

**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: | 1 & 2 Sugarloaf |
| Centre ID: | OSV-0001689 |
| 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: | 4 |
| 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: 24 November 2016 09:30 To: 24 November 2016 21:30

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 14: Governance and Management |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this designated centre. An initial inspection in 2015 was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time the designated centre was not found to be in sufficient compliance with the regulations in order for the chief inspector to grant registration. The purpose of this inspection was to follow up on the previous inspection.

How we gathered our evidence:

As part of the inspection, the inspector visited the designated centre, met with four residents and spoke with the deputy manager 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 resident's communicated in their own preferred manner with the inspector. Some residents allowed the inspector to see their bedrooms and to observe their daily life in the designated centre. Other residents provided the inspector with a tour of their home.

Description of the Service:

This designated centre is operated by Sunbeam House Services (SHS) Limited and is based in Bray, County Wicklow. Four residents resided in the designated centre at the time of this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose.

Overall Judgments of our findings:

Ten outcomes were inspected against with five outcomes found to be moderately non-compliant. The governance and management arrangements required significant improvement the inspector was reassured that some of the key issues here, including revised person in charge arrangements and access to finances were addressed promptly. Five outcomes were found substantially compliant.

The deputy manager facilitated the inspection as the person in charge was not on duty.

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):

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

Findings:

The inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection and found one of the two actions had not been addressed in relation to complaints.

The inspector found staff members were not aware of some of the outcomes of complaints, therefore were unable to implement measures required for improvement. This issue was also identified during the previous inspection.

The inspector requested to view complaints within the computerised system however, the staff member facilitating the inspection did not have access to this aspect of the system.

The inspector acknowledged the improvements made to the living space since the previous inspection.

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 reviewed this outcome in relation to the non-compliances identified on the previous inspection and found the two actions had not been addressed in relation personal plans.

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 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' personal plans and all were dated in 2016.

- One resident had an assessment commenced in 15 October 2014 this was not completed until the 07 April 2016 resulting in a 17 month assessment. The inspector found this timeframe to be excessive and not in accordance with the organization's policy. For example, goals were identified and reviews were completed without an assessment fully conducted. The inspector was informed the system required a member of the organizations quality team to sign off on the assessment before the document could be implemented. This system was found to be delaying the implementation of goals and related planning meetings for the resident due to delays in this sign-off process
- personal plans contained goals these included areas such as, going on holidays and meeting friends and family members. These were clearly based on the assessment completed however, other goals set were not based on any assessment and related to basic provision of social care needs. For example, receiving hair cuts without any evidence why this was in place and what progression had been achieved by the resident in relation to this
- some personal plans contained very clear progress of goals set, while other did not and no level of review of the effectiveness of goals set were evident for some residents. For example, it was unclear to the inspector if actions agreed on review had been implemented or the level of progress made in relation to the specified goals. Staff members were also unable to identify progress.

Residents spoken with were familiar with some of the information contained within their plans and some of the goals they were working towards achieving. Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence of this maintained within some resident's files while others contained blank sections in relation to family consultation.

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):

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 three actions had been addressed.

The inspector found suitable storage was available throughout the designated centre in accordance with resident's preferences and in accordance with schedule 6.

The house was in a good state of repair and was clean and suitable decorated on the day of inspection.

However, when the inspector spoke with some residents they expressed they would like to have curtains fitted in their bedroom. The resident asked the inspector to view their bedroom. The inspector identified the dignity of the resident was maintained via a blind however, a curtain pole was present without curtains. The resident identified they did not know why they had not got any curtains yet. The inspector spoke with staff members whom identified curtains were yet to be purchased as they were awaiting confirmation from the person in charge in relation to who paid for these items.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The inspector found the two actions from the previous inspection had been achieved in relation to infection control and fire training. During this inspection, the inspector found improvements were required in the area of risk and fire management.

The designated centre had an organisational risk management policy in place, this included the specific risks identified in regulation 26. The designated centre risk register was currently being review to accurately reflect the number of risks within the designated centre and the controls in place to address these.

The inspector viewed residents individual risk assessments and found some of these required review. The inspector found inconsistencies between information contained within resident's files and risk assessments. This related to supports residents required from staff members and control measures in place. The inspector found the system of risk management in place was not ensuring residents safety nor was this effectively guiding staff members. For example, some areas were risk rated as high risks and when the inspector discussed this with staff members they confirmed these were no longer high risks for specific residents. The inspector also found oversight of risk assessments were not taking place as the person in charge had not reviewed some risk assessments as required by the organizations policy.

