

**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 The Irish Society for Autism
Centre ID:	OSV-0002001
Centre county:	Meath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Irish Society for Autism
Provider Nominee:	Susan Alexandra (Lexi) Kennedy
Lead inspector:	Ciara McShane
Support inspector(s):	Bríd McGoldrick
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
27 May 2015 09:30	27 May 2015 14:00
01 October 2015 09:30	01 October 2015 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The following report identifies findings from a two day inspection, one day completed May 2015 and the second day completed October 2015. The inspections took place resulting from on-going concerns found on inspection November 2014 and March 2015. This was the centres' fifth inspection. As with previous inspections major non compliances were found. At the time of the inspection eight residents resided at the centre. The residents' primary diagnosis was autism. Seven of the residents were of medium dependency while one was of high dependency. However, with some activities of daily living, such as self care, two residents had high support needs. Five residents had been identified as requiring high support regarding their mental health needs.

Overall there continued to be significant, sustained and consistent breeches and non compliances with the Health Care Act 2007 as amended. The inspectors acknowledge that some improvement had occurred. For example, some residents had attended

new activities such as cycling by their local canal and attending their local library. A person in charge had been recently recruited and there was also a fulltime team leader present. The team leader was often the third staff member on duty and assisted with activities. The provider had also recruited a new general manager of services for the three designated centres. They were also put forward to be the person to represent the organisation. Communication assessments had been completed by a speech and language therapist and improvements regarding the premises were also found.

Major non-compliances were found in six of the 13 outcomes inspected. Four outcomes with moderate non compliances, two substantially compliant and one compliant were found which are further outlined in the body of the report. The provider had not put in place effective, accountable and responsive management at an appropriate level to the centre. While a general manger has been appointed they did not have access to, or control of the resources required and necessary to deliver a safe, comprehensive and responsive service. The arrangement whereby the new general manger was required to seek approval for routine expenditure contributed significantly to the failures identified throughout the report.

The inspectors found that all residents were not safe and protected from abuse; this is outlined in Outcome eight of the report. The inspectors found the centre was not effectively monitored or that the needs of all residents were being met. For example, needs in relation to positive behaviour support. Each resident was not assisted and supported to communicate in accordance with their needs and wishes; this is described in outcome 5.

As a result of the inspectors' findings on inspection 01 October 2015 the inspectors issued three immediate actions relating to the use of chemical restraint, safeguarding residents and staffing levels. These actions, along with additional findings, are detail in the body of this report and in the action plan at the end. Significant action and improvement was required to ensure residents were safe and their needs were met and also to comply with the requirements of the Health Care Act 2007 as amended.

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 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):

Findings:

Inspectors found that some improvements had occurred at the centre however, non compliances and repeated breeches were identified.

The provider had updated the complaints policy and nominated a complaints officer locally to ensure complaints were responded to. Staff were guided through the process by using a flow chart that was outlined in the policy. A complaints log was maintained in the centre. From a review of the complaints log the inspectors found there had been a complaint logged since the most recent inspection. This was found to be adequately addressed.

The inspectors found the method used to consult with all residents remained ineffective. It was unclear how residents, whom had limited communication skills, were consulted with in the running of the centre using the predefined consultation form. For example, a picture exchange communication system had not been trialed as an alternative.

From a review of activities schedules and from speaking with staff it was evident those activities, engaged in by residents, were more varied. For example, residents went cycling and had gone to the library the day previous to inspection for the first time. The team leader told the inspectors of plans to develop a multi sensory room where residents could also attend for massage therapy. This was not complete at the time of inspection. Activities, for the most part, remained group based and one to one activities were limited. This was attributed to the low staffing levels. The inspectors' found instances where staff had raised their concern of low staffing levels with supervisors and senior management and their resultant inability to provide activity for residents.

Judgment: Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Since the inspection March 2015, the provider had linked with an external service provider to ensure each resident had a communication assessment completed by a speech and language therapist. These assessments were completed in May 2015. The speech and language therapist made a number of recommendations however, for the most part these had not been implemented.

From a review of residents' personal plans and through conversation with staff it was evident that for those residents who were non-verbal, and for those who had limited verbal communication, effective communication tools were not in place. For example, Picture Exchange Communication System (PECS). The inspectors also read in documentation where a staff member stated they found it difficult to communicate with residents' and difficult to understand their needs and wants.

