

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Villa Maria
Centre ID:	OSV-0001686
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Company Limited by Guarantee
Provider Nominee:	John Hannigan
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 14 February 2017 09:30 To: 14 February 2017 20:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this designated centre. The purpose of this inspection was to follow up on the actions identified from the previous inspection and to assess ongoing regulatory compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013.

How we gathered our evidence:

As part of the inspection, the inspector visited the designated centre, met with six residents and spoke with the person in charge and four staff members. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures. Over the course of this inspection residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the designated centre. This included meal times and activities.

Description of the service:

This designated centre is operated by Sunbeam House Services (SHS) Limited and is based in Bray, County Wicklow. Six residents resided in the designated centre at the time of this inspection: five male and one female. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The inspector found the service provided was in line with the statement of purpose.

Overall judgments of our findings:

Eleven outcomes were inspected against and one outcome was found to be in major non-compliance. Within Outcome 7: Health Safety and Risk Management significant improvements were required in relation to the risk management system and infection control provisions. Six outcomes were found to be moderately non-compliant with two outcomes substantially compliant and two outcomes compliant.

The person in charge facilitated the inspection.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

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):

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

Findings:

The inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection and found the action had been addressed in relation to complaints.

The inspector found the complaints policy met with the requirements of the regulations.

Judgment:

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 inspector viewed written agreements and found all residents had a written agreement in place. However, the details contained within the agreements were not accurate for example; services provided were not accurately reflected within the documents.

The tenancy agreement specified the tenant was responsible for all internal decoration and for any breakages of glass in the windows or any damage to fixtures and fitting. It also stated the tenant was responsible for insuring the contents of their dwelling. The inspector was informed this document was not reflective of actual practice within the designated centre.

Judgment:

Substantially Compliant

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 inspector found the social care needs of each resident were being supported and facilitated in the designated centre. However, some residents' plans were not reflective of practice and one resident did not have a plan completed since 2015.

The system of personal social plans within the designated centre involved personal outcome measures encompassing 23 quality-of-life indicators as an assessment. This plan was to be completed once every three years. The inspector was informed this system was currently under review. The information gained during the process contributed to the development of a personal plan. This plan was to be completed annually and reviewed every six months.

The inspector viewed four residents' social plans. One resident had no social plan in place with the exception of a handwritten sheet of paper. This was dated 11 March 2015 outlining four goals. There was no evidence of the resident participating in this process, nor was there a review was present or was there any evidence of any level of

progression of the identified goals. The person in charge was asked to provide the inspector with a copy of the resident's social plan however, the hand written sheet of paper was the only documentation available on the day of inspection.

The other three residents' social plan viewed were dated within 2016. Goals were identified within these plans however; the inspector found the review process was not effective in some cases. For example, some goals set were not reviewed within the review process and dates in which reviews were completed were inconsistent between various documents within the plan.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The inspector found the premises required improvements as the house did not provide sufficient communal space for the number and needs of residents within the house. This was also identified within the previous inspection.

The house contained a small sitting room and a kitchen cum dining room. The kitchen area was separated by a timber divider and this was locked by staff members to ensure safety of residents. This left very limited space for residents and staff to comfortably have meals together. The inspector observed meals were provided at two intervals with two groups of residents. The inspector asked if this was the preference of residents or due to the limited space available. Staff confirmed it was due to both as some residents preferred a quiet environment and preferred not to be in the company of certain residents at times.

The inspector asked what was being done in relation to the communal space as this was identified in the previous inspection. However, there was no evidence of this being discussed at meetings. The person in charge identified this was discussed initially following the previous inspection however, since then nothing had progressed.

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):

No actions were required from the previous inspection.

Findings:

The inspector found the designated centre was not suitable and safe for the number and needs of residents. Improvements were required in relation to the risk management system and infection control provisions.

The inspector viewed one resident's bedroom with a separate toilet installed within an internal room. This room contained a window for ventilation. However, there was no hand basin for the resident to wash their hands. The inspector discussed this with the person in charge who identified the resident would wash their hands within the main bathroom. The inspector found this practice did not meet infection control standards and no hand hygiene facility was available for the resident within their bedroom. The practice of a resident washing their hands within the main bathroom had the potential to cross contaminate the environment for other residents. Three doors were required to be opened during this process in order for the resident to wash their hands.

The inspector also found the toilet did not have a lid on the cistern. In order for the toilet to be flushed staff had to place their hand into the cistern and manually activate the flush mechanism, this was identified with in a health a safety audit on the 13 September 2016 and remained outstanding on the day of inspection.

