

**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 Brothers of Charity Services South East |
| Centre ID: | OSV-0003281 |
| Centre county: | Tipperary |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | Brothers of Charity Services South East |
| Provider Nominee: | Johanna Cooney |
| Lead inspector: | Ann-Marie O'Neill |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 2 |
| Number of vacancies on the date of inspection: | 2 |

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 22 March 2016 10:00 To: 22 March 2016 20:20

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

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

Summary of findings from this inspection

This was the first inspection of the designated centre and the purpose was to monitor ongoing regulatory compliance. The inspection took place over one day and eight Outcomes were inspected against.

The centre is located in the perimeters of a town in South Tipperary. The location of the centre ensured residents were within easy access to all amenities and services within their locality. As part of the inspection the inspector met with all residents and staff members on duty the day of inspection, the person in charge, team leader and regional manager. The inspector also met residents living in the centre. They did not wish to actively engage with the inspector and their wishes were respected. The inspector observed practices and reviewed documentation including personal plans, medical records, accident and incident reports, policies procedures.

At the time of inspection the provider had intended to register the centre with two residential units one a full time residential dwelling and the other a respite residential unit for adults with intellectual disabilities. During conversations with the person in charge prior to the inspection and during the inspection the inspector was informed that it was the provider's intention to re-configure the designated centre so that it comprised only of full time residential units. The respite unit would be re-configured

into another designated centre. Therefore the inspector carried out the inspection in the residential unit of the centre only.

The residential unit of the centre comprised of a single story large detached house which could accommodate four residents comfortably. The premises were suitable for its purpose. There were suitable spaces outside for residents to access safely for their preferred leisure pursuits, such as using a go-kart.

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

This inspection found the provider was not in compliance with the regulations in a number of areas. There had been a lack of oversight and governance of the centre which contributed to the number of non compliances found on this inspection. Good practice was found in medication management.

The inspector found that there was a lack of effective governance and management systems which had resulted in:

- Inadequate implementation and updating of residents personal plans and goals which impacted on residents' opportunities to experience social inclusion and participation and also to ensure care practices being implemented were within best practice guidelines. (Outcome 5)
- Inadequate fire containment systems (Outcome 7)
- A lack of understanding of what constituted restraint or restrictive practices which resulted in restraints in use not adequately monitored to ensure they were the least restrictive and used for the least amount of time. (Outcome 8)
- Failure to submit to the Chief Inspector the required notifications in relation restraint (Outcome 9).
- Some health care interventions were not supported by written documentation from relevant prescribing medical professionals. Some care planning was generic and not dated or signed off by relevant clinicians with authority and accountability to prescribe such care practices. (Outcome 11)
- Inadequate auditing of the quality of care by the provider as required in the Regulations. (Outcome 14)
- Inadequate staff numbers to meet some residents' social care goals and not enough staff trained to carry out intimate care procedures resulting in the team leader for the centre coming in to carry out the procedure on their days off. (Outcome 17)

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

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

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The inspector reviewed the personal plans, medical records, daily records and multidisciplinary reports of the two residents living in the residential unit of the centre. Improvements were required to ensure goals established for residents were acted upon to ensure they were met within a reasonable time frame. Some identified needs for residents were not supported with adequate, timely care planning in some instances.

There was evidence of comprehensive assessments of needs in place for residents. A personal outcome measure assessment tool was used to assess residents' overall social care needs. From these assessments needs and goals were identified and set the focus of circle of support/person centred planning meetings where goals were identified and set out.

There was also evidence of multidisciplinary assessments from speech and language, psychiatry, dieticians and physiotherapy. The interventions advised by these assessments were maintained in residents' personal plans and incorporated into residents' daily support interventions.

However, the inspector found there was repetition of goals identified for residents with little evidence that goals set previously had been achieved. This resulted in the same unachieved goals being reassigned again at follow up personal planning meetings. For example, in April 2015 a resident's goal was to seek a volunteer for them to facilitate them to have more opportunities to access community based activities. However, their person centred planning review in January 2016 indicated that the organisation hadn't been successful in identifying a volunteer for the resident. This goal was reinstated for

2016 but with no outline of how it would be achieved or what was to be put in place for the resident in the interim to ensure they had suitable opportunities for social inclusion and activity. This issue is further discussed in Outcome 17: Workforce.

