Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Clew Bay
Centre ID:	OSV-0002334
Centre county:	Dublin 11
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Conan O'Hara
Support inspector(s):	Anna Doyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
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 compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2017 09:30	23 May 2017 17:30

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

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 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was an unannounced inspection that was conducted in line with HIQA's remit 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. The required actions from the centre's registration inspection in April 2015 were also followed up as part of this inspection. This was HIQA's second inspection of this designated centre.

Description of the service

The centre was operated by St. Micheal's House (SMH) and is situated in North Dublin. The centre comprised of a end of terrence community based two storey house. The centre was home to five residents over 18 years of age. The service provider had produced a statement of purpose which outlined the service provided within this centre. The statement of purpose stated that the centre provided a home for people encouraging every individual to make choices and take control over the direction of their lives. Care is provided by social care workers based on the current needs of the residents and nursing support was accessed through an on call service provided by SMH.

How we gathered our evidence

Over the course of the inspection, the inspectors spent time speaking with the five residents. The inspectors met with the person in charge and staff team and reviewed various sources of documentation which included the statement of purpose and residents' files. The inspectors also completed a walkthrough of the centre's premises.

The person in charge was present for the inspection and was very responsive to any requests for records requested. The person in charge and the service manager for the centre attended the feedback meeting. Additional information not available at the inspection was submitted post inspection as requested at the feedback meeting.

Overall judgment of our findings
Of the eight outcomes inspected against, inspectors found safeguarding to be in major non compliance. Four outcomes were found to be in moderate non compliances namely; health and safety and risk management, healthcare needs, medication management and governance and management. Substantial compliance with the regulations was found in workforce and social care needs. Regulatory compliance was found in records and documentation.

The actions from the last inspection had been implemented as required. 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 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:
Overall the inspectors found residents had opportunities to participate in meaningful social activities in line with their preferences. However, improvements were required to ensure residents were supported in line with their wishes and needs, the development and implementation of personal plans and review of these plans.

The inspectors reviewed a sample of files and found that each resident had an up-to-date assessment of need completed. Support plans were in place for some of the needs outlined in the assessment tool. However, there were no support plans for some healthcare needs. In addition, some plans were not fully implemented. For example, one plan stated an activity schedule would be beneficial for a resident, however this was not implemented.

An annual review had been completed for some residents and of the sample reviewed they included the resident's representative in line with residents' wishes.

Residents' person plans outlined some goals and objectives. However, it did not outline the person responsible for supporting the resident to achieve the goals. In addition, not all residents had a copy of the personal plan in an accessible format.

The residents informed inspectors that they enjoyed going to a local choir, local employment, bowling, snooker, going to matches and on holidays. The residents were supported to access day services and local employment. However, some residents chose not to engage in a day service and were supported by staff from the centre.

Residents were supported with developing independent living skills. For example, residents took a turn cooking meals in the centre and one resident was being supported to complete the driving theory test. However, one resident informed the inspectors about their wishes for future living arrangements and the person in charge confirmed that this was something that the resident spoke about. Inspectors found that this was not reflected anywhere in their personal plan and it was not clear how the resident was being supported with this.

The inspectors found that residents had access to assistive devices and equipment as appropriate.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall, the health and safety of residents, visitors and staff was promoted however the areas of risk management and fire containment required improvement.

The centre had a health and safety statement in place and health and safety audits were completed weekly. Inspectors reviewed a sample of incidents and found that there was appropriate follow up to individual incidents.

The centre had arrangements in place for the management of fire. The evacuation map was on display in a prominent location. The equipment (alarm, fire blankets, extinguishers and emergency lighting) was suitably serviced. Each resident had a personal emergency evacuation plan in place. The centre completed regular fire drills. While, some residents spoken to informed inspectors on what they would do in the event of a fire there were no records to demonstrate that all residents would evacuate the centre in the event of staff not being present in the centre. In addition, it was unclear is the fire containment measures in the centre were adequate.

The centre had risk management policy in place. The centre maintained a risk register which included lone working, chemicals, manual handling and infection control. Individual risk assessments were also in place. Inspectors found that not all risks were actively managed in the centre. For example, a risk assessment for one resident who resided on their own in the centre for short periods had not been reviewed after an incident that occurred in the centre that may have posed a risk to the resident. In

addition, concerns had been raised at a staff meeting around this practice and no actions had been implemented from this.

The inspectors found that there was appropriate infection control practice in place. Residents were proud of their home and were actively engaged in the cleaning of their homes. Inspectors observed the centre to be clean. Adequate hand wash facilities and personal protective equipment were available throughout the centre.