The inspector viewed systems in place should a resident leave or not return to the designated centre, however this information required updating as staff members referred to were no longer employed within the designated centre.

The inspector viewed the fire procedure however; this document was currently under review to reflect changes within the designated centre.

The inspector viewed four residents PEEP's (personal emergency evacuation plans) and found contained sufficient information to guide staff members in the event of an emergency.

The inspector viewed fire drills completed within the designated centre. However, records present in the designated centre did not identify if all four residents could safely evacuate the designated centre. Nor was there evidence of learning from fire drills completed within the designated centre.

From a sample of nine staff members training records all staff members had received training in the area of fire, except for one staff member had not attended training since 2004.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company as required by regulations. Annual service was completed in December 2015 and the previous quarterly completed in September 2016.

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):

No actions were required from the previous inspection.

Findings:

The inspector found there were some measures to protect residents from being harmed in place within the designated centre. However, improvements were required in relation to behavioural support plans and the use of restrictive practices.

There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided clear guidance to staff on how to manage any incident of concern arising in the designated centre. The policy provided staff with knowledge on how to recognise abuse and their responsibility in reporting it.

From speaking with some staff members the inspector found they understood their role in protecting residents however, they were unsure of the reporting procedures if they had any concerns. The inspector viewed a copy of the reporting procedure present within the designated centre, this involved staff members no longer employed within the designated centre. This resulted in confusion in relation to the reporting structure.

The inspector found some measures to protect residents from being harmed were in place within the designated centre. However, improvements were required in relation to behavioural support plans and the use of restrictive practices.

There was a policy in place on the use of restrictive practices in the designated centre. The inspector found some restrictive practices in the designated centre were not reviewed, to ensure the least restrictive practice was been implemented. The inspector found some inconsistent information between right restrictions documents and actual

practice within the designated centre. For example, items were identified as locked away within the rights restriction documents however, on the day of inspection these were unlocked. Staff identified these items were no longer required to be locked away. The inspector also viewed evidence of environmental restrictions, however, the plan in place to support this restriction did not correspond with the restriction in place this was discussed with staff members on the day of inspection.

The inspectors viewed a behavioural support plans in place however, the information contained within some of these were not reflective of reviews conducted by members of the multi disciplinary team in relation to supervision in the community.

The inspector viewed incidences involving displays of behaviours that challenge, while these were being recorded no evidences of learning or follow up from incidences were present.

Intimate care plans were in place for residents; however, some of these required updating to reflect current practice within the designated centre in relation to the provision and delivery of care.

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 best possible health. However, improvements were required in the information contained in resident's healthcare plans.

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 four resident's plans. However, some healthcare conditions were not identified. The inspector found interventions were in place for some healthcare condition. However, some of these conditions were not identified within a health assessment. The inspector also found interventions in place for specific healthcare conditions were not taking place as documented with the support plans such as, weight monitoring. The inspector found there was a review system in place for goals set, however, this review did not assess the effectiveness of the interventions in place.

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 staff members and some of these areas were not relevant to residents.

The inspector viewed some epilepsy plans in place and found these were detailed to guide staff members in effective delivery of care. The physical description of the seizure was present in relation to seizure management.

Some residents and staff members spoken with were familiar with some of the healthcare interventions in place and discussed these with the inspector.

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. Residents participated in cooking and or meal preparation in accordance with their own preferences and abilities.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

The inspector found the action from the previous inspection remained outstanding.

The inspector found policies and procedures were in place for the safe management of medications. This related to the administration, transcribing, storage, disposal and transfer of medicines dated 01 September 2016. Medication was recorded when received.

The inspector found staff members were not guided effectively in the administration of some p.r.n medications (medicine only taken as the need arises) for example, when two

or more medications were prescribed for the same purpose. No guidance was available to staff in relation to which medication to administer or if both medications could be administered. Staff members spoken with were unsure if both medications could be administered.

The inspector identified some residents were facilitated to self administer their own medication with support from staff members as required.

The inspector crossed checked the balances of some medication and found these to be accurate.

Staff signatures were present within the signature bank.

The inspector observed all medication was stored in a secure, locked container and the keys to access the medication cabinet were held securely by staff.

There was a system in place for recording, reporting and reviewing medication errors.