Residents had been prescribed health care interventions requiring specific skills and care planning to ensure they were carried out correctly. However, there was evidence which indicated that residents' personal plans were not updated in a timely way to reflect a change in residents' personal circumstances. In one instance a health care intervention, which had begun in January 2016, did not have an associated support plan in place for staff to follow until March 2016. The resident had received the health care intervention every day since January 2016.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The health and safety of residents, visitors and staff were promoted in some parts. However, systems relating to fire and smoke containment in the centre were inadequate.

There was a risk management policy in place which contained the matters as set out in the regulations. Individual personal risks had been identified for each resident and had associated control measures in place to mitigate risks identified and prevent them from occurring in other instances.

Infection control measures for the centre were adequate given the purpose and function of the centre and the needs of the residents. Colour coded mops and buckets were designated for cleaning particular surfaces. There were adequate hand washing facilities in the centre, hand soap was in supply and paper hand towels were used for hand drying purposes.

There was a working fire alarm in the centre and there was evidence indicating it had been serviced regularly with its most recent service 14 January 2016. Fire extinguishers were also available and had also received an annual service the most recent dated November 2015. The chimney in the centre had been cleaned October 2015. A carbon monoxide detector was located in the sitting room which contained a solid fuel burner. It had been checked February 2016.

However, there were inadequate fire containment measures in place. There were no fire doors for rooms which could be identified as high risk areas where smoke or fire could occur, such as the kitchen or utility room. Where doors had smoke seals in place they had been rendered ineffective due to paint on them.

Fire drills had been carried out at regular intervals and no issues of concern were noted in evacuating the residents. The most recent fire drill dated 9 January 2016 had indicated there were no issues that had occurred during the drill with an evacuation time of one minute.

A number of safety audits of the environment and work practices had been undertaken with the most recent dated 5 March 2016. The audit reviewed fire systems, medication management systems, waste disposal, money management, electrical appliances, infection control, manual handling and first aid management systems in the centre. However, the safety audits had not identified the lack of fire doors in the centre as an issue.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

There were systems in place for the protection of residents including the management of behaviours that challenge. However, the inspector was not assured that staff and management had an appropriate knowledge of restrictive practice. This in turn resulted in the inspector finding evidence that there were inadequate systems in place to monitor and review the use of restrictive practices.

Organisational policies and procedures for the protection of vulnerable adults was in accordance with the Health Service Executive (HSE) policy to ensure satisfactory screening, implementation of safeguarding plans and adequate review of incidents.

Staff spoken with during the course of inspection demonstrated knowledge of abuse, indicators of abuse and outlined appropriate procedures they would implement should they witness or receive an allegation of abuse. The inspector observed staff had established a genuine warmth, rapport and respect for the residents they supported.

All staff had received training in de-escalation and management of behaviours that challenge. Residents that presented with behaviours that challenge were reviewed by their psychiatrist and had been also reviewed by the psychologist for the organisation. However, there had been a gap in this support as the psychologist was on extended leave and at the time of inspection. Staff were working from behaviour support plans which were not up to date and did not reflect residents' current support needs.

Improvements were required in the management of restrictive practices to ensure they were safe, clinically overseen and managed. Restrictive practices used were chemical restraint for the management of anxiety which could lead to behaviours that challenge, locking the kitchen door between 6am - 8am and the use of a helmet to protect a resident's head during instances where they engaged in self injurious behaviour.

There had been a reduction in the use of one of the restrictions in the centre. This was the reduction of time the kitchen door was locked from 12 hours to 2 hours. The reduction in this practice had been brought about by an increase in staffing resources in the centre. A review by the organisation's Human Rights Committee had acknowledged the reduction in this restriction but had recommended that a new referral be submitted to them with regards to the locking of the kitchen door between 6am - 8am. This recommendation was made 25 January 2016. However, a referral had not been made for the Human Rights Committee to review the existing restriction at the time of inspection 22 March 2016.

Restrictive practices such as chemical restraint or the use of a helmet for a resident when they engaged in self injurious behaviour were not deemed restraint by management of the centre and therefore appropriate monitoring or review systems were not in place to ensure they it was used in line with best practice and as a last resort.

The inspector reviewed a number of PRN (as required) medication incident forms which had been completed between September to December 2016. The inspector specifically reviewed the number of times chemical restraint was administered during that period. Incident forms indicated what medication had been given and the reason for its administration.

