

**Health Information and Quality Authority  
Regulation Directorate**

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



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| <b>Centre name:</b>                                   | Dunavon                                |
| <b>Centre ID:</b>                                     | OSV-0001707                            |
| <b>Centre county:</b>                                 | Wicklow                                |
| <b>Type of centre:</b>                                | Health Act 2004 Section 38 Arrangement |
| <b>Registered provider:</b>                           | Sunbeam House Services Limited         |
| <b>Provider Nominee:</b>                              | John Hannigan                          |
| <b>Lead inspector:</b>                                | Karina O'Sullivan                      |
| <b>Support inspector(s):</b>                          | None                                   |
| <b>Type of inspection</b>                             | Unannounced                            |
| <b>Number of residents on the date of inspection:</b> | 8                                      |
| <b>Number of vacancies on the date of inspection:</b> | 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 inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 20 October 2016 10:30 To: 20 October 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 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   |

**Summary of findings from this inspection**

Background to the inspection:

This was the second inspection of this designated centre. This inspection was to monitor ongoing 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 eight residents and spoke with the person in charge and six staff member. 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 Rathdrum County Wicklow. Eight 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 inspector found the service provided was in line with the statement of purpose. The designated centre aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities and complex medical issues as outlined in the statement of purpose.

The designated centre was a large two story house located close to a village. There was eight bedrooms in use with seven located on the ground floor and one was located on the first floor.

Overall Judgments of our findings:

Ten outcomes were inspected against and eight outcomes were found to be moderately non-compliant. Two outcomes were found to be substantially compliant. Areas of improvement included, social care needs, information contained within residents' files, the maintenance of the premises and staff training and supervision.

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):**

No actions were required from the previous inspection.

**Findings:**

Some aspects of care operating in the designated centre were found to be impacting upon the privacy and dignity of residents. For example, staff conducted 15 minutes checks on residents throughout the night. This practice involved staff entering residents' bedrooms. No assessment of need was available to identify the need for this practice. The rationale provided for this practice was based on historical practices within the designated centre.

No other component of this outcome was inspected against during this inspection.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

Residents had written agreements in place within their files these included a service level agreement and a tenancy agreement. Two of these were unsigned by residents or their representatives.

Additional fees charged to some residents were not clearly identified as the tenancy agreement. The document 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.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector found the wellbeing and welfare for residents required improvement in a number of areas within residents' plans. This included, evidence of participation in activities, the detail contained within plans, evidence of implementation and in the review of 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, 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 five residents' personal plans and identified the following issues with these plans:

- some assessments were not completed to inform the development of a personal plan. For example, one assessment was half completed despite, a personal plan present and

dated 2016. Another personal plan was completed, however, this was not completed in accordance with the assessment

- some personal plans were not completed on an annual basis. The inspector viewed personal plans dated 2014 and 2016, there was no plan dated 2015. Another plan viewed was dated 2015 with a handwritten date of 2016. A copy of the plan dated 2015 was unavailable

- some goals set were very general such as, a goal of moving to a smaller location. This was ongoing for a number of years with no level of progression identified. Other goals related to day service provision. However, there was no evidence of collaboration with the day service in relation to this goal

- the monitoring to assess the effectiveness of the implementation of the areas identified in residents' personal plans was not evident

- activities logs were maintained for each resident however, records were not documented consistently. For example, 10 days were blank within a sample viewed. The inspector asked why activities were not documented and staff identified this was due to the designated centre being short staffed. A sample of these dates were crossed referenced with the completed rota and the inspector found staffing levels were provided in accordance with the statement of purpose on these dates. Therefore, there was no evidence to support the opinion that activities had not taken place due to reduced staffing levels. On the day of inspection there were five staff members and six residents as two residents had attended day services. However, only one resident was taken out of the designated centre for a walk during the day. Two residents did go to the cinema in the evening time accompanied by two staff members. Staff members outlined this was an exceptional occurrence to have five staff members on in the evening time. However, the actual rota's identified five staff members were on duty on a number of occasions.