Residents had also not been supported to access assistive technology aids and appliances to promote their full capabilities. For example, residents were not availing of computerised applications, social stories, visual cues or communication scrapbook. A number of these had also been highlighted and recommended by the speech and language therapist. Residents did not have access to a computer or internet should they wish to avail of same. One resident used the internet on occasions to speak with a family member living abroad however, they could only do this when the office was open as the computer was stored there.

Judgment:
Non Compliant - Major

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

From conversations with staff and from a review of resident's activity sheets, the inspectors were informed, that residents interactions with their community had somewhat improved. Residents availed of local services for example, attending the hairdressers, local shops, coffee shops and had, at the time of inspection, commenced using the library. The residents told the inspector they enjoyed the experience and speaking with the staff at the library. There were further opportunities for residents to link with their community. The newly appointed general manager of services stated she had plans to create more links. The inspectors also read suggestions that staff had put forward, on behalf of residents, which would result in greater community involvement. One of these examples was cycling which had commenced for some of the residents.

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors reviewed a sample of residents' contract of care and found that the actions from the inspection March 2015, first identified on inspection November 2014, had not been fully completed.

From a review of sample contracts inspectors found that some aspects of their contracts had been updated. For example, the type of accommodation and details of the overall charge the resident incurred. However, all charges for all aspects of the service were not fully broken-down. For example, it was not clear that residents incurred some charges while staff were assisting them with certain activities.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors reviewed a sample of personal plans and noted that some improvements had occurred but actions identified on inspection March 2015 had not been fully completed.

No further developments had occurred to make personal plans accessible to residents. An assessment had been completed, for each of the eight residents, by a speech and language therapist. However, the recommendations had not been acted on in ensuring residents had a personal plan that was accessible to them.

The inspectors, from a review of sample personal plans, found that personal plans were not reflective of residents' needs or updated to take account of changes in circumstances. For example, the inspectors reviewed the intimate care plan for one resident. The information within was not reflective of their actual needs and was contradictory as another section of the care plan identified alternate information.

Changes in circumstances were also not reflected in personal plans. For example, a resident's emotional health had not been updated at times when their emotional wellbeing was altered. Personal plans were also not updated to reflect changes in weight. The inspectors reviewed weight records for a number of residents. One resident had lost nine pounds over three months. This had not been identified by staff nor had a care plan been drawn up on the resident's needs regarding this assessed.

The inspectors were not assured residents were being assessed or referred for assessments as required. A resident who had complex needs did not have a comprehensive assessment of their needs completed. For example, a functional analysis,

sensory assessment or environmental assessment had not been completed.

A multi-disciplinary review had also not taken place for this resident. From a review of numerous incidents of a serious nature, it was evident that the complex needs of this resident were not sufficiently addressed. This is further outlined in Outcome eight.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

The inspectors reviewed the premises and found they were well maintained and suitably decorated.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The actions from the inspection completed in March 2015 had partially been completed.

The centre had a risk register in place. It was last reviewed 02 May 2015. The inspectors, from a review of the register, found that a number of environmental and non

environmental risks had been outlined, with risk ratings and control measures identified for each hazard. Although improvements to the risk register had occurred, such as the risks associated with the premises being updated on the register, it was not a live document. It failed to outline all risks, actual and potential, hazards at the centre. Risks were also not updated to reflect changes in circumstances. For example, there were a number of incidents involving a resident, which occurred at different times since the risk register was reviewed. These incidents had impacted negatively on the resident involved but also impacted on those residents witnessing the incidents.

The risk register was not updated to reflect the changes in risk. The controls that were put in place were not reflective of the actual controls used. For example, access to a psychologist had been outlined as a control however this had not been sought. It was also unclear what the residual risk was once a control had been put in place therefore the effectiveness of the control measures used to mitigate the risks were not being reviewed.

From a review of the accident and incident log, the inspectors found there had been a significant number of incidents, mainly related to one resident, since the inspection in May 2015. On review of these incidents the inspectors were not assured they were being analysed in such a way to ensure that appropriate controls and measures were in place to reduce the risk and the severity of the potential outcome.

The inspectors were also not assured that learning was being identified from these serious incidents. From a review of these incidents, and the negative outcomes of same, the inspectors concluded the resident was not safe, nor were the other residents who witnessed these significant incidents. This is further outlined in Outcome eight. Staff were also injured as a result of these incidents.

