purpose built, it was adapted to suit the needs of residents. Although risk assessments with stated controls to mitigate risk identified were available, they were mostly generic and did not comprehensively identify all specific risks including environmental risks associated with this centre. For example, overflowing waste bins were located in the area where residents were observed to access by inspectors, external to the building. A fire exit route pathway to the front of the building ended at the edge of a raised garden with a drop to the level of the drive without the presence of adequate signage to alert users in place and a risk of ingestion of vegetation and plants. Although inspectors were told that all vegetation and plants were assessed by the gardener to ensure they were not poisonous if ingested, there was no documentation to support this. .

Inspectors found that staff were well-informed in relation to fire safety procedures and evacuation of residents. However a record of fire drills carried out did not record a commentary evaluating the procedure, the time of day the drill simulated to ensure day and night evacuation was assessed or where the source of the simulated fire was, This lack of information did not inform the adequacy of this procedure. In addition residents did not have individual evacuation plans completed to inform their safe and timely evacuation in the event of a fire. Windows and doors including final fire exits located in areas of the building external to a high secured fence surrounding part of the building. This fence effectively limits the distance residents and others can move to in the event of fire evacuation. There was a risk of entrapment due to the secure fencing arrangement around a small garden off a dining room, that persons who entered this area in the event of fire would be trapped in the absence of a staff member to open the key operated lock providing access to the assembly area. Inspectors were told that each staff member carries a key to this lock.

An evacuation route pathway to the front of the building ended with a drop onto a drive. There was no signage displayed to alert users of this risk. There was a risk associated with an internal fire door on a corridor which had a key code lock fitted. As many residents had increased sensitivity to noise, the inspectors were told that a practice of silencing the fire alarm was in place to aide ease of evacuation of these residents. However, one internal fire door which automatically disengaged and closed on activation of the alarm was fitted with a redundant electronic key-code, the procedure of silencing the alarm re-engaged the electromagnetic lock on this door in the closed position and obstructed further exit through this area taking place. These findings were brought to the attention of the provider and person in charge on the day of inspection.

A programme of staff training was described by staff and management. Inspectors were informed that mandatory training completed by all staff included training in manual handling, fire safety, food and hand hygiene, medication administration, adult protection and professional management of aggression and violence.

The centre was visibly clean and practices observed and in place supported infection prevention and control. There were cleaning staff scheduled on the staff roster and working on the day of inspection. However, inspectors noted a heavy smell of urine in some bedrooms and in an internal room used by residents with padded surfaces to protect them from injury. Many bedroom windows were locked and arrangements to ventilate same were not in place. This finding is discussed in outcome 6. Many staff had

personal alcohol hand gel on their person which inspectors observed them using appropriately. The provider advised that cleaning was taking place in excess of that recorded on cleaning schedules. A cleaning schedule viewed by inspectors did not accurately reflect cleaning frequencies. This finding was discussed during feedback with the provider and person in charge.

The sluice room, kitchen, laundry and cleaner's room were located in an area inaccessible to residents unless accompanied by staff.

Judgment:

Non Compliant - Major

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:

Inspectors found that measures were in place to safeguard and protect residents however required comprehensive review to inform and support practice. There was a policy dated September 2013, informing the prevention, detection and response to abuse. There were no incidents of abuse in the centre reported to the Authority or under investigation in the centre. Inspectors observed staff to be respectful and supportive in their interactions with residents.

Each resident had a behavioural support plan in place however, there were multiple examples found where this document was not kept updated in response to review of risk assessments, evaluation of proactive support strategies or specific behavioural guidelines. For example, a positive behaviour support plan for one resident was not reviewed since October 2012 and behaviour guidelines for a resident leaving without supervision dated 28 March 2013 had not reviewed.

The policies informing management of behaviour that challenges and application of restrictive practices were insufficient, approval for use was not confirmed by signature and therefore there was risk that these policies did not inform best practice in these areas for residents in the centre. Inspectors observed from resident documentation reviewed that most residents in the centre presented with behaviour that challenged including self-injurious behaviour. Behavioural support plans reviewed by inspectors

required comprehensive review to ensure residents had adequate personal supports to promote a positive approach to behaviours that challenged.