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence of this within the resident's files.

**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):**

No actions were required from the previous inspection.

**Findings:**

During the course of the inspection, the inspector found areas of improvement were required in relation to the premises, these included the following:

One room upstairs had damp marks on the ceiling with paint work flaking, staff confirmed this was the result of a leak.

The toilets and bathrooms upstairs required repair as tiles were missing and timber panels required attention.

A number of radiations required repair as rust was evident.

Floor covering outside one toilet and within a resident's bedroom downstairs required repair as this was lifting and uneven in places.

Water marks were evident under the window in the sitting room on the ground floor.

**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 suitable and safe for the number and needs of residents. Improvements were required in the area of infection prevention and control and sharp management.

Sharps were used within the designated centre and the inspector requested to see documentation in relation to the management and disposal of sharps. This was not available. The sharps box had no label or tagging system in place. The inspector also viewed evidence of infection control and prevention practices were not adhered to. Plastic urinal bottles were located on the floor of one toilet and another within the handwash basin in the same toilet. The inspector also observed a container filled with used disposable plastic gloves and other waste items. These items were not contained within a bin or plastic bag despite a bin located in the area. The inspector found this



practice not in adherence with evidence based practice in the prevention of infection and the spread airborne microorganisms.

The designated centre had a health and safety statement dated August 2013. This document required updating. The responsibilities of the various staff members within the organization was 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. The plan did not identify overnight accommodation to be provided in the case residents could not return to the designated centre.

The designated centre had an organisational risk management policy in place this included the specific risks identified in regulation 26. The designated centre had a risk register, this recorded a number of risks within the house and the controls in place to address these. There were individual risk assessments for residents in place these included, self-harm and choking and aspiration the person in charge had reviewed and signed these off.

The inspector asked to view fire drills, these were not present within the designated centre and staff subsequently provided these to the inspector following inspection. There was no issues identified with all residents evacuating the designated centre safely.

The inspector viewed six residents PEEPs (personal emergency evacuation plans) and found these contained up-to-date information.

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.

The inspector viewed evidence of beds and air mattress being serviced along with hoists within the designated centre. On the day of inspection the wheelchair lift on the bus was serviced.

Staff members also had up-to-date training in manual handling with four staff members requiring first aid training. The person in charge identified these individuals would not be working together or in a lone worker capacity with residents until training was completed.

**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):**

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

**Findings:**

The inspector found appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans and guidance on the use of restrictive practices.

Positive behaviour support plans were in place. However, information within these plans were unclear and therefore, did not effectively guide practice. Issues identified included:

- restrictive practice intervention was ticked as both required and not required, the inspector found this did not guide effective and consistent practice
- the type of restrictive intervention to be used was not always documented
- environmental restrictions in the form of locking internal doors was in place. The inspector was unable to view duration and frequency of this intervention being implemented as no log was maintained. This was not in accordance with evidence based practice nor with SHS restrictive practices policy dated 07 October 2016. The inspector did view an incident form dated 12 November 2015 however, this did not specify how long the intervention was implemented.

Three staff members required training in behaviour management.

Intimate care plans were in place however, some of the plans were not reviewed annually for example, some were dated July 2015. These were completed by support workers and nursing staff completed care plans in the area of intimate care also. The inspector found this practice of duplication of documentation could potentially lead to inconsistent care delivery.

There was a policy in place on the prevention, detection and response to abuse. Staff members spoken with by the inspector were knowledgeable in relation to the management of an allegation of abuse. Staff members could outline the procedures to be followed should such an allegation arise.

**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. Improvements were required in the information contained in resident's healthcare plans and in the implementation of recommendations from allied health professionals.

