

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	15 Abbey Manor
Centre ID:	OSV-0001710
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 39 Assistance
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:	7
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: 07 December 2016 11:00 To: 07 December 2016 20:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was the third inspection of this designated centre. This inspection was conducted following an application from the Provider to vary their registration conditions. The designated centre was previously inspected in July 2014 and was found to be complaint across 14 of the 18 outcomes inspected against. The designated centre was registered for occupancy of nine residents and the provider had now applied to reduce this number to seven.

How we gathered our evidence:

As part of the inspection, the inspector visited the designated centre, met with four residents and spoke with the person in charge and one staff member. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs and 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. The inspector spoke with four residents, each resident allowed the inspector to view their bedroom, some of these were currently being redecorated. Residents also showed the inspector a room previously used as a bedroom, this had been redecorated. This room now facilitated residents to engage

in their hobbies with a computer and other activity items present. One resident stated "I love living here and relaxing in this room, this is our new room".

Description of the Service:

This designated centre is operated by Sunbeam House Services (SHS) Limited and is based in Arklow County Wicklow. Seven residents resided in the designated centre at the time of this inspection. Four residents in one house and three residents in a second house located next door to each other. 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 not in line with the statement of purpose. This is discussed under outcome 13.

Overall Judgments of our findings:

Nine outcomes were inspected against and one outcome, governance and management, was found to be in major non-compliance. The inspector found the provider had not put adequate arrangements in place. There was a lack of effective governance and management systems within the designated centre. Seven outcomes were found to be moderately non-compliant. One outcome was found to be substantially compliant.

The person in charge facilitated the inspection.

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

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

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

Outcome 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):

No actions were required from the previous inspection.

Findings:

Residents had written agreements in place including a service level agreement and a tenancy agreement.

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

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The inspector found some of the social care needs of each resident were being supported and facilitated in the designated centre. However, some residents' plans were not reflective of practice and some residents did not have plans completed in 2016.

However, the inspector viewed several examples of person-centred care provision. This included facilitating a resident to visit their family members abroad, attend sporting events and going on overnight hotel breaks. On the day before this inspection a resident took a family member out to dinner and staff members assisted in the organisation of this. On the day of inspection residents put up the Christmas decorations and were planning their Christmas party in the house where staff members attend along with their family and also residents family members and friends.

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 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. For example, one assessment was commenced in August 2014 and completed in May 2016. The inspector found this 21 months process to be excessive and unproductive for the resident.

The inspector viewed seven residents' personal plans some of these were dated in 2015.

Personal plans contained goals these included areas such as, holidays, community activities including hobbies of interests such as trains. Some of these goals contained clear levels of progress however, others did not.

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 the resident's files.

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 risk, fire 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 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. The inspector identified this document required updating for example, the water temperature was unregulated. The inspector brought this to the attention of the person in charge on the day of inspection.

The inspector also viewed individual resident's risk assessments in place however, some of these did not correspond with other information contained within residents' plans. For example, the procedure to be implemented when a resident engages in a social activity was not reflective of the control measures in place. The inspector found these documents did not guide staff effectively or consistently in the provision of safe care delivery.

The inspector viewed fire drills, taking place within the two houses. However, within the house not staffed full time no evidence was available if residents were able to evacuate by themselves. Six of the eight fire drills completed within the house required one resident to be assisted. The person in charge identified a fire drill would be completed without the aid of staff to ensure residents were able to safely evacuate the designated centre.

The designated centre had a health and safety statement this was currently under review to reflect a lone working environment and other changes within the designated centre.

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

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 appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans.

Behaviour support plans were in place. However, information within these plans were unclear and therefore, did not effectively guide practice. Within one file, one version of the plan was available however, another version was being updated this was also present within the designated centre. The inspector found this practice did not guide staff consistently in the management of displays of behaviours.

Another behaviour support plan contained two dates. Page one was dated the 15 July 2015 and page 10 was dated 02 February 2016. It was unclear to the inspector how current this document was, staff members were unable to confirm if this plan was completed in 2015 or 2016. Further inconsistencies were identified within the review section of the document dated 03 February 2016. The inspector queried why a review would take place one day after the plan was developed however, staff were unable to provide a rationale for this practice. The inspector also found the review of the plan required significant improvement as the review process documented the following information "did not have a formal meeting" this was followed by a list of frontline staff members whom were telephoned in relation to the review of the behavioural plan. The inspector found this document and the process of review required attention to ensure residents and staff members were effectively and consistently supported and guided in the management of displays of behaviours.

From the sample of eight staff member's training records viewed one staff member required training in the management of displays of behaviour.