Judgment:

Substantially 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):

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

Findings:

The two actions from the previous inspection remained outstanding, in relation to completing an annual review, while this was completed this did not provide for consultation with residents and their representatives. The inspector also found improvements were required within the overall governance and management structure in place within the designated centre as identified on the previous inspection.

The inspector also became aware that no money was present within the designated centre for the previous three days through viewing the finance records within the designated centre. Staff also confirmed this and identified during some other occasions

they had to go to another designated centre to source food items when money was not available or use their own money to ensure resident's needs were met. The inspector requested this to be rectified and the deputy manager provided verbal assurances to the inspector this would be resolved the following morning.

The person in charge was responsible for two designated centres along with a day service. On the day of inspection staff members were not aware if the person in charge was on duty. Staff members proceeded to make a number of telephone calls to various members of management and left voice mails for them. The inspector was informed this was the practice within the designated centre as staff were not aware if the person in charge or the deputy manager were on duty on any day therefore, they would call their mobile numbers. The inspector requested staff to outline the process in the event of an emergency and staff identified they would be the same process. The inspector found this system of management required review in order to be effective for staff members, especially when staff members were at times employed in a lone worker capacity.

The inspector was not able to determine how frequently the person in charge was present in the designated centre nor did the staff rota identify this to other staff members. Staff members and residents confirmed they did not see the person in charge very often within the designated centre as the deputy manager was present more frequently. However, this member of staff was also not present on the rota.

The inspector was informed this person in charge had taken on the role in a temporary capacity and another person had been recruited to commence in the role in a number of weeks.

The inspector did identify there was a clearly defined manage structure in place within the organization and staff members were familiar with these individuals. The inspector viewed minutes of the person in charge attending the senior management team meeting. This was dated 25 October 2016. Areas discussed related to the whole organization including an organizational update, financial update and policy update in relation to the complaints policy.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings). However, these meetings were not available for review within the designated centre.

An annual review of the quality and safety of care in the designated centre was completed, this was dated 01 February 2016. The inspector found this document did not meet with regulations as consultation with residents and their representatives was not evident.

The provider had nominated a person to conduct visits to the designated centre at least once every six months and produce a report. The last unannounced visit was conducted on the 01 October 2016. The action plan for this report was not yet completed. The inspector requested to view the previous report, however, this was not available within the designated centre. This was subsequently provided to the inspector, dated 09 and 10 March 2016 with no action plan developed.

The inspector viewed minutes of staff meetings within the designated centre some of these were held in conjunction with another designated centre. Since July four meeting had been conducted two of these pertained to this designated centre only. The person in charge attended two of the staff meetings. The inspector found lack of clarity in relation to the progress of items discussed at team meetings as some items were not followed through within the minutes. Other areas discussed within meetings were not reflective of current practice within the designated centre. For example, supervision discussed on the 18 July 2016, it was documented that another person in charge of a different designated centre was to continue supervising staff members in this designated centre.

The inspector was informed this had changed and supervision was conducted by the deputy manager of the designated centre however, the person in charge did not have access to these. The inspector found no evidence was evident between this staff member and the person in charge in relation to ensuring effective governance of staff supervision. The inspector therefore, was unable to establish how the person in charge had effective oversight in relation to this process.

The inspector viewed inconsistent guidance provided to staff members between the person in charge and the deputy manager. The inspector discussed this with the deputy manager on the day of inspection. The deputy manager had rectified the issue however, this was not followed through within the minutes of meetings maintained.

The inspector was unable to view any audits conducted by the person in charge within the designated centre for example, in the area of medication management. Therefore, the inspector found improvements were required in the local management systems in place to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment:

Non Compliant - Moderate

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

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 these had been addressed.

During the course of this inspection, the inspector became aware transport was not available for residents with the exception of public transport, some staff spoke of a revised arrangement in relation to this. Other members of staff were very unclear about this and identified taxi's were scheduled to be cancelled. However, this plan had changed without any explanation to staff or residents in relation to what transportation was available within the designated centre. It was unclear to the inspector if the assessed needs of residents were analysed in relation to this proposed plan as staff members from the designated centre would be required to drive residents and leave the 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):

No actions were required from the previous inspection.

Findings:

The inspector was unable to determine if sufficient staff numbers with experience were deployed to meet the assessed needs of the residents within the designated centre. Improvements were also required in relation to the staff rota.

The inspector viewed nine staff members training records, five required training in the area of first aid, as this was a lone working environment at times. Two staff members required refresher training in epilepsy and the administration of rescue medication, one staff member required refresher training in medication administration and people moving and handling. The inspector also viewed evidence where a staff member was present in the designated centre for four months without training in detecting and responding to allegations of abuse.