There was a vehicle available to the residents. The inspectors reviewed the vehicles documentation and found that it was up-to-date.

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:
Overall, inspectors found that while there were systems in place to safeguard and protect residents from abuse, improvements were required in positive behaviour support plans and restrictive practices.

Residents highlighted that they felt safe in the designated centre. Staff members were observed treating residents with dignity and respect. Staff members spoken with were familiar with what constitutes abuse and what to do in the event of an allegation, suspicion or disclosure of abuse. The inspectors found that staff had received training in safeguarding and that refresher training was scheduled to take place for staff this year.

However, the inspectors found that there were no clear guidelines in place as to when safegaurding measures should be implemented in response to behaviours of concern. For example, residents' home alone risk assessment stated that the length of time certain residents could be left alone in the house should be reduced in response to behaviours of concern. Inspectors found that there was no clear guidance to staff on how/when to make this decision. In addition, the inspectors noted in one personal plan it was stated to follow the complaints procedure in the event of an allegation and not

the safeguarding procedure. This was discussed with the person in charge.

The inspectors found that some improvement was required in the management of behaviours that challenge. Positive behavioural support plans were provided as required however the inspectors found that the recommendations in the behaviour support plans were not fully implemented. The behavioural support plans recommended a particular intervention to support a resident. Inspectors were informed that the resident did not want to partake in this, however this was not recorded in the plan, nor had an alternative been explored to support this resident with the behaviours of concern.

The inspectors identified that there were a number of environmental restraints in use in the centre and found that the management of restrictive practices required significant review. These included a locked fridge, locked press and limited access to certain items. However, inspectors found that the rationale for the use of these restrictive practices were not clear. For example inspectors were told that restrictions were in place around one resident's fluid intake on advice from an allied health professional. However, the information contained in the plan was conflicting as there were three different recommendations around fluid intake recorded. The inspectors found that this restriction was impacting on the resident and other residents in the centre. Most of these restrictive practices were not identified as restrictive and had therefore not been reviewed by the organisational approval committee in line their own policy.

Judgment:
Non Compliant - Major

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:
Overall, the inspectors found that residents' health care needs were being met. However, improvement was required to ensure all residents achieve and enjoy the best possible health.

Residents were supported to have timely access to appropriate healthcare services and treatments. This included opticians, dentists and chiropody. Residents were supported by a General Practitioner of their choice.

The inspectors reviewed a sample of health care plans and found that residents' healthcare needs were identified, assessed and care interventions were developed for

some healthcare needs. However, the inspector's identified that care interventions were not in place for all identified health care needs in order to guide practice and identify the supports required for the resident. This included kidney impairment and mental health issues.

In addition, the inspectors found that the detail contained in some care interventions did not appropriately guide staff as conflicting information was recorded. Staff were not clear about which information was correct.

Inspectors also noted that some recommendations around residents' health care needs had not been implemented. For example, monitoring a resident's blood pressure.

There was evidence that a nutritional and varied diet was available for residents. Residents were involved in menu planning and cooking meals in the centre. Within the house, refreshments and snacks were available for the residents outside mealtimes. Residents were supported to maintain a healthy diet and were supported to access a dietician where required.

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 inspectors found there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, improvements were required in one policy, medication records and prescribed 'as required' medication guidelines.

The inspectors reviewed a sample of medication prescription and administration records and found that the information recorded was for the most part complete. However, it had not been recorded on one resident's prescription sheet that a prescribed medication for pain should not be administered. This was highlighted to the person in charge on the day of inspection who intended to address this the following day when the resident's GP was available.

There were appropriate procedures in place for the disposal of unused or out of date medication.

Some residents in the centre self administered their own medication. These medications were re-dispensed from pharmacy supplies by staff into a medication pill box. The inspectors requested a copy of the organisation's policy to be submitted after the inspection as it was not available in the centre that day. On review it did not guidance around dispensing, labelling or storage of medication outside its original packaging.

An assessment had been completed for residents to self administer medication in the centre. The assessments had recently been reviewed.

A medication audit was completed by staff in the centre and inspectors found from a sample viewed that issues identified from the audit had been followed up.

Inspectors reviewed a sample of protocols in place around PRN 'as required' medication. One protocol in place did not guide staff on the recommended length of time that this medication could be administered for. For example, the protocol stated that this medication should only be discontinued following a 12 hour period mental health issues improving. However, it was recorded that mental health issus may last for up to 10 days. Inspectors found that this was not appropriately guiding practice. This was discussed with the person in charge who advised the inspectors that this medication had not been required for almost two years and intended to review this protocol.