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. The designated officer for this designated centre had changed however, this was not reflected within documentation available within the designated centre.

Intimate care plans were in place for residents as required.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

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

The healthcare needs of residents were completed via a plan entitled 'my health development plan'. From this a care plan and/or support plan was developed. The inspector viewed seven resident's plans. However, some healthcare conditions were not identified. There were also no interventions in place within plans for some identified healthcare conditions.

Support plans and care plans within some residents' healthcare plans were not based on any assessed needs, and some were no longer relevant. For example, a wound management plan remained active in file however, the wound had healed. Other support plans were not reflective of current practice for example a plan in place to support gastrointestinal issues was dated February 2014 and reviewed in September 2016. No changes were identified within the information in the plan. The inspector discussed this with the person in charge and identified this plan was not reflective of current practice within the designated centre.

The inspector viewed plans in relation to epilepsy management. The inspector identified staff were not guided in relation to the identification of the type of seizures and the management of seizures from the plans viewed.

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 residents themselves. The inspector discussed this with the person in charge and some of these areas were not relevant to residents.

Residents had access to allied healthcare professionals, the inspector viewed evidence of this including physiotherapy and dentist. However, the inspector viewed recommendations from a physiotherapist and recording sheets for the use of devices. The inspector observed devices were implemented for longer than recommended

without any identification why this practice occurred.

Residents had access to a G.P. (general practitioner), all residents except one had received an annual review. The resident whom had not received an annual review in 2016, their last annual review was completed on the 02 December 2015.

Recommendations from this review included the need for a dietician and diabetic specialist review. The inspector requested to view these reviews however, this information was not available within the residents file nor within the computerised system. Staff members present were unable to identify if the resident had been reviewed by a dietician and diabetic specialist.

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. During the inspection residents made tea and coffee for themselves, staff members and the inspector.

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

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):

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

Findings:

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

The inspector viewed four administration recording documents in place for residents. These were found to be up-to-date and showed staff administered and signed for medication. However, administration recording sheets did not match the administration records for example, the 24 hours clock was identified in one document and the 12 hours clock was specified in the other document.

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

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

The maximum dosage of p.r.n. medicines was specified for the sample of p.r.n. medication viewed.

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

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

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

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.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found the statement of purpose submitted with the application to vary the conditions attached with the designated centre did not fully meet the requirement of schedule 1 of the regulations.

The statement of purpose did not accurately describe the consultation and participation within both houses.

The statement of purpose did not reflect current resident's numbers. Nine residents were identified within the document despite seven residents currently being accommodated within the designated centre.

The complaints procedure was not reflective of current practice within the designated centre.

The staff arrangements were not reflective of the current staffing numbers.

The organisational structure required updating.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found significant improvements were required within the overall governance and management structure in place within the designated centre. Improvements were needed in relation to risk management, staff supervision and effective systems to ensure safe delivery of care to all residents within the designated centre.

Both houses were managed by one person in charge during the previous registration inspection. During this inspection the inspector established the designated centre was managed by two individuals a person in charge in one house and a manager in the second house. The person in charge did not have effective governance arrangements in place within the second house. The inspector was informed residents in the second house were independent and the house was mistakenly registered as a designated centre. Plans were underway to deregister the house, however, no such documentation was received by HIQA. The inspector made contact with the provider to seek clarification in relation to the status of the designated centre. They confirmed the application to vary the condition pertained to a reduction in numbers and the two houses were to remain part of the designated centre.

One the day of inspection the residents in the second house were not present as one resident was gone on an overnight break and the other two residents were gone on a day trip. The person in charge was not aware of this, except for the resident on an

overnight break.

No supervision had been conducted with staff members since the person in charge commenced in the role on the 10 June 2016. The person in charge did not have access to previous staff member's supervision. The inspector found this system was not effective in ensuring effective arrangements to support, develop and performance manage all members of the workforce. To ensure staff members were afforded with the opportunities to exercise their personal and professional responsibility for the quality and safety of the services they were delivering. The person in charge identified plans were in place to conduct supervision with staff members in conjunction with the manager in the second house however, these had not taken place at the time of this inspection.

The inspector found the designated centre did not have suitable management systems in place to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The person in charge met with during this inspection had responsibility for the two houses within this designated centre which accommodated seven residents. However, they had limited knowledge of the residents residing in one house, this was home to three residents. There was a separate manager identified in this house. Furthermore, findings from this inspection suggest the two houses comprising of the designated centre were in effect operating as standalone centres. There were separate managers, separate team meetings, separate rota's. No rota's existed for the house home to three residents. The person in charge did not attend team meetings in the house, home to three residents.