The healthcare needs of residents were completed via a plan called 'my health and wellbeing plan'. These were completed by support workers and nursing staff members completed care plans in relation to areas identified. The inspector found improvements were required in healthcare plans. The inspector viewed five residents' plans and identified the following issues with these plans:

- some health and wellbeing plans were not reviewed annually for example, one was dated 28 April 2015

- some healthcare areas identified within the health and wellbeing plan did not have a care plan developed. Other care plans were not related to areas identified within the health and wellbeing plan

- some healthcare goals were not reviewed annually for example, 'vision' was dated 05 May 2013. Another care plan viewed identified a community intervention nurse came to the designated to change supra pubic catheter. However, the inspector was informed this was no longer current information. Staff members within the designated had received training in this area of care provision in order to provide a more person-centred approach to care

- the monitoring and implementation required to assess the effectiveness in treatment and deterioration in the areas identified in residents' plans were not evident

- staff identified both groups of staff complete different aspects of plans. The inspector was unable to identify collaboration between the nursing staff and support staff. This led to duplication of aspects of documentation.

The inspector viewed plans in relation to the management of seizures. The inspector found these plans did not contain information on oxygen therapy as prescribed.

Residents had access to allied healthcare professionals, the inspector viewed evidence of this including, psychiatrist and physiotherapist. However, some recommendations remained outstanding for example, one dimmer light switch was recommended in 2014

following a psychological assessment for sensory stimulation. This remained outstanding on the day of inspection.

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 their medication.

The inspector found residents received food at mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices.

Residents requiring modification to the texture of their food was clearly outlined in the residents file. Staff members were knowledgeable in relation to the implementation of resident's food requirements including the cook who was employed within the designated centre. On the day of inspection this member of staff had also baked bread and cakes for the residents using apples from the garden. The inspector viewed feeding, eating, drinking and swallowing (F.E.D.S) assessments in place for some residents.

The inspector viewed user-friendly menu selections for refreshments and snacks available for the residents within the designated centre outside mealtimes.

**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 policies and procedures were in place for the safe management of medications. Improvements were required in relation to the management of p.r.n. (a medicine only taken as the need arises) medication within the designated centre.

The inspector found the process around the administration of p.r.n. medication was unclear, for example no guidance was available for staff in relation to the administration process for this medication. In some instances the rational for use was not documented within the administration sheet, for example, oxygen. The inspector also found the administration of psychotropic p.r.n. medication was not clearly defined and could be open to interpretation from the staff member administering this medication.

The designated centre had written policies and procedures related to the administration,

transcribing, storage, disposal and transfer of medicines dated 01 September 2016. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received.

Administration sheets were in place for each resident, a number of these were viewed by the inspector. These were found to be up-to-date and showed staff administered and signed for medication. Some residents required crushed medication, this was clearly prescribed and guidance was available in relation to the administration of medication via percutaneous endoscopic gastrostomy (p.e.g.). Some residents were also aware of this process themselves.

Schedule controlled drugs were also in place within the designated centre, the management of these were in accordance to the organizations policy. The inspector viewed records of these being counted and signed off by two nursing staff members.

A bank of staff signatures was present within each resident's administration record.

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

There was a system in place for recording, reporting errors and reviewing medication. The person in charge presented some of these to the inspector. Clear learning was evident in relation to the errors within the designated centre in order to mitigate future risk of reoccurrence.

The inspector crossed checked the balances of some medication and found these to be accurate including p.r.n. (a medicine only taken as the need arises) medication stock.

Three support staff required medication training however, medication within this location was administered by nursing staff unless residents were on outings. The person in charge identified these two staff members would not engage in medication administration until training is completed.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall, the inspector found there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision and quality of the service delivered. Improvements were required in the area of auditing and staff supervision.

A sample of staff supervision records were viewed, these were not completed regularly as these were dated October 2015. The person in charge identified they had 69 staff members between the three locations. Therefore, it was not feasible to complete regular staff supervision. The inspector also viewed evidence of the person in charge identifying this issue to their senior service manager.