The designated centre had an organisational risk management policy in place which included the specific risks identified in regulation 26. The designated centre had a risk register, which recorded a number of risks within the house and the controls in place to address these. The inspector identified this document required updating for example, the water temperature was unregulated. The inspector brought this to the attention of the person in charge on the day of inspection.

The inspector also viewed individual resident's risk assessments in place however, some of these did not correspond to resident's safety plans.

The inspector viewed the accidents and incidents for a sample number of residents within the designated centre and found the system unclear in relation to the coding system for incidents. One incident viewed was identified as a minor incident however, this involved one staff member receiving two lacerations to their skin. An item belonging to a resident was broken during the incident. This resulted in one resident requiring chemical restraint. The inspector found the system of classifying this incident as minor

and the rationale for this unclear. The inspector requested to view the trending of incidents within this designated centre however, this was not available. Therefore, the inspector was unable to see effective measures in place to control and identify risks and learn from incidents in order to mitigate risks in the future within the designated centre.

The inspector viewed a fire drill dated 18 January 2017 where all residents safely evacuated the designated centre.

Residents had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents.

The inspector viewed training records for 24 members of staff and found two staff members required full training and one staff member required refresher training in the area of fire.

The designated centre had a health and safety statement. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as fire, adverse weather conditions, flooding and power failure.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company this was dated December 2016.

The designated centre's vehicle was appropriately taxed, insured and had a commercial vehicle roadworthiness test (CRVT) certificate.

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:

The inspector found there were appropriate measures in place to protect residents from being harmed and to keep people safe. However, some improvements were required in relation to the management of displays of behaviours and the reporting structure should an allegation of abuse arise. Staff training was also identified as an issue; this also arose during the previous inspection.

The inspector found intimate care plans were in place for residents requiring them. However, the details within the documents required clarity as some identified female staff members were required, however, if no female staff, then a male nurse will suffice. The inspector discussed this with the person in charge who confirmed this was not based on assessed needs of residents instead this was based on historical practices.

The inspector found the information displayed in relation to the reporting structure in relation to allegations of abuse within the designated centre was inaccurate as members of staff no longer employed were identified within the reporting structure. Some staff were unclear on the reporting structure in relation to allegations of abuse within the designated centre. The person in charge confirmed they were the designated officer for this designated centre.

The inspector viewed training records for 24 members of staff and found five staff members required training and one staff member required refresher training in the area of adult protection and safe guarding training. The inspector found 19 staff members required training in the management to displays of behaviours that challenge including de-escalation and intervention techniques.

The inspector viewed four resident's behavioural support plans, these required updating to ensure the document was effectively and consistently guiding staff in the management of displays of behaviours that challenge. The inspector found the documents did not identify at what stage staff were to administer medication. The inspector identified the review process also required improvement to identify if the specialist interventions were implemented and to what effect. Reviews viewed made no reference to these interventions. The inspector also found inconsistencies between behavioural support plans and rights restriction documentation.

The designated centre had a high level of environmental restrictions in place. The inspector found some of these were not reviewed since August 2015, this was not in accordance with the organisation's policy. The inspector found residents could not access their own bedroom without a staff member, as the doors were locked to prevent another resident gaining entry into the other resident's bedrooms. The rationale for this was due to the potential for residents' property being destroyed. Within the documents viewed there was no identification of alternative or less restrictive alternative being implemented. The person in charge did identify the use of an alternative locking device was trialled however, with no effect. The inspector viewed an audio monitor was in place within one resident's bedroom however, this practice was not reviewed by the restrictions committee. The inspector found the use of restrictions within the house required review to ensure the least restrictive interventions were utilised for the shortest duration of time.

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):

No actions were required from the previous inspection.

Findings:

Each resident was supported to achieve the best possible health. However, improvements were required in the information contained in resident's healthcare plans to reflect actual practice and the follow through of healthcare recommendations.

The healthcare needs of residents were completed via a plan entitled 'my health development plan'. From this, a care plan and or support plan was developed. The inspector viewed five residents' plans. However, some healthcare conditions were not identified within the assessment despite a support plan in place for the condition. The inspector also identified some conditions were identified within the assessment; however, no support plan was present in relation to the specific healthcare need. This was identified and discussed with the person in charge on the day of inspection.

The inspector found interventions were in place for some healthcare conditions. However, some of these conditions were not identified within the healthcare assessment. The details contained within some care plans were not sufficiently detailed to ensure staff members could effectively implement the interventions within some of the care plans viewed.

