

# Lenus: Research Repository



## Ladywell Lodge, Louth

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ladywell Lodge
<b>Centre ID:</b>	OSV-0003025
<b>Centre county:</b>	Louth
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St John of God Community Services Limited
<b>Provider Nominee:</b>	Declan Moore
<b>Lead inspector:</b>	Raymond Lynch
<b>Support inspector(s):</b>	Noelene Dowling
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	10
<b>Number of vacancies on the date of inspection:</b>	2

## **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: 02 February 2017 10:00 To: 02 February 2017 19:00

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

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

**Summary of findings from this inspection**

Background to inspection:

This was an unannounced inspection in order to monitor the centre's on going regulatory compliance with the Health Act 2007 (Care And Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

Three inspections took place in the centre in 2015 where moderate and major non-compliances were found (in all three inspections) in various core outcomes assessed. Of the nine outcomes assessed in this inspection, six were found to have major non-compliances, two had moderate non-compliances while medication management was found to be compliant.

While it was observed that staff treated residents with dignity and respect over the course of this inspection, the centre was not conducive to meeting the residents' intimate care needs adequately, systems of governance and management required urgent review and there was insufficient input from multidisciplinary support teams in order to meet the assessed social and healthcare needs of the residents.

#### How we gathered evidence:

The inspectors met and spoke with all 10 residents over the course of the inspection. One staff member was also spoken with, as well as the clinical nurse manager 1 (CNM 1). The person in charge was met with briefly during the day and was also present on completion of the inspection for feedback from the inspectors.

Key policies and documents were also viewed as part of the process including a sample of rosters, the risk management documentation, the safeguarding policy and a sample of social and healthcare care plans.

#### Description of the service:

The centre was located on a campus-based setting in Co. Louth. It provided support for up to 12 individuals that lived there. The centre comprises two separate single-storey units that were attached to each other via a reception area.

Limited transport was provided in order to provide access to the nearby towns and villages.

#### Overall judgment of our findings:

This inspection highlighted significant concerns with regard to the overall governance and management of the centre. As a result, there were negative outcomes for residents with regard to privacy, dignity, opportunities for social engagement and institutional practices in the provision of personal care.

There were gaps in staff training and insufficient multidisciplinary support in order to meet the assessed health and social care needs of the residents. An immediate action was also issued with regard to fire safety and fire evacuation procedures, which were found not to be satisfactory on the day of this inspection.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

A number of practices in this centre did not promote the rights, privacy and dignity of the residents who lived in this centre. There were issues with regard to the way in which complaints were being managed and residents did not have adequate access to independent advocacy services.

Over the course of the inspection, inspectors observed staff supporting residents in a professional and friendly manner. Staff consulted with the residents and engaged in activities with them.

However, it was observed that some of the practices in the centre were institutional. For example, documentation viewed by the inspectors showed that residents were offered a bath or shower two to three times a week. Taking into account the physical and intimate care support requirements of the residents, the inspectors were not satisfied that this practice was adequate or indeed appropriate in meeting the residents' needs.

It was also observed that the way in which complaints were being managed required review. While there were policies and procedures in place to manage and address complaints, the inspectors observed that on some of the logged complaints there was no evidence of what actions were taken to resolve the issue or indeed if the issue was even escalated to the complaints officer.

The inspectors noted that while there was information available in the centre on how to make contact with an independent advocate, no independent advocate had made a visit

to the centre. While the clinical nurse manager 1 had escalated the need for independent advocacy services for the centre to the director of services in 2016, to date this support had not been sourced.

For the main part, the institutional practice of providing residents with meals from a centralised kitchen based on the campus was in place for this centre.

However, at times, residents were supported to cook and prepare meals of their own choosing and there were pictures of menus available on notice boards to help support resident's choice of meal. Residents also had eating and drinking plans in place and snacks were kept in the kitchen area based on the preferences of each resident.

Regular meetings were also held with residents in order to support menu planning and a new kitchen had been installed to facilitate accessibility for residents. On the day of the inspection one resident was being supported with baking activities in the kitchen.

**Judgment:**

Non Compliant - Major

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Issues with regard to meeting the assessed social care needs of the residents were identified in the previous inspection. Some of those issues were still evident on this inspection.

The inspectors viewed a sample of personal plans and found that meaningful day activities were identified in each resident's file. However, while some of the activities were community based, a lot of them took place inside the centre or on the campus.

For example, activities such as listening to mass on the radio or listening to music were listed as meaningful day activities.