The inspector observed some audits within the designated centre these included housekeeping audits dated 05 September 2016, bedroom audits dated 12 September 2016. However, medication management was not audited since 2013.

There was an annual review of the quality and care completed in this designated centre dated September 2015.

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 the 15 and 16 March 2016 and another one was completed on the 20 September 2016.

The inspector viewed minutes of the person in charge attending the senior management team meeting. These were dated 26 April 2016 with two other meetings taking place on the 26 July 2016 and the 28 June 2016. Areas discussed related to the whole organization including training, budgets and safeguarding and protection.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings) dated 17 June 2016. Issues related to transport, volunteers, complaints, incidents and documentation were discussed during this meeting.

The inspector viewed minutes of staff meetings within the designated centre dated the 23 May 2016 and the 20 June 2016. Areas discussed included policies relating to the designated centre. The roles and responsibilities staff members had in relation to various policies such as, safeguarding were outlined. Health and safety issues were also discussed with outcomes of audits and other information relevant to the designated centre.

The inspector found there was a clearly defined management structure with lines of authority and accountability identified. The designated centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service. The person in charge facilitated this

inspection. From speaking with the person in charge at length over the course of the inspection it was evident they had an in-depth knowledge of the individual needs and support requirements of each resident. Staff members spoken with highlighted how approachable and supportive this member of staff was. 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 all residents knew the person in charge and were very comfortable interacting with them. The person in charge worked on a full time basis between this designated centre and two other designated centres.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

The inspector found there were sufficient staff numbers with experience deployed to meet the assessed needs of the residents. Improvements were required in relation to staff training and the organisation of staffing resources.

From a sample of 22 staff training records reviewed, eleven staff members required refresher training in epilepsy and the administration of rescue medication and five staff members required full training. Three staff members training in behaviour management and four staff members required first aid training.

The inspector found there was adequate staffing supports to meet the assessed needs of residents. However, the staffing levels were not adequately organised around the needs of the residents. For example, from 21:00hrs three members of staff were present until 22:30hrs when the number reduced to two members of staff. On the day of inspection all residents were in bed at 21:30hrs with the exception of one resident. The inspector was unable to identify the need for two awake staff members within this designated centre as no assessment of need in relation to 24 hour care was available nor was their evidence of residents sleep pattern being disturbed.

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 report<sup>1</sup>

|                            |   |
|----------------------------|---|
| <b>Centre name:</b>        | A designated centre for people with disabilities operated by Sunbeam House Services Limited |
| <b>Centre ID:</b>          | OSV-0001707   |
| <b>Date of Inspection:</b> | 20 October 2016   |
| <b>Date of response:</b>   |   |

### 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:**

Resident's privacy and dignity were not being respected in relation to the practice of staff entering bedrooms during the night without an evidence base for this intervention.

#### 1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

An assessment of needs and risk assessment to be carried out on the sleeping pattern of each client to determine what are the needs of these clients during the hours of 21.00 hrs. to 08.00 hrs. To review these needs on a six-monthly basis and sooner if the client's needs should change.

**Proposed Timescale:** 11/12/2016

**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:**

Written agreements in place did not outline all of the fees charged to residents.

**2. Action Required:**

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

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

New Tenancy Agreements to be drawn up to meet the requirements of the new long stay contributions and the necessary amendments as highlighted in this report will be included in the new Tenancy Agreements.

The Service Level Provision of each client to be reviewed to ensure accuracy.

Proposed Timescale: 30th June, 2017 and 11th December, 2016 respectively

**Proposed Timescale:** 30/06/2017

**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:**

Comprehensive assessments of social care needs for some residents was not conducted at least on an annual basis.

**3. Action Required:**

Under Regulation 05 (1) (b) 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC will hold a meeting with each keyworker in this location before the end of December, 2016 to highlight the importance of updating and keeping up to date the goals and Personal Plans of the residents of this location. The importance of consultation with family members, day service staff and any persons involved in the lives of the clients will be highlighted. The PIC will highlight the importance of having realistic and achievable goals for the clients in order to improve their quality of life. The new PIC will then meet with the Keyworkers before the end of January, 2017 to ensure that the above is being achieved.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Some personal plan reviews did not assess the effectiveness of the plan.