The inspectors found that clinical risks had not been highlighted or mitigated as required. A sample of clinical risks identified on the day of inspection including weight loss, skin infection to a wound, head injury and the potential negative effects associated with the use of psychotropic medication (benzodiazepine) post head injury.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

From conversations with staff and a review of documentation, the inspectors found that although some improvements had taken place, significant action was required to ensure that all residents were protected from abuse.

On inspection, March 2015, inspectors identified that staff were using physical restraint in response to behaviours that challenge pertaining to one resident. However, staff were doing so in the absence of the appropriate training and guidelines being in place. The inspectors found on this inspection that staff, working at the centre, had all received training in Management of Actual or Potential Aggression (MAPA).

The inspectors reviewed a behavioural support plan and whilst the document had been updated since the previous inspection it remained insufficient and as a result put the resident at further risk of injury. It failed to identify a plan to support the resident with each of their behaviours that challenge; it dealt with the overarching behaviour and did not address the individual behaviours. The inspectors, from a review of the incident and accident forms and from speaking with staff, found that physical restraint was being used to manage some incidents. From a review of the behavioural support plan, the levels and frequency of engagement staff were to use in terms of the physical intervention, and using the MAPA techniques, were not detailed. The use of any form of physical restraint, as a reactive strategy, was not sufficiently detailed in their behavioural support plan. The only reference to the use of physical restraint was 'MAPA hold as a last resort'. The use of chemical restraint, as a reactive strategy, was also not outlined in detail in their behavioural support plan. The behaviour support plan was also not completed by or signed off by a competent person for example a behavioural psychologist. It was completed in the absence of any baseline assessments, regarding their self injurious behaviour such as a functional analysis, an environmental assessment or a sensory assessment. The inspectors found the resident was not safe as their needs were not appropriately assessed and therefore they were not supported as required. This resident had significant incidents of self injurious behaviour, requiring attendance and treatment at an out of hours service. On more than one occasion attended the accident and emergency department.

Inspectors found that other residents, living at the centre, were also not safeguarded from abuse. Residents often witnessed the aforementioned incidents and were negatively impacted on as a result. The inspectors read impact reports that staff had documented post incident. It highlighted that residents, for example, put their hands "over their ears" and "looked visibly shaken", some "left the room" and one resident was witnessed "crying" whilst another resident "didn't get to finish their dinner". Residents were also left on their own, usually after 18:00hours when there was only one staff on duty in each house, as the staff had to assist in the neighbouring house if the resident had an incident which required support.

The inspectors from a review of a resident's medication administration record found that he/she was administered medication which was used as a chemical restraint. The centre

did not acknowledge this as a chemical restraint nor was it applied in line with evidenced based practice and national policy. In the absence of the resident receiving a full assessment of needs and a robust behavioural support plan, the inspectors were not assured the least restrictive method was trialled prior to administering medication and /or using MAPA techniques.

Prior to completion of this inspection the Provider was issued with an immediate action regarding the use of restraint and ensuring residents were safeguarded.

Judgment:

Non Compliant - Major

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors reviewed documentation and spoke with staff regarding residents' general welfare and development.

The inspectors found that the action from the previous inspection had not been completed. Residents had not been assessed for their wishes or ability to access opportunities for education, training and development. The provider nominee stated this was something she was planning to look into however, there were no concrete plans at the time of inspection. There were no opportunities for residents to access work experience. One resident expressed a desire to inspectors to work, on a previous inspection, however there were no efforts to progress this.

The inspectors acknowledge that since the inspection March 2015, two residents attended the local gym weekly and the day previous to inspection, October 2015, three residents visited their local library. They continued to use local services such as the coffee shop, hairdressers and local shops. The inspectors continued to not be assured that residents were accessing their local community to their full capability and capacity. Staff have attributed this to the low staffing levels which was impacting negatively on their frequency and type of activity. Staffing levels is further outlined in Outcome 16.

Judgment:

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Sustained and repeated breaches were found throughout the inspection. To ensure compliance with the Health Act 2007 as amended, significant and sustained improvements regarding the overall governance and management of the centre was required.