The inspector viewed minutes of team meetings in the house home to four residents dated 25 January 2016. During the meeting staff were informed the house would no longer support the residents in the other house, home to three residents due to downsizing and single staffing in the house home to four residents. Staff in another designated centre were to provide any additional support. The inspector identified this was not in line with the statement of purpose for the designated centre which comprised of both houses. The person in charge identified this was rectified on the 21 June 2016. The following was identified to staff members "the second house is still under this designated centre until it is deregistered in the next two months". The inspector also viewed within the minutes of team meeting in the house home to four residents, that a resident from another designated centre may require emergency accommodation. The inspector identified this to the person in charge, as this was not in accordance with the statement of purpose and no identification of collaboration with residents was evident. In addition this resident had previously lived within the house and the inspector was informed residents incidence of displays of behaviours had decreased since the downsizing with two residents moving to other locations.

In the context of the findings contained within this inspection report, the inspector formed the view the management arrangements in relation to the person in charge did not ensure effective governance, operational management and administration of this designated centre. The inspector found the reporting structure in place within the designated centre was unclear due to the number of people managing the houses and the roles discharged to these individuals varied. Evidence of staff meetings were not

occurring regularly and evidence of oversight in relation to audits were not evident for example, in medication management. Within one residents support plan another designated centre was identified as providing care support for a resident within this designated centre.

The inspector found all staff members did not received mandatory training in the areas required.

An annual review of the quality and safety of care of the service for this designated service was completed in 26 August 2015. No annual review was completed for 2016. The person in charge identified the process of information gathering had commenced.

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 16 June 2016 this included both houses. The person in charge had completed an action plan however, the majority of the actions were still ongoing since June on the day of inspection.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector could not determine if sufficient staff numbers with experience were deployed to meet the assessed needs of the residents were available across the designated centre as staff rosters were not accurately maintained. Improvements were also required in relation to staff training.

From a sample of eight staff training records reviewed, one staff member required training in people moving and handling. Two staff members required training in diabetics and rescue medication. Two staff members required refresher training in epilepsy and rescue medication. Two staff members required refresher training in medication management and one staff member required refresher training in fire training.

The inspector viewed the proposed and actual staff rota for one house and found it to be accurately maintained. The house was staffed with one staff member, this increased to two staff members at specific times to facilitate residents attend community events. There was no rota available in the second house as the person in charge was not responsible for maintaining a rota. Staffing was organised through a manager, the person in charge did not have a role in organising staffing.

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.

The inspector observed residents received assistance in a respectful manner.

These 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

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee
Centre ID:	OSV-0001710
Date of Inspection:	07 December 2016
Date of response:	27 January 2017

Requirements

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

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

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The agreements for the provision of services including the support, care and welfare of the resident and details of the services to be provided for each resident and where appropriate, the fees to be charged were not reflective of actual practice within the designated centre.

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

1. Action Required:

Under Regulation 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:

Tenancy agreements will be reviewed and updated to reflect the current responsibilities of the tenants in the designated centre.

Service Level Agreements forms will be reviewed and updated.

Proposed Timescale: 28/02/2017 - Tenancy Agreements
30/04/2017 – SLA's

Proposed Timescale: 30/04/2017

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:

Some assessments were not conducted annually and were taking several months to complete for example, 21 months.

2. 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:

An organisational review is occurring in relation to the personal outcomes measures, and in the interim an annual personal plan is taking place and the action plan is reviewed regularly if changes necessary.

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 plans were not reviewed annually.

3. 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:

All Residents personal plans have been reviewed and those in need of updating are currently being drafted. These will be reviewed regularly and residents supported to choose new goals annually if they wish.

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 personal plan reviews did not assess the effectiveness of each 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:

All Residents plans are currently under review and some of which need to be updated, personal plans will contain clear levels of progression of residents' individual goals. All documentation will clearly guide staff going forward.

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 assessment, management and ongoing review of both the location risks and individual risks required updating.

5. 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 risk register and individual risks will be reviewed and updated to guide staff effectively.

The health and safety statement has been reviewed and will be updated as soon as

possible.

Proposed Timescale: 30/04/2017

Theme: Effective Services

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

Procedures in relation to the management of sharps were not in place in the designated centre.

6. 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:

Local documentation in relation to the management and disposal of sharps will be drafted to clearly guide all staff encompassing labelling of sharps bin, these guidelines will be available to staff in folder on location.

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 persons in the designated centre and bringing them to safe locations were not evident within one house when no staff were present.