It was also observed that there was insufficient input from multidisciplinary professionals in order to meet the assessed social care needs of the residents. Some plans were not reviewed in a timely manner and there were no sensory assessments undertaken to support residents with sensory support needs.

The inspectors were told that the centre had access to a car for social and community-based activities. Transport was required in order to access the nearby towns and villages as the centre was based on a campus, in a rural setting.

However, it was observed that access to this vehicle was limited and information on the notice board informed inspectors that the centre could only access it on two occasions the week previous to this inspection. This was not adequate to meet the needs of 10 residents.

**Judgment:**  
Non Compliant - Major

**Outcome 06: Safe and suitable premises**

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

**Theme:**  
Effective Services

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

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

**Findings:**

This inspection found that the layout of the premises required evaluation to ensure that the needs of all of the residents could be met in an appropriate and comfortable manner.

It was observed in this centre that two of the bedrooms were of an inadequate size to

support residents that required the use of a wheelchair and a hoist. The clinical nurse manager (CNM) 1 was aware of this and was making some plans so that residents that required a wheelchair and hoist would transition into larger, more appropriate bedrooms.

However, in the meantime a screen had to be placed on a communal corridor to support some residents when they transition from their wheelchair to their bed (this was because a wheelchair and a hoist could not fit into the bedroom at the same time). Inspectors found that this did not promote the privacy needs of residents or safe moving and handling practices.

The centre had the use of two shower rooms; however, these facilities were not adequately sufficient to meet the intimate and personal care requirements of the 10 adults sharing the house at the time of inspection. (As stated earlier in this report, residents were offered a shower two to three times a week and some had significant personal care support needs. There were also two vacancies at the time of inspection).

It was also observed that there was a mal odour coming from one of the shower rooms on the day of the inspection which meant that it was unpleasant to stay in this room for any length of time.

Each resident had their own bedroom that was personalised to their individual likes and preferences. Pictures of the residents and their family members were on display as well.

Overall, the premises were found to be institutional by design and storage space was very limited. This was because some bedrooms were too small to adequately support residents who used wheelchairs and hoists, and there were only two bathrooms to support the intimate care support needs of up to 12 residents

The inspectors also observed that residents' files and notes were inappropriately stored in communal areas in the sitting room, parts of the garden were inaccessible and most of the residents meals continued to be delivered to the centre via a centralised kitchen based on the campus.

It was also observed that some of the equipment (such as chairs) in use by the residents required review and updating.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

The actions required from the previous inspection had been addressed in part with an unsuitable fire door no longer in use and the exit doors appropriately secured. However, significant risks were identified in the procedures for the safe evacuation of residents, particularly at night, in the event of a fire.

An immediate action plan was sent to the provider in relation to this, and the provider was afforded a period of time to respond to this matter and provide written assurance of the action taken. While the provider had not responded at the time of issuing this report the timeframe for return had not yet expired.

All residents required full assistance with mobilisation and some required the use of hoists to assist them from their beds. Records showed that five fire drills were held in 2016 with one taking place at 6am.

Staff from other centres took part in this exercise as this formed part of the evacuation strategy. No resident was evacuated or suitable alternative actions taken to simulate conditions at night. While inspectors acknowledge the potential risks in doing so at that time of day, the entire evacuation process required review in order to assure the effectiveness of the arrangements in place given the complex support needs of some residents.

The personal evacuation plans were not sufficiently detailed to reflect the arrangements or support needs of the residents when evacuating the centre in an emergency.

Seven of the identified centre staff had not undergone training in fire management systems specific to the centre to ensure they were familiar with the layout and procedures required.

The record of daily and weekly checks on the alarms and exits were inconsistently completed and if these checks were not undertaken this could place residents at risk given their vulnerability. Staff were not aware of how the personnel from other centres on the site could access the premises in an emergency, if required.

While there was a risk register maintained it was not supported by sufficiently robust management systems. For example, a medicines error was noted but the remedial actions identified were not followed through on.

There were also deficiencies evident in the provision of risk management strategies and guidelines for specific infection-related risks – although inspectors observed staff taking appropriate generic precautions at the time of inspection.

Areas of risk in the premises, such as unlocked chemical stores and potential resident access to a boiler room, were also identified as risks which the provider had not appropriately mitigated against.

Audits on accidents, incidents or unusual events were not undertaken to promote learning and ongoing improvement. For example, incidents of self-harm or recent levels of infection and antibiotic usage. Such analysis would support ongoing systems for assessment and identification of risk.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

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

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

**Findings:**

The inspectors found that the actions required from the previous inspection had not been satisfactorily addressed.