The inspectors found on inspection that staff had received supervision and performance management. Documentation to reflect this was maintained at the designated centre. The person in charge had a one month review with her direct line manager; the newly recruited general manager of services. A senior quality and compliance manager was recruited in April 2015 with a remit of having oversight for three designated centres. On inspection, May 2015, the inspectors met with them and found some management systems had been put in place. For example, an auditing schedule had been developed, outlining key quality indicators. At that time audits had commenced on residents' personal plans and medication errors. Inspectors were informed that this person no longer worked for the provider. The inspectors were also told the role would not be re-advertised or recruited for. Limited audits had taken place since their departure.

The provider had not put in place effective, accountable and responsive management systems at an appropriate level to the centre. While a general manager had been appointed they did not have access to, or control of the resources required and necessary to deliver a safe, comprehensive and responsive service. The arrangements whereby the new general manager was required to seek approval for routine expenditure contributed significantly to the failures identified throughout this report. On the day of inspection the general manager was also deputising for a person in charge who was absent from another designated centre.

Management did not ensure the centre was resourced to ensure effective delivery of care and support in accordance with the statement of purpose. The inspectors found that staffing levels were insufficient to meet the needs of residents; this is further

outlined under Outcome 16.

On inspection, May 2015, the inspectors met with the newly recruited team leader who was full time at the centre. They had previously worked for the provider and was familiar with the needs of the residents. On inspection 01 October 2015 the inspectors met with the recently recruited person in charge. She was recruited, August 2015. The inspectors also met with the recently recruited general manager of services, with responsibilities for three designated centres. She was recruited September 2015 and had also been put forward to represent the provider. As the team was in its infancy stage they had not developed robust management systems but told the inspectors they had plans to this effect. The person in charge had commenced audits locally. For example, she had completed an audit of the resident's personal plans and she had also completed a review of the centres status of the action plan response from the most recent inspection March 2015. The general manager of services had plans to create a template for audits and was in the process of developing a new template for auditing. A sample of this was not available for the inspectors to review whilst on inspection. On inspection May 2015, the then quality and compliance manager, had developed an alternate audit schedule. No additional audits, other than that of the personal plan audit and review of the action plan responses, were available to inspectors on inspection October 2015.

There was an annual review of the quality safety of care and support in the designated centre. The inspectors reviewed it and found that it failed to sufficiently analyse all quality indicators including data from incidents/accidents, medications error and staff training (to name a few) to identify areas where improvement had taken place or where improvements in the quality of the service delivered was required. The inspectors found the provider did not have full oversight of all aspects of the service as key quality indicators were not being reviewed.

Management systems were not in place to ensure the service provided was safe, appropriate to residents needs, consistent and effectively monitored. As outlined in Outcome 5 and Outcome 8 residents' needs were not being met. Residents were not safe at all times and were not at all times protected from abuse. Management had not taken appropriate or sufficient action to ensure residents were safe and free from abuse. The provider did not demonstrate their ability to ensure that resident's needs could be met in line with the statement of purpose or that it could be sustained. For example, each resident was not assisted and supported to communicate in accordance with their needs and wishes and behavioural support plans, reviewed by the inspectors, were wholly insufficient.

Based on the cumulative and significant findings in addition to the continuous sustained breeches of the Regulations; failure to meet the assessed needs of residents; failure to mitigate risk and safeguard residents; the inspectors were subsequently not assured there were appropriate persons in management or management systems in place to ensure that the service was safe.

To this effect an immediate action was issued to the Provider on inspection, 01 October 2015, regarding the necessity to increase staffing levels, to review the use of chemical restraint and to safeguard all residents from all forms of abuse.

Judgment:

Non Compliant - Major

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

From a review of the roster, discussions with staff and following a review of the revised statement of purpose, the inspectors found that core frontline staffing hours had not increased. The General Manager of Services told the inspector they planned to interview for a panel of relief staff who would be inducted into the service. However, in conversation with the inspectors the General Manager, who had responsibility for the service, had not been delegated the authority to recruit and therefore did not know the number of staff to be recruited.