The inspector viewed the proposed and actual staff rota and found significant improvements were required. The inspector found the rota did not reflect practice within the designated centre. Staff members from this designated centre went to another designated centre for periods when staffing levels were not sufficient in the other designated centre. This was not reflected in the actual rota maintained within the designated centre. Staff names, role, along with hours worked were not reflected within the rota.

The inspector became aware of inconsistent information in relation to the provision of intimate care for one resident in relation to gender preference. From the rota present this was not facilitated to the resident. The deputy manager identified this was not a requirement, however, front line staff members identified it was and some refused to provide that aspect of care provision.

Staff files were not reviewed as part of this inspection as these are held within the organizations head office off-site these were reviewed as part of the previous inspection.

There were no volunteers within the designated centre.

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:

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

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|----------------------------|--|
| Centre name: | A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee |
| Centre ID: | OSV-0001689 |
| Date of Inspection: | 24 November 2016 |
| Date of response: | 02 March 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Staff did not have access to the information from which to implement any measures required for improvement in response to a complaint.

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 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

The outcome of complaints and any learning identified will be discussed at staff team meetings. Complaints will be a standing item on team meetings to encourage discussion and awareness amongst the staff team.

Proposed Timescale: 06/03/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

Some residents did not have interventions in place to meet their assessment needs.

2. 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:

A review of all resident assessed needs will be completed.

On foot of this review, appropriate interventions will be designed to meet all residents identified needs.

Proposed Timescale: 30/04/2017

Theme: Effective Services

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

Some assessments were not completed in a timely manner for example, 17 months to complete one resident's assessment.

3. Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

A review of current assessments will be conducted.

Any current assessments that are not finalised will be completed in a timely manner.

All future assessments will be completed in a timely manner.

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

Some residents personal plan did not reflect the assessed needs of residents.

4. Action Required:

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

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

A review of all personal plans will be conducted.

All personal plans will be updated to reflect the assessed needs of the residents.

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

Some residents person plan reviews did not assess the effectiveness of each goal set and take into account changes in circumstances and new developments.

5. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

All future personal plan reviews will assess the effectiveness of each goal.

Changes to circumstances and new developments will be identified and considered.

This will all be clearly recorded in the personal plan review notes.

Proposed Timescale: 30/04/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Lack of curtains in one bedroom and clarity in relation to who was responsible for the purchase of curtains.

6. Action Required:

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

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

Curtains that reflect the choice of the individual resident concerned will be purchased and hung in the resident's bedroom.

Proposed Timescale: 31/03/2017

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 for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review to ensure this accurately reflected practice within the designated centre.

7. 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:

A comprehensive review of how risks are assessed, managed and reviewed will be conducted. This will include individual risks & location risks. A protocol for responding to emergencies will be drawn up. This will be outlined at a staff team meeting to ensure all staff are aware of the process.

Individual Risk assessments will be completed by keyworkers, the PIC and in collaboration with residents and/or their representatives

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

Adequate arrangements for evacuating all residents in the designated centre and evidence of learning from fire drills completed were not evident within the designated

centre.

8. Action Required:

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

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

A review of all residents Peeps will be undertaken with Keyworkers and the PIC. Any deficits identified will be rectified. Any changes will be communicated to the team via e-mail and a staff meeting.

Learning from evacuation will be discussed at team meetings.

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

One staff member had not received training in the area of fire since 2004.

9. 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:

A comprehensive review of the staff training needs has been conducted.

A training needs analysis has been devised, which highlights training deficits & upcoming training needs. Any training identified has been booked and staff are scheduled for ongoing refresher training.

Proposed Timescale: 06/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The use of restrictive practice required review to ensure the least restrictive intervention was utilised and the organizations policy in relation to restrictions was implemented.

10. 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:

All restrictions in the location will be reviewed in line with the organisational policy.

Any restrictions deemed necessary will clearly identify their rational and will outline how they are the least restrictive option available.

Proposed Timescale: 31/03/2017

Theme: Safe Services

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

Some support plans in place did not effectively and consistently guide staff to respond to displays of behaviour that challenge as inconsistent information was evident between documents available within residents files.

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:

A review of all support plans will be conducted to identify any inconsistencies. Any inconsistent information will be updated to ensure staff are guided effectively to manage behaviours.