From a review of records and speaking with staff, inspectors found that the systems for the support of residents with behaviours that challenge and the use of some restrictions were not underpinned by multidisciplinary assessment, consultation or review of interventions.

The behaviours of concern were primarily related to self-harm. Behaviour support plans for residents were not in place in some instances and in others not adequately implemented. Records showed that a support plan was required for a resident since November 2016 which had not been developed.

Actions were taken to address the immediate risks evident, for example, placing protective dressings on specific areas. However, the therapeutic strategies and oversight of these to help alleviate the symptoms for the residents were not evident.

Where staff had been advised to maintain specific charts of some behaviours these had not been undertaken. This negated the ability of the clinician to assess the effectiveness of the supportive strategies. There were also gaps identified in staff training in the support of residents with behaviours that challenge.

There were a number of restrictive practices used including bedrails, lap belts and a particular type of garment used at night. In the main, these were prescribed by an appropriate clinician and were primarily for residents' safety.

However, while the rationale for use was clear, there was no evidence that these systems were included as part of multidisciplinary reviews of residents' overall needs or to ensure that in all cases they remained necessary and the least restrictive option.

There was also no evidence of consultation with residents or relatives as appropriate for their use. This lack of multidisciplinary review and cohesive intervention involving all specialists, including the mental health and psychological services, into residents' overall care and wellbeing is also detailed under Outcome 5: Social Care Needs.

Inspectors found that no chemical interventions were used for the management of behaviours that challenge at the time of this inspection.

A review of the training matrix indicated that 13 staff had not received updated training in safeguarding vulnerable adults.

Policy and procedures for the protection of vulnerable adults was in accordance with the revised national guidelines and there were designated persons assigned to manage such issues.

On this occasion, residents' personal property were detailed and amended as necessary. Oversight of the management of residents' finances required some improvements, however.

The residents had their own their own personal bank accounts with two people nominated to access these for withdrawal purposes. A review of a sample of records pertaining to residents' finances, fee payments and spending showed that the systems were transparent with all transactions recorded and receipted. There was no evidence of any untoward spending or transactions noted.

However, there was no formal system for oversight of withdrawals or spending on residents' behalf which would further safeguard residents' finances. Staff could articulate the types of situation which would be could be considered abusive.

There were personal and pertinent intimate care guidelines available for the residents. Issues of privacy and access to such care are discussed under Outcome 1 and Outcome 5.

**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:**

From reviewing the healthcare records of five residents, the inspectors were not satisfied that all residents' healthcare needs were promptly responded to on all occasions.

A record seen indicated a delay in seeking timely access to medical advice and review when symptoms indicating possible ill health were evident and recorded by staff over a 48-hour period. The person in charge undertook to carry out a review of this particular occurrence.

It was evident from records that, overall, residents' healthcare needs were responded to in other respects.

There was ongoing access to general practitioner (GP) services. Residents had good access to allied services including neurology, haematology and medicines review, dentistry, ophthalmology and physiotherapy.

There were support plans implemented for healthcare needs and staff were familiar with them. Dietitians and speech and language assessments had been provided and the inspectors observed staff following the interventions as prescribed.

Suitable support plans were also implemented for issues related to potential head injury and skin integrity or wound care. The advice of specialists was also sought in these instances.

There was documentary evidence of advice from dietitians and speech and language therapists available and staff were knowledgeable on the residents' dietary needs.

The inspectors observed that they received the correct consistency of food and fluids.

Meal times as observed were managed in a manner pertinent to the residents' assessed needs for support, with suitable crockery and cutlery available to maintain residents' independence.

**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 that the medicines management policies were satisfactory and that practices described by the clinical nurse manager 1 (CNM 1) were suitable and safe.

All prescribing and administration practices were in line with best practice guidelines and legislation, and systems were in place for reviewing and monitoring safe medication practices. Medication was supplied in a monitored dosage system in a blister pack system for some residents.

Each resident had a designated area in a locked press which ensured medications were safely secured in the centre and individually stored for each resident. This reduced the likelihood of residents' medications being mixed up, for example.

Only qualified nursing staff administered medication to residents. The CNM 1 who spoke to the inspectors was knowledgeable about residents' medications and demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements

The prescription sheets reviewed were clear and distinguished between PRN (as required), short-term and regular medication.

Regular medication audits were carried out to ensure medication management systems were in line with the policies and procedures of the organisation and to ensure best practice was ensured for residents' wellbeing and safety.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

This inspection found that the governance and management structures required review as the arrangements in place for the overall management of the centre were not adequate. The arrangements for the role of person in charge were not adequate. It was also found that, while the centre was being audited, the provider was not taking action to address the significant deficits identified on inspection.