Since the inspection May 2015 a staff member had left the service. Staffing levels at weekends had been increased, on occasion, with an additional shift, a third staff member during the day, identified for a Saturday and/or Sunday. However, this was not consistent. The rosters reviewed demonstrated staffing levels at weekends, at times, consisted of only two staff who would work from 10:00am Saturday to 10:00am Sunday. Staffing levels for the most part during the week and weekend remained low. Regularly there was three staff on duty from 10:00 hours to 18:00 hours, one staff member for each unit and a third staff member who floated between the two units. From 18:00 hours to 10:00 hours the following morning this decreased to two staff, each of whom did a sleeping night in each unit. The third staff member, the floating staff, was mostly the team leader who had responsibility for all eight residents. From an analysis of the rosters for March 2014 and October 2014 the inspectors found there was an average increase of two and half additional hours per weekday. Weekend staffing hours had an average increase of less than one hour. These hours were inclusive of the post of team leader. The inspectors therefore found that overall frontline staffing levels had not increased.

The inspectors found that staffing levels were insufficient to meet the various needs of the residents. The provider had commissioned an external report which also identified that staffing levels required improvement. As outlined in Outcome eight residents were at times left unsupervised as the staff member went to the unit next door to assist staff. Also, as outlined in Outcome ten, activities continued to be predominantly group based activities as opposed to one to one.

As described in outcome eight, one resident did not have access to a psychologist or a behavioural support therapist. In addition, residents who required wound dressings and weight monitoring did not have access to nursing and allied personnel for guidance and support. The inspectors issued an immediate action in respect of staffing.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors reviewed training records for staff and found that staff had received additional and relevant training. For example, staff had received training in safe administration of medication and Management of Actual or Potential Aggression (MAPA).

The inspectors were not assured that, at all times, residents were receiving continuity of care as highlighted on inspection March 2015. At inspection 01 October 2015, agency staff were being used to cover sick leave and a small amount of additional leave. These staff had not all been inducted into the centre prior to commencing a shift. As outlined in Outcome eight, staff practices in respect of restraint were not used in accordance with national policy and evidenced based practice.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspectors, on review of the Schedule 5 policies, found that a number of policies had been updated including but not limited to the Nutrition Policy. However, while this policy had been updated, staff had not implemented aspects of the policy in practice. For example, staff were not using the MUST tool as outlined in the policy.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ciara McShane
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 The Irish Society for Autism
Centre ID:	OSV-0002001
Date of Inspection:	27 May 2015
Date of response:	25 November 2015

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 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:

The method used to consult with residents was found to be ineffective for all residents. Alternate mechanisms had not be trialled or sourced.

1. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

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

The Person in Charge will facilitate individual resident's consultation meetings (using the accessible form as a guideline) with all residents on a weekly basis. This will be overseen by the provider nominee during a weekly meeting with the Person in Charge and other members of staff where deemed appropriate.

Minutes, recorded on the accessible form will be kept of the weekly consultation meetings which will show who was in attendance, issues discussed and who is responsible for actions with clear timelines.

The agenda for the weekly resident consultation meetings will include: menus, activities, complaints and feedback, holidays and staffing changes. The Person in Charge in consultation with the resident and staff will set the agenda, which will vary from time to time according to the needs of the residents.

During the weekly resident consultation meeting the Person in Charge will use communication systems appropriate to the individuals communication needs including PECs, information technology and LAMH. The resident and a staff member will attend the meeting. The Person in charge will attend where additional communication needs are highlighted.

Any communication deficits that are detected for residents will be addressed through individualised training and support for staff in conjunction with the findings from the speech and language assessment.

Proposed Timescale: 25/11/2015

Theme: Individualised Supports and Care

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

Activities remained predominantly group based which did not afford residents to exercise choice and control in his or her daily life.

2. 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:

Since the 2.10.15 24 additional staff hours have been deployed per day, to ensure the appropriate balance between group and individual activities is maintained.

Residents views on the balance of activities will be actively sought at the weekly consultation meetings and any issues highlighted will be acted on.

Proposed Timescale: 02/10/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

It remained, for those residents who were non-verbal or whom had limited speech, effective communication tools were not in place or being actively used to assist them with communicating their needs and wants.

3. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

Communication assessments CATTs were completed for residents by May 2015

The findings of the assessments will be implemented by 1.12.15 including any training for staff and the purchase of required equipment or other resources. Additional support will be sought from the speech and language as required.

Proposed Timescale: 01/12/2015

Theme: Individualised Supports and Care

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

Residents did not have free access to a computer or the internet. This was limited to when the office was opened and the computer was not being used for administrative purposes.

4. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

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

The office in the centre is open at all times and the IT equipment is available for all residents to use as appropriate. Staff currently assist residents to access IT equipment and support them where appropriate. This is ongoing practice.

Proposed Timescale: 02/10/2015

Theme: Individualised Supports and Care

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

Residents have not been supported to access assistive technology and aids or appliances. The speech and language therapist made recommendations regarding same which had not been addressed.

5. Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

Communication assessments CATTs were completed for residents by May 2015

The findings of the assessments will be implemented by 1.12.15 including any training for staff and the purchase of required equipment or other resources. Additional support will be sought from the speech and language as required. The Person in Charge completed LAMH training on 19.11.15.

Proposed Timescale: 01/12/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

Further development was required regarding resident's links and integration with their local community.

6. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

The Provider has created a comprehensive plan to increase links with the wider community. The plan has been compiled in consultation with the residents.

Proposed Timescale: 01/12/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Details regarding the additional costs that maybe incurred as part of their service were not entirely updated.

7. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

The contract of care will be updated to reflect all additional charges that will be incurred. The cost of staff assisting for some activities with residents will be clearly set out.

Proposed Timescale: 02/11/2015

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 effectiveness of personal plans were not assessed. In addition changes in circumstances did not result in a review of all necessary aspects of the personal plans.

8. 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:

There is an audit schedule in place for reviewing care plans by the Person in Charge. Individual care plans will be discussed in monthly staff meetings. The person in charge has provided staff with a guidance form on reviewing care plans. An external provider has completed a comprehensive dependency assessment for each resident which is in Care Plans. In the event of a sudden change in a resident's needs, any short term or long term recommendations from Allied health professionals will be recorded, monitored and evaluated in the individuals care plan, a process which will be discussed in the monthly staff meeting, and overseen by the Person In Charge. If necessary this will be monitored by the Person In Charge on a more regular basis.

Proposed Timescale: 16/11/2015

Theme: Effective Services

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

Personal plans were not made available in a format accessible to the residents.

9. Action Required:

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

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

Person Centred Plans for each resident are now available in accessible format which have developed in line with the recommendations from the Behaviour Support Specialist.

Access is improved by using an easy read format supported with photographs and symbols.

Copies of the accessible plans are available for both residents and their families.

Proposed Timescale: 30/10/2015

Theme: Effective Services

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

A multidisciplinary approach had not occurred where required.

10. 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:

Personal Plan reviews will be multidisciplinary and will include where appropriate:

- Psychiatry
- Psychology – The Behaviour Support Specialist will be engaged on a monthly Behaviour Consultancy Clinic for ongoing maintenance and review of the plan including ongoing review of the service user
- Speech and language
- Occupational therapy
- Dietician

Outside of the periodic review of personal plans additional support from the multidisciplinary team will be sourced as required.

Presently a Nurse is availed of from local GP services in relation to wound care. We have also contacted several recruitment agencies regarding agency nurses and we have been assured by the agency that they can address our needs.

Proposed Timescale: 01/12/2015

Theme: Effective Services

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

As outlined in the body of the report personal plans were not reflective of resident's needs.

11. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

As previously referenced in Action 8.0 an external provider has completed a comprehensive dependency assessment for each resident. The Person in Charge and staff member will conduct an in-depth assessment of needs for each resident using the information ascertained from the completed dependency assessments and any follow-ups which have occurred with allied health professionals. These identified individual needs will be recorded, monitored and updated and the personal plans adjusted as appropriate to reflect any changes in each individual's needs and to monitor ongoing individual needs.

Presently referrals have been made as follows:

- 4 residents for Speech & Language
- 4 residents for Occupational Therapy
- 4 residents for psychology
- 4 residents Occupational Guidance
- 1 resident for Dietician (2nd awaiting for GP referral for Dietician).
- 1 resident for Sensory Integration Occupational Therapy, Behavioural Support Therapist
- 4 residents have been visited by a disability liaison nurse

Proposed Timescale: 16/11/2015

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:

From a review of incidents and accidents at the centre the inspectors found that risks were not being thoroughly assessed, managed or that on-going reviews of the risk were taking place.