**4. 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:**

The PIC when meeting with the keyworkers in December, 2016 will highlight the importance of completing assessments fully and on a yearly basis. It will also be highlighted that if a review takes place that the personal plan must be updated to highlight changes and clearly recorded.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Some residents' personal plans were not reviewed annually.

**5. 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:**

The PIC will meet with all keyworker staff in December, 2016 and the new PIC will meet

with all staff on a regular basis to ensure that all clients personal plans are updated annually or when required.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Limited evidence of collaboration with multidisciplinary team members was evident. Some plans identified day services however, no evidence of consultation with day service staff was evident.

**6. Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The PIC when meeting with keyworkers in December, 2016 will highlight to them the importance of Multidisciplinary team members contribution to the personal plan of the clients. The PIC will discuss the importance of information being obtained from client's families, day service staff, nursing staff, physio, SALT etc. The new PIC to ensure that this is followed through on.

**Proposed Timescale:** 31/01/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

One room upstairs had damp marks on the ceiling with paint work flaking.

The toilets and bathrooms upstairs required repair as tiles were missing and timber panels required attention.

A number of radiations required repair upstairs and down stairs as rust was evident.

Floor covering outside one toilet and within one resident's bedroom down stairs required repair as this was lifting and uneven in places.

Water marks were evident under the window in the sitting room on the ground floor.

A number of blinds required replacing.

**7. Action Required:**

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

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

Following consultation with the PIC and the Maintenance manager this work will be completed by February, 2017.

A quote has been received and new blinds will be replaced in December, 2016

Proposed Timescale: 28th February, 2017 and 11th December, 2016 respectively.

**Proposed Timescale:** 28/02/2017

**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 health and safety statement required updating with the inclusion of the overnight accommodation to be provided. In the event residents could not return to the designated centre.

**8. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

The PIC has met with the Health and safety officer and the safety statement is being reviewed and will be updated shortly.

The PIC has contacted SCRL who dispose of the clinical waste and sharps and a tagging system will be in place shortly and a recording system set up.

The issue of infection control and prevention practices relation to urinals and waste items in the bathroom will be discussed with the staff team at a Team meeting on December 2016. A checklist will be introduced and staff will be delegated to ensure that the bathrooms/showers are cleaned every morning, afternoon and evening.

**Proposed Timescale:** 11/12/2016

**Theme:** Effective Services

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

Improvements were required in relation to procedures and practices to ensure prevention and control of healthcare associated infections.

**9. 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:**

The PIC will put in place a system whereby a staff is accountable for the cleaning, disposal and disinfecting of the bathrooms/shower room daily. A checklist will also be placed in the bathrooms/shower rooms for staff to tick that they have completed this task every morning, afternoon and evening.

At the staff team meeting in December, 2016 the discussion of Infection Control Guidelines will be discussed to ensure that staff are aware and kept updated on this policy

**Proposed Timescale:** 11/12/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Documentation for recording the use and duration of environmental restraint was not maintained within the designated centre.

The use of chemical restraint was not clearly outlined within residents' files.

**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:**

The keyworker in question have been requested to review/rewrite the Behavioural Support Plan. Once completed they will be discussed in detail with the staff team on 5th December, 2016 at the staff team meeting. The PIC will discuss this plan with the Psychiatrist once rewritten, checked by the PIC and discussed at the staff team meeting.

A recording system will be in place to monitor this client on a continuous basis if the need should arise for the doors to be locked again. A chart has been drawn up that the staff member who is monitoring this client must sign and comment every five minutes whilst this client is being supported in a room with the door locked.