All incident forms for the three month period were documented as having been reviewed on the 6 January 2016. The inspector was not assured that administration of chemical restraint was adequately reviewed and assessed in a timely manner so as to monitor its use and ensure it was a last resort.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

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

Findings:

A review of the accident and incident logs and residents' records indicated the provider had failed to notify the Chief Inspector of restrictive practices in use in the centre in quarterly notifications.

The inspector noted there had been numerous instances whereby chemical restraint had been administered to residents for the management of anxiety which could lead to behaviours that challenge. This had not been notified.

The door to the kitchen of the centre was locked for periods of time to prevent a resident's unsupervised access. This had not been notified as a restrictive practice.

The use of a helmet to prevent injury to a resident had not been notified as a restrictive practice on quarterly notifications as a restrictive 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:

The inspector found evidence that residents' health care needs were supported, however, there were improvements required.

Documentation and interviews with staff indicated there was frequent and timely access to allied health services. There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, mental health specialists,

dietician and physiotherapy.

There was evidence that families were kept fully informed and involved in regards to any external medical appointments and regularly attended with the residents. Hospital passports were available in the event a resident required admission to hospital or emergency services, for example.

While residents had access to appropriate medical and allied health professional assessment and review, improvements were required to ensure residents health care needs were being met in line with recommendations from medical professionals.

In some instances support planning was inadequate to guide staff how to support residents. For example, where residents engaged in behaviours that challenge which could result in head injury, there was inadequate care planning documentation in place to guide staff. The plan in place was generic in nature and did not provide adequate person specific guidance on how to manage a head injury for the resident it was intended for. For example, the information did not indicate the resident would require specific neurological observations but rather gave an overview of symptoms to look out for after a head injury. The support plan required more information to guide staff on how to monitor the resident as they could not verbally inform staff if they had pain or felt nauseous after sustaining a head injury.

In another instance a resident was receiving a health care intervention daily. This intervention was to support their continence and required staff to have specific training and skills in order for it to be implemented. (This is also referenced in Outcome 17: Workforce). However, there was no recommendation by the resident's consultant maintained in the centre. Staff were implementing the intervention based on notes a support staff had written up after an appointment the resident attended. The inspector was not assured that the intervention could be determined as being in line with the consultant's recommendations given the absence of written instruction or documentation from them or an appropriate clinician.

Residents' nutritional needs were being addressed and monitored. There was documentary evidence of advice from dieticians and speech and language therapists where necessary. Staff were aware of residents' personal preferences. Resident's weights were monitored regularly.

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:

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

Only staff who had undergone medication management training were administering medication and competency was assessed following the training. The training records confirmed this training had taken place.

The inspector saw evidence that medication was reviewed regularly by residents' GPs and the prescribing psychiatrists.

Medication was securely stored in the centre in a locked press in the staff room. Access to the key was prohibited to only those who knew a code to the container it was stored in. Residents medications were stored individually and clearly labelled to ensure they could not be mixed up with other residents' medications.

The person participating in management confirmed she had audited medication management practices in the centre. This is further discussed under Outcome 14: Governance and Management

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The governance and management arrangements for the centre were not configured in a way that ensured effective oversight of the quality of care and support residents

received.

Staff informed the inspector that the service manager /person in charge was supportive and responsive to them. However, the findings in a number of Outcomes on this inspection indicated that there has not been effective oversight of practices and systems in the centre for some time.

Six monthly provider-led audits had occurred in 2014 however, there were none available for 2015. The inspector asked for the audits at the beginning of the inspection. However, they were still not available at the close of inspection. The person participating in management of the centre had not seen the audits and was not aware of their content or what was to be actioned to improve the service.

An annual report for 2015 had been drafted but it was not adequate. There had been no six monthly provider-led audits and therefore it was not a useful document to improve quality and standards of care and support for residents in the centre as it did not contain information with regards to the quality and standard of care residents received in 2015.

The inspector was told that medication audits had occurred and a list of dates was shown to the inspector indicating when they had happened. However on further review, the medication audits were not adequate as the only documentation associated with them comprised of the date they had been carried out. The audit did not comprise of a template or list of items the manager reviewed and therefore it was not possible to identify what came about from the audit in relation to improvement or change in practices, for example. There were no audits on incidents or accidents undertaken which would further inform quality assurance systems.