The inspector found healthcare plans contained generic information not relevant to residents. For example, the document stated staff teach me personal care, eating well, being more active, smoking, alcohol and drug intake. Some of these documents were signed by the resident themselves. The inspector discussed this with the person in charge and some of these areas were not relevant to residents.

The inspector viewed some epilepsy plans in place and found these were not detailed enough to guide staff members in effective delivery of care in relation to seizure management. For example, oxygen therapy was not specified within the document within one plan viewed. Another plan viewed was unclear in relation to the administration of a second dose of rescue medication. The following was stated "urgent medical review required". The inspector identified this was incorrect as the resident was not prescribed a second dosage therefore, the document should clearly state this, to

effectively and consistently guide staff members in the delivery of care.

The inspector viewed evidence of a dietitian review dated 02 March 2015 with a nutritional plan dated 2008. The inspector requested evidence of the most up-to-date reviews and the person in charge confirmed both documents were the most recent. No follow up was evident.

The inspector viewed a resident requiring a physiotherapy plan. This plan was dated 2015. No evidence of review was evident or if the interventions were effective for the resident. The inspector noted inconsistent information in relation to the duration of the interventions specified within the physiotherapy plan and the care plan devised for the same condition.

The inspector found some of the interventions specified within residents' care plans were not completed as identified within the plan in relation to weight monitoring and the management of gastro intestinal issues. For example, the inspector found 21 days without a record maintained for one resident.

Residents had access to a G.P. (general practitioner). All residents had received an annual review, including phlebotomy tests as required for some residents due to medication prescribed.

Regarding food and nutrition, the inspector found residents participating in mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices.

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):

No actions were required from the previous inspection.

Findings:

The inspector found the medication management system within the designated centre required some improvement in relation to the management and administration of medication.

No guidance was available in relation to the administration of some PRN medicine (a medicine only taken as the need arises). The inspector found staff members were not

guided effectively and consistently in the administration of medication for example, when a resident was experiencing pain.

The maximum dosage of PRN medication was not specified for some of PRN medication viewed.

The administration sheet for some residents' did not identify the G.P (general practitioner) or the resident's date of birth.

The dosage for one medication did not correspond with the product for example, milligrams was specified for a liquid medication.

The inspector observed some medication was stored with other non-medicated items within the kitchen. The inspector also viewed a separate medication press located upstairs.

The inspector cross checked balances of some medication and found accurate records maintained. However, some medication was unaccounted for in the centre, as identified within the six-monthly visit. The inspector discussed this with the person in charge and measures were currently under way to establish how this occurred.

The designated centre had written policies and procedures related to the administration, transcribing, storing, disposal and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received and a stock check was carried out once a week.

There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the designated centre and found preventative measure were put in place to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the designated centre was completed.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspector found improvements were required in the area of staff meetings and auditing to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The inspector found limited auditing of areas within the designated centre. For example, no medication administration audits had taken place. The inspector was presented with a stock audit completed as a result of the provider's six-monthly visit. The lack of auditing was discussed with the person in charge.

The inspector viewed minutes of staff meetings within the designated centre. The inspector found a six month gap within staff meetings from, May 2016 to November 2016. The inspector was informed these would take place on a more regular basis in 2017 due to a change in the workload of the person in charge.

There was an annual review of the quality and care completed in this designated centre dated 2016.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six-monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. The inspector viewed one completed on 05 July 2016 with an action plan to address areas identified. The inspector also viewed another one dated the 26 and 27 January 2017. The action plan was currently being devised.

The inspector viewed minutes of the senior management team meeting. One was dated November 2016 and discussed areas relating to the whole organisation including training, budgets, safeguarding and protection and plans for 2017 in relation to the structure of meetings and topics. These were available for the person in charge to read within the computerised system.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings) dated 25 October 2016 and 22 November 2016. Issues relating to complaints, staffing, finance, and safeguarding procedure were discussed during these meetings.

The inspector found there was a clearly defined management structure with lines of authority and accountability identified. From speaking with the person in charge in length over the course of the inspection it was evident they had knowledge of the individual needs and support requirements of each resident. The person in charge was supported in their role by a senior service manager. The person in charge was aware of their statutory obligations and responsibilities with regard to the role of person in charge, the management of the designated centre and the remit of the Health Act (2007) and Regulations. Throughout the course of the inspection, the inspector observed residents knew the person in charge and were very comfortable in approaching them. The person in charge worked on a full time basis between this designated centre and another designated centre.