12. 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 Provider Nominee has weekly meetings with the Person in Charge to discuss incident reports, safety audits and other feedback from residents and staff. This includes relevant feedback from the resident consultation reviews and the weekly meeting between the person in charge and the team leader. A review of risk assessments and the risk register is also conducted at this time.

Weekly meetings will also include examination of documents pertaining to incident reports, meetings of staff meetings, audits carried out and health needs.

Any changes required to the risk assessments, behaviour support guidelines, care plans and the risk register will be made as appropriate.

Any learning from these reviews is communicated through the residents/ staff meetings, memos and one to one staff meetings.

Proposed Timescale: 07/10/2015

Theme: Effective Services

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

Although the centres policy outlined the arrangements in place to identify learning from serious incidents involving residents. The inspectors found that in practice serious learning had not be gained subsequent to serious incidents and as a result the serious incidents continued.

13. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The provider nominee, in collaboration with the person in charge have steered weekly meetings to focus on health, safety and protection of all residents which includes learnings from all serious incidents. This includes discussions with staff on the use of restrictive procedures during episodes of challenging behaviour, how to re-direct other residents to prevent disruption and to protect them from unsettling incidents.

These meeting also offer guidance to staff in how best to implement all organisational policies including correct recording of all incidents as well as the risk register.

Positive Behaviour support training sessions are presently taking place which provide additional support to staff members. These training sessions commenced on 30th

October.

Proposed Timescale: 07/10/2015

Theme: Effective Services

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

Although the policy referred to self harm the inspectors were not assured the measures and actions in place to control self harm were appropriate to the resident's needs.

14. 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:

All restrictive practices are recorded on both incident reports and on the reports which is submitted to HIQA on a quarterly basis.

The use of such procedures are guided by best practice, recommendations from consultant psychiatrists and other multidisciplinary advisors as well as internal organisational policies.

All staff at the designated centre have attended a full 2 day course in MAPA and staff are attending positive behaviour support training at present to ensure that all possible avenues to reduce potential self-harm in resident/s are explored from the perspective of staff knowledge and ability to fully support.

Furthermore the Registered Provider has amended the risk policy to include the measures and actions in place to control self-harm and this change of policy have been communicated to staff through the residents/ staff meetings.

Proposed Timescale: 07/10/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

As outlined in the body of the report the use of restrictive practices were not applied in accordance with national policy and evidence based practice. This was subject of an immediate action.

15. 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:

The Immediate action plan was responded to on the day of the inspection.

Where any residents behaviour necessitates restrictive measures all efforts are made to identify and alleviate the causes, to ensure that all alternative measures are considered and that any intervention is for the shortest possible duration.

Detailed incident reports are compiled whenever restrictive measures are used and going forward incident reports will be trended and reviewed by the provider nominee.

Any use of restrictive measures either planned or unplanned is reviewed at the weekly incident review meetings.

The advice of a Positive Behaviour specialist has been sought, the staff have been trained and a monthly behaviour consultation clinic has commenced.

This training has commenced on 30.10.15 and is due to be completed by 18.12.15

The training will be inclusive of:

1. Basic principle of behaviour and positive behaviour support.

Team Work

Defining the behaviour problem

2. Environmental assessment

Keys to successful environments

Functional assessment

3. Functionally equivalent replacement behaviours

General positive skills

Skills teaching and reinforcement

PECS

4. Reactive strategies – overview of best practice

Restrictive practices – recognising and monitoring use.

Setting behavioural goals

Final write up of support plan

5. Implementing the plan

Evaluating the plan

Troubleshooting

Self-care: Coping with burnout.

Positive behavioural training commenced on the 30th Oct. Additional dates are the 20th Nov, 27th Nov, 4th Dec, 11th Dec 2015.

Proposed Timescale: 05/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

1. Every effort to identify and alleviate the cause of the resident's behaviour had not been made. For example there was an absence of a functional analysis, an environmental assessment or a sensory assessment completed by a competent person.
2. As outlined in the report the inspectors were not assured that all alternative measures were considered prior to the use of a restrictive procedure.

16. 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:

For the resident involved both functional and environmental assessments have been conducted by sensory O.T and Behavioural Support Therapist.

These have been used to identify the cause of the behaviour, a behaviour support plan has been put in place with the guidance of the positive Behaviour Specialist.

The behaviour support plan is detailed and clearly sets out how staff are to interact and respond to the resident in question.

A sensory assessment will be completed by a Sensory O.T on 17th November..