The person in charge worked in a full time capacity and was a registered nurse with skills and competencies to meet the role of person in charge. However, she was not present in the centre on a consistent basis to ensure adequate oversight and supervision of practice and staff. Recently she had been appointed to a director of services role and this conflicted with her role as person in charge of the centre as both roles had a large remit to cover. The person in charge, at the time of inspection, was not acting in her role full time as required in the Regulations.

These issues were discussed with the regional manger and person in charge at the feedback meeting. They acknowledged the difficulties in the governance structures and also that current workload of the person in charge did not support effective delivery of care as they had a management remit across a number of designated centres, respite services and also day services.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The inspector found that there were insufficient staff available at times to support residents in achieving set social care goals in community inclusion and participation. Not enough staff were trained in specific health care interventions which would ensure residents could have their needs met on a daily basis.

Staff spoken with and observed during the inspection were understanding and supportive of residents' primary, health and social care needs. However, they were not sufficiently trained to support residents with specific health care interventions which needed to be implemented on a daily basis. At the time of inspection only the team leader and manager from the day service were deemed competent to implement an intimate care continence management procedure for a resident. This resulted in the team leader of the residential unit coming into work on her days off and weekends in order to support the resident and implement the intervention.

At the time of the inspection a resident's personal plan documented one of their social care goals was to increase their opportunities for social inclusion and participation. However, their day placement could not facilitate this for them as the resident required two staff in order to facilitate social activities. The inspector was informed that the residential staff could not meet the resident's social care goals either as they did not have two staff available to support the resident to attend social activities. The inspector was not satisfied that the provider had reviewed staffing numbers to meet residents' social care goals.

Another example where staffing arrangements required review was indicated by the necessity for night staff to lock the kitchen door of the residential unit between the hours of 6am - 8am. The rationale for this restrictive practice was due to the lack of supervision they could provide residents during this time. One sleep over staff and waking night staff were allocated to the residential unit, however, should both residents wake between 6am - 8am the waking staff could not adequately supervise both residents and the door was locked to prevent residents gaining access to the kitchen unsupervised which could lead to one of them eating uncooked/raw meat, for example.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill
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 Brothers of Charity Services South East |
| Centre ID: | OSV-0003281 |
| Date of Inspection: | 22 March 2016 |
| Date of response: | 27 April 2016 |

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

Satisfactory arrangements were not put in place to support residents to achieve their goals. There was repetition of goals identified for residents with little evidence that goals set previously had been achieved. This resulted in the same unachieved goals being reassigned again at follow up person centre planning meetings.

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

1. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

This action relates to a specific goal for an individual. Additional staffing hours have been allocated to meet this individual's needs pending recruitment of a volunteer.

Proposed Timescale: 05/04/2016

Theme: Effective Services

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

There was evidence which indicated that residents' personal plans were not updated in a timely way to reflect a change in their personal circumstances.

2. Action Required:

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

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

Residents personal plans have been updated to for example incorporate specific health care interventions. Family members, day support service staff members, residential key worker and team leader and the individual's consultant doctor were consulted in its review.

Proposed Timescale: 04/04/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There were inadequate fire containment measures in place. There were no fire doors for rooms which could be identified as high risk areas where smoke or fire could occur, such as the kitchen or utility room.

Where doors had smoke seals in place they had been rendered ineffective due to paint on them.

3. Action Required:

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

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

The smoke seals have been replaced on the affected doors and fire doors have been fitted to the identified doors.

Proposed Timescale: 06/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff were working from behaviour support plans which were not up to date and did not reflect residents' current support needs.

4. 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:

Behaviour Support Plans will be updated by the Psychologist, Psychiatrist and staff team to reflect resident's current support needs.

Proposed Timescale: 12/05/2016

Theme: Safe Services

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

There were inadequate systems in place to monitor and review the use of restrictive practices.

5. 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:

1. Risk assessment relating to the use of a protective helmet has been carried out and a referral made to the Human Rights Committee on 20th April 2016.

2. The restriction relating to the locked kitchen door will be reviewed on 10th May 2016 by the staff team.

3. The Consultant Psychiatrist has a protocol in place regarding the review of the use of PRN medication. When it exceeds a specific threshold as stated in the individual's drug

prescription chart it is referred to the Psychiatrist for review as per the protocol. This individual is reviewed regularly by the Consultant and was reviewed most recently on 11/04/2016.