Restrictive practices and equipment were in use in the centre however frequency of use was not consistently reflected in some residents behavioural support plans. The policy advising on restrictive procedures and physical restraint was dated as effective from April 2011 and did not adequately describe approved types/levels of restraint to be used. In addition this policy made reference to a policy advising on assessing capacity and obtaining consent that had not been completed or available to inform practice.

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:

This outcome was partially reviewed on this inspection. There was evidence that there were services and supports in place to assist and support residents' health and well-being. There was evidence of referrals and meetings with key significant personnel in the lives of residents. Some residents' General Practitioner was in attendance on the day of inspection. Inspectors saw where two residents had specific bed types to manage incontinence, however there was no supporting documentation to confirm that these beds were assessed and appropriately monitored by allied health professionals to evaluate suitability and effects of long term use. Another protection for a resident was the fitting of padding around the edges of bathroom fittings and wall corner surfaces which was done with the assistance and co-operation of the resident and the occupational therapy service.

There was evidence that PRN medication protocol documentation advising on the care of residents with epilepsy was not adequately referenced in practice in respect of timely intervention in care of residents suffering prolonged seizure. In addition inspectors found inconsistencies in the care plan documentation of one resident with a diagnosis of epilepsy who was experiencing seizure activity.

Inspectors spoke with catering staff and the catering manager. Catering staff were well informed about residents' likes, dislikes and needs. The chef spoke to the inspector about how she ensured residents needs and preferences were satisfied including cooking individual dishes for residents with specific needs and/or preferences. Meals

were noted to be varied, provided choice and were provided at times suitable to the residents. Residents with swallowing difficulties were provided with soft consistency dishes. Snacks were available and fruit was incorporated into the menu for residents to support their dietary intake. Residents' records showed that resident weights were monitored.

Judgment:
Non Compliant - Moderate

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 medication management procedures and safeguards met the requirements of the legislation and professional standards. Nursing staff administered medication to residents in the centre. A staff signature record was available for reference as part of medication management in the centre.

Inspectors reviewed residents' medication prescriptions and administration records and found that they were adequate with the exception of 'as required' (PRN) medication administration protocols to advise staff on appropriate administration frequency. However, inspectors were informed that this area of practice was due to be strengthened with the introduction of relevant protocols.

Inspectors observed that no residents were receiving their medication in crushed format. One resident was in receipt of a medication in broken format which staff had ensured was not contraindicated prior to administration. Each resident's allergy status was stated on prescription documentation.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Catherine Rose Connolly Gargan
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

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|----------------------------|---|
| Centre name: | A designated centre for people with disabilities operated by Redwood Extended Care Facility Ltd |
| Centre ID: | OSV-0002437 |
| Date of Inspection: | 26 May 2014 |
| Date of response: | 08 August 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.

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Limitations on freedom aimed to protect some residents were applied to all residents, for example high railings and locked doors to parts of the centre. There was limited documentation to demonstrate that the impact of limitations imposed on one resident did not negatively impact on the freedom of others.

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

Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

The centre has in a place a risk assessment regarding the fencing and freedom of access with information relevant for each resident within the centre.

The centre completed a risk assessment regarding the internal keypads on 17th July 2014

Proposed Timescale: 17/07/2014

Theme: Individualised Supports and Care

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

Inspectors were advised that advocacy services were available to assist residents for specific issues on a sessional basis. This finding did not robustly support residents to make choices in that their designated advocate may not be adequately familiar to them and vice versa.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

Families provide regular support to residents and provide advocacy for the residents. Referrals are made to the National Advocacy Service as required.

Easy to Read information on advocacy and rights will be available within the unit by 31st August 2014.

Proposed Timescale: 31/08/2014

Theme: Individualised Supports and Care

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

Notices informing of CCTV recording were displayed on the back of doors and as such may not be clearly visible.

Peep-holes were located in all residents' doors. Inspectors were told that they were seldom used however, there was no evidence that they were closed off when not required. In addition there was no documented process to assess, monitor and support their use whilst minimising any impact on the privacy and dignity of individual residents.

One resident did not have a shower curtain fitted in her en-suite to ensure her privacy

needs were met

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

All CCTV signs are fixed to the walls within the centre in a location making them clearly visible.

Peep holes will be covered and when required to facilitate monitoring for safety reasons a risk assessment will be completed for the resident by 31st August 2014

On discussion with the resident in question a shower curtain of their choice was fitted on 16/07/14

Proposed Timescale: 31/08/2014

Theme: Individualised Supports and Care

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

A complaints process was in place and was displayed on the wall behind a reception counter in the entrance lobby. It was not readily accessible.