The timescale is based on the completion date of training from behavioural support therapist.

Proposed Timescale: 18/12/2015

Theme: Safe Services

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

As outlined in Outcome 8 and based on those cumulative findings, the inspectors found that residents were not protected from all forms of abuse. This was subject of an immediate action.

17. 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:

An impact assessment regarding the effect that a resident's behaviour has on each other residents has been undertaken by the Provider Nominee in October 2015. Following the completion of the impact assessment individual Safety Plans have been put in place as appropriate. The safety plans are communicated to residents through the use of social stories. The Person in Charge in conjunction with the Behaviour Support Specialist will review the safety plans on an ongoing basis. The Provider Nominee is linking with the

relevant funders to communicate relevant issues. Copies of the safeguarding plan/ social stores are being communicated to all representatives.

Proposed Timescale: 01/12/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Residents were not supported to access opportunities for education, training and employment.

18. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Each resident will be assessed regarding their wishes and abilities to access opportunities for education, training and development. Where possible and following consultation with residents the findings of these assessments will be put in place. Vocational and training assessments for all residents will be completed in conjunction with the Provider nominee by 01.12.15 using vocational assessment and supported employment assessment tools. Four residents have been referred to Occupational Guidance regarding training and education needs.

Proposed Timescale: 01/12/2015

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:

As outlined in the body of the report robust management systems were required to ensure the service provided was safe, appropriate to resident's needs, consistent and effectively monitored.

19. 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 following management systems are in place to ensure the service provided is safe:

- The Person in Charge and the Provider Nominee meet twice weekly to discuss issues relating the smooth running of the designated centre.
- The key quality indicators include: incident reports, drug errors, use of PRNS, referrals made, health appointments made. .
- Incident Reviews undertaken weekly with the Person in Charge and provider nominee in attendance.
- Any issues of concern are acted upon and risk assessments and the risk register are amended as required.
- The Person in Charge compiles a monthly report on the quality and safety of the designated centre for the Provider Nominee.

The Provider nominee currently conducts unannounced and announced visits of the designated centre to assess the quality and safety. Reports are available for these visits.

A full 18 outcome audit inspection based on the HIQA standards was carried out by the provider nominee on the 02nd of November. The report includes an action plan. There is a programme of audit for the service which include a list of audits which are be carried out to ensure the quality and safety of the designated centre.

A behavioural support therapist will provide an ongoing clinic to ensure oversight of the behaviour support plans and the use of restrictive measures.

Proposed Timescale: 16/11/2015

Theme: Leadership, Governance and Management

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

Although there was an annual review available in the designated centre failed to sufficiently review all aspects of the quality and safety of care and support.

20. 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:

The provider nominee will conduct the next annual review of quality and safety of care and support in line with the audit tool which is based on the 18 outcomes. This will be completed by 31.12.15.

Proposed Timescale: 31/12/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

Staffing levels remained low and insufficient to meet resident's needs and to ensure they were safe. This was subject of an immediate action.

21. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

The appropriate levels of staff are now in place to meet the needs of the residents, the staffing levels are reconsidered each week at the weekly management meetings. Staffing levels have been increased in line with recommendations from external consultants and in response to changing resident's needs.

The provider nominee is constantly monitoring staff levels.

Proposed Timescale: 02/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Agency staff had commenced at the centre and were scheduled in the absence of core staff being scheduled. Also a number of the agency staff, at the time of inspection, had not been inducted into the service.

22. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

All agency staff used since 2.10.15 have been fully inducted by Person in Charge, Team Leader or senior member of staff. The Person in Charge links in with agency provider regarding performance of agency staff. They all have MAPA training, fire and behaviours that challenge training. The organisation induction training includes fire training, policy training, general information on the residents and an overview of the residents.

The Person in Charge retains records pertaining to this.

Proposed Timescale: 02/10/2015

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 food and nutrition policy had not been implemented in practice.

23. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Food and Nutrition policy has been implemented into Care Plans including the MUST (Malnutrition Universal Screening) tool from 14.10.15

The person in Charge has implemented the MUST tool into care plans and overviews this presently.

A dietician has been engaged by the organisation to assist staff.

It is also part of the care plan audit and guidance developed to support staff in reviewing and updating care plans.

Proposed Timescale: 14/10/2015