Judgment:
Substantially Compliant

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

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

Findings:

The inspector found the number, qualifications and skill-mix of staff was not accurately maintained. For example, two awake staff members were present at night however, no assessment of need was available to identify why this was in place.

The inspector also found five days when there was no nurse present within the designated centre since the 08 of December 2016. This centre was described as a nurse-led location. The person in charge identified no one was available to fill the position on those days. On the day of inspection, four staff members were present. The nurse on shift was an agency nurse accompanied by an agency healthcare attendant with two regular staff members. From viewing the rota available the reliance on relief or agency staff was evident within each rota viewed on the day of inspection.

The inspector also found the rota was not maintained accurately for example, some days viewed did not identify if the person in charge was available or the deputy manager for the designated centre.

One resident was in receipt of one-to-one staffing however, there was no assessment of need identifying this requirement of care provision.

The inspector viewed training records for 24 members of staff and one staff member required training with four staff members requiring refresher training in people moving and handling. Thirteen staff members required training in the area of epilepsy and the administration of rescue medication.

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 inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection and found the two actions had been fully addressed in relation to records and documentation.

The inspector found the resident's guide met the requirements of the regulations.

The inspector found schedule 5 policies were in place.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Karina O'Sullivan
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 Sunbeam House Services Company Limited by Guarantee
Centre ID:	OSV-0001686
Date of Inspection:	14 February 2017
Date of response:	07 April 2017

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 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:

The details contained within some written agreements viewed were not reflective of the provision of services provided to each resident.

1. Action Required:

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

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:

Service Level Agreements are currently under review by SHS Ltd.
New Service Level Provisions will be in place by the end of July 2017.

Proposed Timescale: 31/07/2017

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:

One resident's personal plan was dated 2015 there was no evidence available within the designated centre that this plan had been reviewed annually.

2. Action Required:

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

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

Both the staff team and PIC are in the process of reviewing all clients' personal plans.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

Some reviews of personal plans did not assess the effectiveness of each plan and take into account changes in circumstances and new developments.

3. 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:

PIC will include this item on the agenda of our next staff meeting.

In future, keyworkers will use "Steps towards PP Priority" tab in CID on a monthly basis to provide an update on each residents' goals.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

Some reviews present did not identify resident's participation and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

4. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Our residents do not display any desire to participate in reviews.

We will record correspondence in relation to requests for families or representatives to attend reviews.

Proposed Timescale: 31/05/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The design and lay out of the sitting room and dining area was not sufficient to meet the number and needs of residents.

5. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

Senior management are considering this problem. An action plan will be in place by 31/08/2017.

Proposed Timescale: 31/08/2017

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:

The system in place within the designated centre in relation to risk management required review in relation to individual risk and location risk management.

The inspector found the rationale for classifying incidents within the designated centre unclear.

The inspector was unable to see effective measures in place to control and identify risks and learn from incidents in order to mitigate risks in the future within the designated centre.

6. 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:

Every client has Risk Management Assessments in place.

Any individual Risk Assessments that have a risk rating of 12 or more are brought to the attention of my SSM and included in the Location Risk Register.

Staff report Adverse Event on CID to CSM. They would classify the event as Major or Minor.

Event is reviewed by CSM. Any requests for amendments of form, or need for further clarification are made by CSM.

Any Action Plans or other interventions are noted and implemented by CSM on a date specified on form.

The CSM then signs off the form.

The CSM then sends a 3/12 review of these incidents to his SSM. They are further analysed by her and she may recommend further actions, if necessary.

The Health & Safety Department carry out analysis and trending of Accident/Incident adverse events on CID and report this data to Senior Management Team.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

Adequate hand hygiene facilities were not available within one resident's bedroom where a toilet was located without a hand wash basin.

7. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Maintenance department have assessed the problem.
They will provide a wash hand basin in the resident's bedroom by the end of July 2017

Proposed Timescale: 31/07/2017

Theme: Effective Services

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

Some staff members required fire training and other staff members required refresher training.

8. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Audit carried out on mandatory courses for staff.
Any requirements were identified and staff have been scheduled to attend those courses.

Proposed Timescale: 31/05/2017

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:

Some staff members required training in the management of displays of behaviour including de-escalation and intervention techniques.

9. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Audit carried out on mandatory courses for staff.
Any requirements were identified and staff are scheduled to attend those courses.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

Evidence of alternative measures being considered before a restrictive procedure was used was not evident for all environmental restrictions in place within the designated centre.