Proposed Timescale: 30/04/2017

Theme: Safe Services

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

Staff were unsure of the reporting structure should an allegation of abuse arise and the information available within the designated centre contained individuals no longer working within the organization.

12. Action Required:

Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

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

All information relating to the reporting of abuse within the designated centre, will be update to reflect the current reporting structures and personnel.
The process for reporting abuse will be explained at the next team meeting.
Safeguarding & Protection will remain as standing item on all team meeting agenda's.

Proposed Timescale: 06/03/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Healthcare plans contained generic information not relevant to some residents

Some healthcare conditions were not identified within healthcare plans

Some healthcare interventions were not taking place

Some reviews did not access the effectiveness of the healthcare interventions in place.

13. 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:

All healthcare plans will be reviewed and the following actions will be completed;

1. any generic information not relating to the specific resident will be removed.
2. All healthcare conditions relating to the resident will be outline in their healthcare plan.
3. All relevant healthcare interventions will be implemented
4. All future reviews of healthcare plans will access the effectiveness of the healthcare interventions in place. This will be clearly documented in the review notes.

Proposed Timescale: 30/04/2017

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 to staff in relation to which medication to administer if a resident was prescribed two or more medications for the same indication or if both medications could be administered. Staff members spoken with were unsure if both medications could be administered.

14. 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:

All resident prescription sheets will be reviewed. All PRN medication protocols will be updated to clearly indicate their usage.

Staff will be advised of these protocols at a staff team meeting

Proposed Timescale: 31/03/2017

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:

The inspector found the person in charge was in charge of more than one designated centre and was unable to ensure effective governance, operational management and administration of the designated centres concerned.

15. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The person in charge at the time of this inspection was only as an Acting Role, there is now a full time permanent Person in Charge of this location. Further changes to downsize the cluster have also been made and should be completed by end of March as interviews will be held on 16th Feb 2017.

Proposed Timescale: 31/03/2017

Theme: Leadership, Governance and Management

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

The arrangement in place to support, develop and performance manage all members of the workforce required improvement to ensure the person in charge was aware of staff members reviews in relation to the quality and safety of the service they delivered.

16. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

A supervision schedule will be devised to provide support to staff at regular periods, in line with the organisational policy. This supervision will be conducted by the Person In Charge

Proposed Timescale: 06/03/2017**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The annual review of the quality and safety of care and support in the designated centre did not provide for consultation with residents and their representatives.

17. Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

The 2016 annual review of quality and safety will clearly demonstrate how residents and their representatives were consulted with

Proposed Timescale: 30/04/2017**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The management systems in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. For example, lack of finance available to staff and residents to effectively operate the service, lack of an effective on call system and lack of follow up on the limited audits available within the designated centre.

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:

Management systems within the designated centre have been reviewed by the new permanent PIC.

Arrangements are now in place to ensure an appropriate amount of finances is available on a weekly basis to operate the service.

Organisationally there is a on call system, if the PIC or Deputy are unavailable staff can call any member of the senior management team. This system will be reiterated at the next staff meeting

All future audits will be actioned by the PIC.

Proposed Timescale: 06/03/2017

Outcome 16: Use of Resources

Theme: Use of Resources

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

Lack of clarity in relation to the provision of transport for residents.

19. Action Required:

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

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

The location now has access to a car when the residents are at home. This is used to support resident to appointments and their day service.

If the car is unavailable and transport is required, the use of Taxi's is authorised. Additionally, some staff are indemnified and are insured to drive clients in their own cars.

Proposed Timescale: 02/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The actual and planned rota within the designated centre was not accurate.

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:

Planned and actual rosters are now kept in the Designated Centre.

Proposed Timescale: 06/03/2017

Theme: Responsive Workforce

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

The number of appropriate staff members to meet the assessed needs of residents was not evident as staff members were required to support residents in other locations on some occasions this was not reflected within the rota.

21. 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:

An appropriate number of experienced staff will be allocated to the location to meet the assessed needs of residents.

This will be clearly noted on the planned rota. Should changes occur to the planned rota they will be clearly identifiable on the actual rota.

Proposed Timescale: 06/03/2017

Theme: Responsive Workforce

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

Some staff required training while other required refresher training in the area of fire, first aid, medication, people moving and handling and epilepsy.

22. 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:

A comprehensive review of the staff training needs has been conducted.

A training needs analysis has been devised, which highlights training deficits & upcoming training needs. Any training identified has been booked and staff are scheduled for ongoing refresher training.

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| Proposed Timescale: 06/03/2017 |