4. A log book is in place to record all instances of restriction and this is reviewed fortnightly by the person in charge.

5. Multi-Disciplinary review of all restrictions is scheduled for the 27th May 2016.

Proposed Timescale: 27/05/2016

Theme: Safe Services

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

The organisation's Human Rights Committee had recommended that a new referral be submitted to them with regards to the locking of the kitchen door between 6am - 8am. This recommendation was made 25 January 2016, however, the referral had not been made at the time of inspection which occurred 22 March 2016.

6. 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:

This restriction will be referred to the Human Rights Committee. This restriction will be reviewed at Team Meeting of the 10th May 2016 with a view to removing this restriction completely.

Proposed Timescale: 10/05/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

A review of the accident and incident logs and residents' records indicated the provider had failed to notify the Chief Inspector of restrictive practices in use in the centre in quarterly notifications.

7. Action Required:

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

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

NF39 returns for Q1 2016 will show an accurate return of all restrictions including those deemed as 'enablers'

Proposed Timescale: 30/04/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Where residents engaged in behaviours that challenge which could result in head injury, there was inadequate care planning documentation in place to guide staff. The plan in place was generic in nature and did not provide adequate person specific guidance on how to manage a head injury for the resident it was intended for.

The support plan did not guide or instruct staff how to carry out specific neurological observations of residents after they sustained a head injury.

8. 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:

This individual's head injury care plan will be updated to ensure person specific guidance on how to manage a head injury for this individual.

The head injury care plan includes specific neurological observations to be carried out post head injury which support staff will be trained to implement.

Proposed Timescale: 20/05/2016

Theme: Health and Development

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

A resident was receiving a health care intervention daily. However, there was no recommendation by the resident's consultant maintained in the centre. The inspector was not assured that the intervention could be determined as being in line with the consultant's recommendations given the absence of written instruction or documentation from them or an appropriate clinician.

9. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

Correspondence is now on file from the individual's hospital consultant to direct the care of the individual and all staff have been briefed on the intervention by the Continence Nurse Specialist.

Proposed Timescale: 04/04/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The person in charge, at the time of inspection, was not acting in her role full time as required in the Regulations.

10. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The Services will review the allocation of the role of the person in charge to ensure the presence of a fulltime PIC. A more detailed response has been provided to the Authority on this matter.

Proposed Timescale: 30/05/2016

Theme: Leadership, Governance and Management

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

The governance and management arrangements for the centre were not configured in a way that ensured effective oversight of the quality of care and support residents received.

11. 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 organisation will review its structures to ensure effective governance and management of the designated centre with clear roles of authority and accountability.

A more detailed response has been provided to the Authority on this matter.

Proposed Timescale: 30/05/2016

Theme: Leadership, Governance and Management

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

An annual report for 2015 was available but it did not reflect the quality and safety of care provided in the centre.

12. 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 annual review for 2015 will be revised and will reflect the quality and safety of care provided in the centre.

Proposed Timescale: 27/05/2016

Theme: Leadership, Governance and Management

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

Six monthly provider-led audits had occurred in 2014 however, there were none available for 2015.

13. Action Required:

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

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

Six monthly provider led audits have been scheduled for 2016 by the Learning & Development, Quality & Advocacy Department on behalf of the Provider. Auditors are allocated from our senior staff members across the Services. Actions identified will be implemented by the Person in Charge and the Provider.

Proposed Timescale: 27/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The inspector found that staff numbers required review at certain times.

14. Action Required:

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

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

Staff resources have been reviewed and additional supports put in place to support individual care and social needs e.g. additional staff hours have been allocated at weekends to support an individual's social and recreational needs pending recruitment of a suitable volunteer.

Proposed Timescale: 05/04/2016

Theme: Responsive Workforce

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

Not enough staff were trained in specific health care interventions which would ensure residents could have their needs met on a daily basis.

15. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Staff training in the specialised health care intervention has been scheduled to take place. Nine identified staff members will be trained in this technique at both care assistant and nursing grade. The training will be provided by an external training body which has advised on the process required to deem individuals competent to carry out this intervention safely and correctly. The intervention in place will be reviewed by the individual's consultant doctor at his clinic.

Proposed Timescale: 06/06/2016