10. 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:

We have completed a Rights Restriction Assessment to cover this issue.
We are awaiting the decision of the RRC.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

Staff members were not guided effectively within behavioural support plans to respond consistently to displays of behaviours that challenge as detailed within the main body of this report.

11. 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:

Audit carried out on MAPA training courses for staff.
Any requirements were identified and staff will attend scheduled course.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

The use of chemical restraint was unclear within documents viewed.

The management of environmental restraints were not in accordance with the organisation's policy.

12. 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:

Key worker is working on Positive Behaviour Support Plan.

Our Consultant Psychiatrist will review the timescale to administer chemical restraint when all other measures have been tried.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

Some staff members required training in relation to safeguarding residents and the prevention, detection and response to abuse.

13. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Staff meeting arranged.

One of the items on the agenda will be the correct report reporting procedure in relation to allegations of abuse within the centre.

The inaccurate information that was displayed has been taken down.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

Some staff were unclear on the reporting structure in relation to allegations of abuse within the designated centre.

Information displayed within the designated centre was inaccurate in relation to the current reporting structure for allegations of abuse within the designated centre.

14. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects

the resident's dignity and bodily integrity.

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

Audit carried out on attendance of mandatory courses by staff.

Any requirements were identified and staff were scheduled to attend those courses.

Proposed Timescale: 31/05/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Follow up recommendations and or plans from dietitian were not available staff were using dated documents to implement this aspect of care provision.

Recommendations from a physiotherapy plan, dated 2015 was not fully reflected within the care plan developed for this area no review was available for 2016.

Some of the interventions specified within residents healthcare plans were not completed as identified within the healthcare plan.

15. 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:

Clients Care Plans are in the process of being updated by Key Workers to include all the recommendations made above.

We will ensure that all recommendations made made by AHPs will be incorporated into each resident's care and support plan.

Proposed Timescale: 31/05/2017

Theme: Health and Development

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

Some healthcare conditions were not identified within the assessment despite a support plan in place for the healthcare condition.

Other healthcare conditions were identified within the assessment however, no support plan was present in relation to the specific healthcare needs.

The details contained within some healthcare plans were not sufficiently detailed to ensure staff members could effectively implement the interventions within some of the

care plan viewed.

Healthcare plans contained generic information not relevant to residents.

Some epilepsy plans in place and found these were not detailed enough to guide staff members in effective delivery of care in relation to seizure management.

16. 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:

Clients Care Plans are in the process of being updated by Key Workers to include all the recommendations made above.

Proposed Timescale: 31/05/2017

Outcome 12. Medication Management

Theme: Health and Development

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

No guidance was available in relation to the administration of some PRN medication.

The inspector found staff members were not guided effectively and consistently in the administration of medication for example, when a resident was experiencing pain.

The maximum dosage of PRN medicines was not specified for some of PRN medication viewed.

The administration sheet for some resident's did not identify the G.P (general practitioner) or the resident's date of birth.

The dosage for one medication did not correspond with the product for example, milligrams was specified for a liquid medication.

The inspector observed some medication was stored with other non medicated items within the kitchen, the inspector also viewed a separate medication press located upstairs.

17. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

The maximum dosage of medications have been specified.

All information required on Kardexes has now been populated.

We now have a separate, locked medication press in the downstairs bathroom to store medication, when necessary. Only medication items are stored in this cabinet.

Proposed Timescale: 24/04/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Management systems in place in the designated centre to ensure the service provided is safe, appropriate to residents' needs, consistent and effectively monitored required improvement.

Limited audits were available.

Staff meetings were not completed on a regular bases.

18. 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:

CSM will undertake 3/12 local audits commencing 01/04/2017
House staff meetings will take place every 4 to 6 weeks.

Proposed Timescale: 31/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The assessed needs of residents were not available within the designated centre.

19. 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:

CSM currently reviewing 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.

Proposed Timescale: 30/04/2017

Theme: Responsive Workforce

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

Accurate rota's were not maintained within the designated centre reflecting staff members on duty at any time during the day and night.

20. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

We will maintain a planned and actual rota showing staff on duty at any time during the day and night.

Proposed Timescale: 30/04/2017

Theme: Responsive Workforce

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

Some staff members required mandatory training and refresher training.

21. 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:

Audit carried out of staff training.

Where deficiencies arose, staff were allocated places in next available course.

Proposed Timescale: 30/04/2017