7. 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:

Fire Drills will continue to take place monthly in the house which is not staffed full time, this will be completed without the aid of staff to ensure they can evacuate independently themselves and correct recording of same.

Proposed Timescale: 31/01/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Behaviour support plans did not ensure staff members had up-to-date knowledge appropriate to their role, to respond to displays of behaviours and to support residents to manage their behaviours. The review process was unclear and information contained within these plans were inconsistent.

8. 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:

New Positive Behavioural Support Plans are now available in resident's personal folders, old PBSP's have been archived.

Proposed Timescale: 27/01/2017

Theme: Safe Services

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

One staff member required training in the management of displays of behaviour.

9. Action Required:

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

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

Staff have been booked onto CPI training.

Proposed Timescale: 31/03/2017

Theme: Safe Services

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

Documentation in relation to the reporting structure and the designated officer was not current in the designated centre.

10. 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:

New documentation in relation the designated officer and reporting structure is currently under review at an organisational level, as soon as this documentation is available, it will be put up on the notice board in the designated centre.

Proposed Timescale: 31/03/2017

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:

Medical treatment recommended for some residents was not evident for example, physiotherapy, dietician and diabetic specialist and staff members did not have knowledge of these.

11. 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:

Appointments will be made with the necessary health care practitioners and follow up on medical treatments, these procedures/guidelines will be available in resident's personal files ensuring they correctly guide staff.

Proposed Timescale: 30/04/2017

Theme: Health and Development

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

Some healthcare plans were not reflective of the healthcare needs of residents.

Some support plans and care plans did not guide staff effectively in care delivery.

Generic information not relevant to some residents was contained in residents plans.

12. 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 health and wellbeing plans will be reviewed and updated ensuring all health needs are recorded in same. Any changes to the resident's health will be updated going forward.

Care plans that are no longer relevant have been archived as was the generic information which was not relevant to the resident.

Proposed Timescale: 31/03/2017

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:

Administration recording sheets did not match the administration records for example, the 24 hours clock was identified in one document and the 12 hours clock was specified in the other document.

No guidance was available in relation to the administration of some p.r.n medicines.

13. 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 residents MARS have been changed to reflect the 24hr clock to match other documents.

Clearer local guidelines will be drafted to guide staff in relation to the administration of P.R.N medication.

Proposed Timescale: 30/04/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose statement of purpose did not contain accurate information as set out in Schedule 1.

14. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The statement of purpose and function is currently being reviewed and updated.

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:

Effective governance, operational management and administration of the designated centre was not evident between the two houses. For example, the person in charge did not have knowledge in relation to the personal and healthcare plans and the whereabouts of the residents reading in the second house home to three residents.

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 open line of communication has been established between the PIC, the CSM of the second house and both staff teams, the PIC now has a greater understanding of the supports in place for the residents in the second house and will continue to work with the CSM, Community staff team and residents ensuring there is effective governance of the designated centre.

Proposed Timescale: 27/01/2017

Theme: Leadership, Governance and Management

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

No annual review was completed for 2016.

16. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The annual review for 2016 has been completed and is available for viewing in audit folder in the designated centre.

Proposed Timescale: 27/01/2017

Theme: Leadership, Governance and Management

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

Management structure in the designated centre was unclear with inconsistent information provided to staff members in relation to the governance of the second house home to three residents.

17. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

A meeting has taken place on the 23.01.2017 with two senior services managers, the Pic of the designated centre and the CSM of the second house (unstaffed) to discuss the management structure of the designated centre. The PIC along with CSM will work alongside each other to govern the second house home to three residents. Supervision of staff, staff meetings, documentation reviews etc will be done together. There will be a more open line of communication between the PIC, the CSM of the second house and also both staff teams to ensure the service provided is safe, appropriate to the resident's needs, consistent and is effectively monitored.

Proposed Timescale: Completed

Proposed Timescale: 27/01/2017

Theme: Leadership, Governance and Management

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

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 they delivered was not in place in the designated centre.

18. 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:

Supervision has now taken place for all staff.

Proposed Timescale: 27/01/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Planned and actual staff rotas, showing staff on duty at any time during the day and night were not maintained across the designated centre.

19. 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:

All staff rosters are available for viewing in staff off duty folder for both houses.

Proposed Timescale: 27/01/2017

Theme: Responsive Workforce

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

One staff member training in people moving and handling.

Two staff members required training in diabetics and rescue medication.

Two staff members required refresher training in epilepsy and rescue medication.

Two staff members required refresher training in medication management.

One staff member refresher training in fire training.

20. 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 have been booked on the necessary training courses for 2017.

Proposed Timescale: 30/04/2017