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The complaints policy is on display in the reception area, in addition there are copies in accessible format available within the dining room, the OT kitchen and the hallway for all residents to access, this was available on the day of inspection.

All residents are provided with their own copy of the accessible version of the complaints policy.

Completed

Proposed Timescale: 08/08/2014

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:

Residents had their personal goals outlined however, there was inadequate documented evidence to enable evaluation of each residents progress with achieving same.

While a goal tracker folder was in use, daily progress notes were not informative as goals were not always commented on. Inspectors found that a communication profile completed for each resident was not consistently used as a basis to make affirmative judgements regarding progress for example, there was much use of 'appeared to' to describe the outcomes of social experiences and interactions for some residents.

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:

Staff in the centre will reference the goal tracking sheets within the daily progress notes to direct the reader for relevant information from 14th July 2014. Staff will ensure that they provide known markers of contentment/enjoyment within the residents notes from July 14th 2014.

Speech and language therapist to facilitate training regarding total communication and to provide specific communicatory information regarding specific clients. To be completed 31st August.

Proposed Timescale: 31/08/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The surface of a radiator in one en-suite was rusted and one of two curtains was missing from a window in one resident's bedroom

Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The resident chose the curtains they wanted and will be fitted on delivery by 30th September 2014

Maintenance reviewed the radiator and any identified remedial work was completed on 7th July

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

Windows in bedrooms outside of the external area enclosed by secure fencing were locked, two bedrooms smelled of urine. There was evidence that the smell of urine was recognised as an issue and two residents' furniture was reviewed and adapted as a solution to same. There was no evidence available of a strategy to ventilate these or other rooms with locked windows. In addition one internal room without windows also smelled heavily of urine.

Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

Windows were locked as a safety precaution. Maintenance will fix window restrictors so that the windows may be opened for ventilation purposes while maintaining safety by 31st August 2014

An extractor fan will be fitted to promote ventilation for the internal room by 30th September 2014

Proposed Timescale: 30/09/2014

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:

Although risk assessments with stated controls to mitigate risk identified were available, they were mostly generic and did not comprehensively identify all specific risks including environmental risks associated with this centre. For example, overflowing waste bins were located in the area where residents were external to the building. A fire exit route pathway to the front of the building ended at the edge of a raised garden with a drop to the level of the drive without the presence of adequate signage to alert users in place and a risk of ingestion of vegetation and plants. Although inspectors were told that all vegetation and plants were assessed by the gardener to ensure they were not poisonous if ingested, there was no documentation to support this. .

Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

Horticulture will complete a written risk assessment of the plants within the grounds of the unit by 31st August 2014

A warning sign in accessible format & railings will be put in place by maintenance where there is a drop to the drive by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A risk management policy to inform the measures and actions to be taken to control risks that were of significance to protect the well-being of the resident population in the centre including the unexpected absence of a resident was required. .

Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The risk management policy was updated to guide management of the unexpected absence of a resident on 4th July 2014. Staff will sign to confirm that they have read & understood the policy by 31st August 2014.

Summary information will be available on all schedule 5 policies for all staff by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A risk management policy to inform the measures and actions to be taken to control risks that were of significance to protect the well-being of the resident population in the centre including; accidental injury to residents, visitors or staff.

Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

The risk management policy was updated to guide management of accidental injury to

resident, visitors or staff on 4th July 2014. Staff will sign to confirm that they have read & understood the policy by 31st August 2014.
Summary information will be available on all schedule 5 policies for all staff by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A risk management policy to inform the measures and actions to be taken to control risks that were of significance to protect the well-being of the resident population in the centre including aggression and violence.

Action Required:

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

The risk management policy was updated to guide management of aggression and violence on 4th July 2014. Staff will sign to confirm that they have read & understood the policy by 31st August 2014.

Summary information will be available on all schedule 5 policies for all staff by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A risk management policy to inform the measures and actions to be taken to control risks that were of significance to protect the well-being of the resident population in the centre including self harm was not completed.

Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

The risk management policy was updated to guide management of self-harm on 4th July 2014. Staff will sign to confirm that they have read & understood the policy by 31st August 2014.