Staff were trained in safe administration of medication in the centre.

Medications were dispensed from local pharmacy and stored securely in the centre.

There were no controlled medication in the centre and there was a fridge available in the centre for medications to be stored in.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors found that there were management structures in place in the centre. However, the staffing resources from this centre were shared with the centre nearby and this needed to be addressed in order to ensure clear lines of accountability were in place for this centre.

The inspectors found that there was a clear management structure in place with clear lines of accountability. The person in charge reported to the services manager, who in turn reported to the provider. The person in charge met with the newly appointed service manager and the plan going forward was to meet with the service manager on a regular basis.

Staff meetings were held in the centre, however the minutes viewed found that some contained very little detail and did not record who was responsible for implementing actions arising from issues raised. Staff spoken with informed inspectors that they felt supported in their role by the centre manager. Formal supervision of staff was in place. The inspectors reviewed a sample of supervision meetings and found that supervision was not consistently in place for all staff. This had been identified by the person in charge.

There was an annual review of the quality and safety of care completed for 2016. The annual review included consultation with family, residents and staff. The review identified areas for improvement and an action plan was in place. The provider also completed 6 monthly unannounced quality and safety visits in line with the regulations.

The person in charge was full time, suitably qualified and experienced. They were knowledgeable of the residents' needs and their responsibilities under the regulations. The person in charge had protected time every week in order to ensure effective governance of the centre. The person in charge was also responsible for another adjoining centre. The residents could identify the person in charge.

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:
Overall, the inspectors found that the staffing levels and skill mix was appropriate to meet the current needs of the residents. However the staff team were collectively part of the team for this centre and the adjoining centre and improvements were required in the staff rota to ensure accuracy.

The centre maintained a planned and actual rota. However, the rota included the staffing for the adjoining centre for which the person in charge had governance for. The rota did not clearly outline the shifts assigned to staff.

The inspectors observed that residents received support in a respectful and timely manner.

The inspectors reviewed training records and found all staff had received mandatory training in safeguarding and manual handling. However, one staff member's fire safety training was out-of-date.

Staff files were not reviewed as part of this inspection as it was found to meet the requirements of Schedule 2 in the previous inspection. There were no volunteers active in the centre.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The centre had policies in place for the provision of information to residents and access to education, training and employment.

Not all aspects of this outcome were inspected against as part of this inspection.

Judgment: Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Conan O'Hara
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[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002334
Date of Inspection:	23 May 2017
Date of response:	20 June 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 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 plans were not fully implemented.
Some residents had no annual review completed.

1. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

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 person in charge with the residents key worker will review all support plans to ensure they are fully implemented. The one residents whose personal plan is more than one year old will have an annual review completed. The PIC will request additional training and support on Person Centred Planning for the staff team to ensure that in future all element of the personal plan are in line with the organisations policy on Person Centred Planning

Proposed Timescale: Action to be completed by 31/07/2017

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no support plan in place to support a resident acheive their wishes for future living arrangements.

2. Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that a support plan is developed to support the resident to work towards their goal of living independently. The plan will be developed in consultation with the resident their keyworker and multi-disciplinary team.

Proposed Timescale: Action to be completed by 30/06/17

Proposed Timescale: 30/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had an accessible version of their personal plan

3. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
The person in charge will support the relevant keyworkers to develop accessible versions of personal plans for any resident who requires or wants one.

Proposed Timescale: Action to be completed by 31/07/17

Proposed Timescale: 31/07/2017

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:
Risk assessments were not refective of current risks in the centre

4. 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:
Risk assessments will be reviewed by PIC and updated to ensure appropriate responses to emergencies. The PIC will ensure the risk assessments address the risk to the resident who stays alone in the centre for periods of time.

Proposed Timescale: Action to be completed by 31/07/2017

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear is the fire containment measures in the centre were adequate.

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

Please state the actions you have taken or are planning to take:
A full review of the designed centre fire management procedures will take place with the fire officer for the organisation. This will identify high risk areas and additional control measures will be identified. The Registered Provider has a systematic risk based approach to address environmental fire actions identified.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records to demonstrate that all residents would evacuate in the event of a fire when no staff are present in the centre.

6. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The PIC will organise for a fire drill to be held where staff offer no support to the residents. This will identify if there are residents who do not evacuate when the fire alarm is activated and appropriate supports will be put in place to support evacuation if this is deemed necessary following the drill. A record of the fire drill will be maintained in the fire log in the centre.