**Proposed Timescale:** 31/12/2016

**Theme:** Safe Services

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

Some behaviour support plans did not contain up-to-date information in relation to responding to displays of behaviours in order for staff to effectively and consistently support residents.

**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:**

Two of the three staff members requiring training have now completed this course. The third staff is booked for the course on the 15th and 16th February, 2017.

Proposed Timescale: 31st December, 2016 and 16th February, 2017 respectively.

**Proposed Timescale:** 16/02/2017

**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:**

Some recommendations for residents were not implemented such as, the use of a dimmer light switch for sensory stimulation.

**12. 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:**

Following consultation with the Maintenance Manager this work with the dimmer switch will be completed in early 2017.

**Proposed Timescale:** 28/02/2017

**Theme:** Health and Development

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

Some health and wellbeing plans were not reviewed annually.

Some healthcare areas identified did not have a care plan developed.

Some care plans were not related the healthcare assessment.

Some healthcare goals were not reviewed annually.

The monitoring and implementation required to assess the effectiveness in treatment and deterioration in the areas identified in residents' plans were not evident.

**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:**

The PIC will meet with all Keyworkers and Key nurses in December, 2016 and same will be discussed at the staff team meeting on 5th December, 2016. It will be highlighted to all staff that the Health and Wellbeing Plans and Care plans must be reviewed annually or if the need should change earlier. Both these documents must complement each other and thus both staff must work together to ensure the information is correct in both documents. When reviewed, the new PIC will meet with the key staff to ensure that care plans and health and wellbeing plans are accurate. The Keyworker and Key Nurse must also work together to ensure that all aspects of care are included in these plans and that duplication is no longer acceptable but team work to ensure consistency.

**Proposed Timescale:** 31/12/2016

**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:**

Some p.r.n. medication administration sheets did not have the purpose of the medication identified.

The process for administration of some p.r.n. medication was also unclear as no guidance was available for staff members.

**14. Action Required:**

Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

All Kardex will be reviewed and the purpose of prn medication to be clearly identified. On a weekly basis night staff will be allocated to check that all drugs delivered are correctly labelled, that expiry dates are clearly marked, that creams, liquids and syrup medication is clearly marked when opened, that all Kardex are properly signed. This



check list will be signed and dated by staff each week.  
Staff that are awaiting training in medication management will be offered courses in 2017.

Proposed Timescale: 11th December, 2016 and 30th April, 2017 respectively.

**Proposed Timescale:** 30/04/2017

#### **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:**

Effective regular 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 care delivery was not evident.

**15. 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:**

The new PIC will set up a system of Supervision with the staff in this location and manage this on a quarterly basis.

**Proposed Timescale:** 31/05/2017

**Theme:** Leadership, Governance and Management

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

The medication management systems in place in the designated centre required improvement as an auditing system was not in place.

**16. 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:**

An audit was completed by the Pharmacy on the 1st December, 2015. This audit report was stored in the medication drawer in the Nurse's office.

An internal auditing system will be put in place whereby night staff will complete a weekly check on the medication cabinet to check dates, labelling, signing of Kardex.

The drugs are delivered on a weekly basis to this location and drug stock are checked on a weekly basis and any error recorded. This will remain in place as an auditing tool for the drugs.

**Proposed Timescale:** 11/12/2016

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Staffing resources were not adequately linked to the assessed needs of residents.

**17. 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:**

A workforce planning review is currently underway in this Designated Centre to ensure that staff resources are linked more effectively to the assessed needs of the residents. The review will be completed by the 9th December, 2016 and discussions will commence thereafter with the staff team to implement the proposed finding of the review.

**Proposed Timescale:** 28/02/2017

**Theme:** Responsive Workforce

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

Staff members required training in behavioural management, first aid, epilepsy and the administration of rescue medication and the medication management.

**18. 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:**

All staff that require training in the courses mentioned above will be offered courses in 2017. Behavioural management February, 2017, First Aid February, 2017, Epilepsy, Rescue medication and medications management during February – April, 2017.