Summary information will be available on all schedule 5 policies for all staff by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A record of fire drills carried out did not record a commentary evaluating the procedure, the time of day the drill simulated to ensure day and night evacuation was assessed or where the source of the simulated fire was, This lack of information did not inform the adequacy of this procedure.

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:

The centre will complete a commentary evaluating the fire drill procedure to incorporate whether day or night evacuation, where the source of the simulated fire was and the length of time to complete the evacuation from 14th July 2014

Completed

Proposed Timescale: 08/08/2014

Theme: Effective Services

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

Residents did not have individual evacuation plans completed to inform their safe and timely evacuation in the event of a fire.

Windows and doors including final fire exits located in areas of the building external to a high secured fence surrounding part of the building were locked with a key.

The surrounding high fence effectively limited the distance residents and others could move to in the event of fire evacuation. There was a risk of entrapment due to the secure fencing arrangement around a small garden off a dining room, that persons who entered this area in the event of fire would be trapped in the absence of a staff member to open the key operated lock providing access to the assembly area.

An evacuation route pathway to the front of the building ended with a drop onto a drive. There was no signage displayed to alert users of this risk.

There was a risk associated with an internal fire door on a corridor which had a key code lock fitted. As many residents had increased sensitivity to noise, the inspectors were told that a practice of silencing the fire alarm was in place to aide ease of

evacuation of these residents. However, one internal fire door which automatically disengaged and closed on activation of the alarm was fitted with a redundant electronic key-code, the procedure of silencing the alarm re-engaged the electromagnetic lock on this door in the closed position and obstructed further exit through this area taking place.

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:

Personal Emergency Evacuation Plans will be developed for all residents in the centre by 31st August 2014

All staff members have keys (attached to personal alarms) to open the doors and windows in question. This is included in the fire protocol, the environmental risk assessment and the fire procedure. This is also explained to staff during fire training.

Staff do not silence the alarm when completing fire drills/evacuations.

Signs in easy to read format will be placed at the evacuation point highlighted and rails will be fitted to promote safety by 30th September 2014

Proposed Timescale: 30/09/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive practices and equipment were in use in the centre however frequency of use was not consistently reflected in some residents behavioural support plans.

The policy advising on restrictive procedures and physical restraint was dated as effective from April 2011 and did not adequately describe approved types/levels of restraint to be used. In addition this policy made reference to a policy advising on assessing capacity and obtaining consent that had not been completed or available to inform practice.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

The centres policy on restrictive practices was updated on 16th July 2014
Staff will sign to confirm that they have read & understood the policy by 31st August

2014.

Summary information will be available on all schedule 5 policies for all staff by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Safe Services

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

Each resident had a behavioural support plan in place however, there were multiple examples found where this document was not kept updated in response to review of risk assessments, evaluation of proactive support strategies or specific behavioural guidelines. For example, a positive behaviour support plan for one resident was not reviewed since October 2012 and behaviour guidelines for a resident leaving without supervision dated 28 March 2013 had not been reviewed.

The policies informing management of behaviour that challenges and application of restrictive practices were insufficient, approval for use was not confirmed by signature and therefore there was risk that these policies did not inform best practice in these areas for residents in the centre.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

The policy on positive behaviour support was updated on 10th July 2014 and the policy on restrictive practices was updated on 14th July 2014

All Behaviour Support Plans are updated and in place as of the 7th July.

All staff working within the centre complete training in the Professional Management of Aggression and Violence (PMAV) to manage behaviour that is challenging. Training for Household staff completed on 7th August 2014

Proposed Timescale: 07/08/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Inspectors saw where two residents had specific bed types to manage incontinence, however there was no supporting documentation to confirm that these beds were

assessed and appropriately monitored by allied health professionals to evaluate suitability and effects of long term use.

Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

A development plan and a monitoring schedule will be developed by August 31st 2014

Proposed Timescale: 31/08/2014

Theme: Health and Development

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

There was evidence that PRN medication protocol documentation advising on the care of residents with epilepsy was not referenced in practice in respect of timely intervention in care of residents suffering prolonged seizure. In addition inspectors found inconsistencies in the care plan documentation of one resident with a diagnosis of epilepsy who was experiencing seizure activity.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

The centre will review all the epilepsy care plans and ensure consistency in response to intervention by 31st August 2014

Proposed Timescale: 31/08/2014