Proposed Timescale: Action to be completed by 30/06/17

Proposed Timescale: 30/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restraints were not suitably identified and reviewed.
The rationale for the restrictive procedures were unclear.

7. 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 PIC has reviewed environmental restraints in the centre and approval for the use of these restraints has been sought from Positive Approaches Monitoring Group (PAMG). The application for the use of these restraints is included in the application to PAMG and it outlines the least restrictive options considered in advance of implementing the restrictions. These will be reviewed regularly and will be reported to The Authority as restrictive practices in the next quarterly returns.

Proposed Timescale: Actions to be completed by 30/06/2017

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all recommendations for behavioural support were implemented as outlined in the report.

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:
The PIC and centre psychologist have reviewed the positive behaviour support plan for the resident. The behavioural support plan have been updated to reflect the complex and changing needs of the resident and now outlines in detail the psychology supports required for the resident. This will be discussed at the staff meeting on 05/07/2017 and will be filed in the residents file.

Proposed Timescale: 05/07/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no clear guidelines in place as to when safegaurding measures should be implemented in response to behaviours of concern.

One personal plan it was stated to follow the complaints procedure in the event of an allegation and not the safeguarding procedure.

9. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
The residents support plans will be updated, by the PIC in consultation with the multi-disciplinary team, to ensure it reflects when safeguarding measures should be implemented in response to behaviours of concern. The psychology support plan will be discussed at the staff meeting on 5/07/2017 to ensure staff are clear that it is not a compliant but a safeguarding concern. The updated support plan will be filed in the residents file.

Proposed Timescale: Actions to be completed by 05/07/2017

Proposed Timescale: 05/07/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care interventions were not in place for all health care needs.

Some interventions did not appropriately guide staff.

Not all interventions recommended had been implemented.

10. 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:
The PIC will review all Health Care Plans and interventions to ensure they address all the health care needs of residents. The review will consider additional actions required to guide staff practice and to identify actions which required to be implemented.

Proposed Timescale: Action to be completed by 31/07/17

Proposed Timescale: 31/07/2017

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:
The policy in place to guide staff practice in supporting residents who self medicate did no contain guidance on the use of pillboxes in the centre, in relation to approporiate labels and the suitablity of medication stored in these pillboxes.

It had not been recorded on one resident's prescription sheet that a prescribed medication for pain should not be administered to one resident.

11. 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:
The PIC has reviewed the medication management system and is in the process of implementing a 'blister pack' arrangement for service users who self medicate. This will be introduced in consultation with the residents, their local pharmacist and St. Michael's House Safe Administration of Medication Committee. Additional briefings for the staff team will be organised by the PIC to ensure staff are aware of the new procedures for the Safe Administration of Medication. The new practices will be in line with the organisations policy on Safe Administration of Medication.

Proposed Timescale: Action to be completed by 31/07/17

Proposed Timescale: 31/07/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One PRN protocol did not appropriately guide staff.

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

Please state the actions you have taken or are planning to take:
The PIC has reviewed residents prescription sheets and one residents Medication Administration Sheet has been updated to accurately reflect PRN for pain management procedures

Proposed Timescale: 30/06/2017

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:
Supervision was provided inconsistantly

13. 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 PIC will implement a timetable of regular staff supervision using a standardised template recently developed by St. Michael's House.

Proposed Timescale: Action to be completed by 31/07/2017

Proposed Timescale: 31/07/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing resources from this centre were shared with the centre nearby and this needed to be addressed in order to ensure clear lines of accountability were in place for this centre.

14. 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:
This Registered Provider has submitted an application to vary to become a designated centre with a unit of the designated centre close by. Staff meetings will have a regular structure and clear lines of responsibility will be established to ensure accountability for all elements of service.

Proposed Timescale: Action to be completed by 30/06/17

Proposed Timescale: 30/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The rota covered another designated centre and the staff who were assigned to shifts were not always clearly identifed in the rota.

15. 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:
The PIC has updated the staff roster to ensure shifts are clear and recorded on the roster.

Proposed Timescale: Action to be completed 30/06/2017

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date training in fire safety

16. 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:
The PIC has reviewed Fire Training for all permanent and contracted members of staff. The review highlighted that all permanent and contracted staff have completed fire safety training in the past 12 months. The review did highlight one relief staff who has worked sporadically in the centre has not had refresher fire training in the past 12 months. The PIC has emailed the Training Department to request fire safety refresher training for the relief staff.

Proposed Timescale: 16/06/2017