It was observed over the course of this inspection that the person in charge was also the director of care and support for the eight centres on the campus and the person in charge for two centres. This meant that the role and remit of the person in charge was too vast in order to monitor and manage the centre adequately or effectively.

For example, on the day of the inspection the person in charge met with the inspectors briefly but could not participate in the inspection process as he had to deal with issues in a different centre on the campus.

It was also observed that the CNM 1, who was the most senior management person who worked in the house on the day of inspection, had to work on the floor and forego her protected management hours on the day of the inspection due to unforeseen staff absences.

While the centre was being audited as required and an annual review of the quality and care had been facilitated, the inspectors observed that the actions arising from these audits were not being implemented in a timely manner.

For example, the most recent audits in 2016 identified issues with delays regarding multi-disciplinary input into the care of residents and also with the arrangements in place for the governance and management of the centre. The provider had not taken action to ensure that these issues were addressed and improvements sustained.

The CNM 1 had also brought the issues regarding the inadequate governance and management arrangements to the attention of the person in charge, however, and as already stated, the issue was on-going at the time of this 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):**

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

**Findings:**

The inspectors found that there were sufficient staff numbers with a variety of skill-mix, qualifications and experience to support the residents. However, as with the last inspection, issues were identified with the process of staff supervision and staff training.

There was a team of registered nurses working in the centre and a team of healthcare assistants. The inspectors observed that residents received assistance in a caring, timely and respectful manner on many occasions during the inspection.

From observing staff in action, it was evident that they were competent to deliver the care and support required by the residents and a family member spoken with on the day of the inspection was very positive about the service provided.

The person in charge met with the CNM 1 on a weekly basis in order to support her in her role.

A sample of supervision notes was viewed by the inspectors. However, it was found that the supervision process required review so as to better support the process of staff development.

It was also found that there were gaps in staff training such as site- specific fire training and safeguarding. Many staff required training to ensure that they could support residents who complex needs to evacuate from the centre.

Staff files were not viewed as part of this inspection.

**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:***

Raymond Lynch  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St John of God Community Services Limited
<b>Centre ID:</b>	OSV-0003025
<b>Date of Inspection:</b>	02 February 2017
<b>Date of response:</b>	23 February 2017

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

There was no access to independent advocacy services in the centre

**1. Action Required:**

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access

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

to advocacy services and information about his or her rights.

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

1. Previous referrals to the National Advocacy Service have proved fruitless, referrals to an alternative external advocacy service were made on the 15/02/2017 to request support for residents and staff. Information training session has been scheduled for the 9th of March for staff and residents.
2. Pictorial information is available to residents outlining advocacy services available to them on notice boards. Information on advocacy support is also available in residents IPP.

**Proposed Timescale:** 10/03/2017

**Theme:** Individualised Supports and Care

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

While some progress had been made with supporting residents to buy and prepare their own food, the majority of meals were delivered to the centre via a centralised kitchen. In this instance residents were not involved in the preparing and cooking of their own meals

**2. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

1. There were 77 resident meetings carried out in the designated centre within a 12 month period. These will continue to be held on a weekly basis with the resident continuing to have their input into the overall organisation within the designated centre.
2. Staff will discuss the menu options for the coming week during residents meetings and support residents to make choices around meals
3. Pictures and menus of foods are available on notice boards for residents, with staff ensuring they are updated for each meal time.
4. Residents are presented with menus at each meal to offer them the choice of meals they would prefer.
5. Each resident also has an eating and drinking plan in place which outlines resident's preferences and all staff are aware of these plans.
6. There are snack baskets in kitchen presses for each resident, reflective of their likes. Residents are supported to go shopping to select their preference for these baskets.
7. Residents are supported in the kitchen to access these snack baskets and to participate in preparing snacks for themselves.

**Proposed Timescale:** 26/02/2017

**Theme:** Individualised Supports and Care

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

Offering residents a bath or shower two to three times a week was inappropriate and inadequate to ensure that their intimate care needs were met sufficiently.

**3. Action Required:**

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

1. Intimate care plans have been updated to reflect the needs and preferences of residents in relation to bathing/ showering.
2. All residents are supported to have showers/ baths when they choose, or as required.

**Proposed Timescale:** 27/02/2017

**Theme:** Individualised Supports and Care

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

Some complaints were not adequately followed up on or addressed

**4. Action Required:**

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

1. Complaints log has been updated to reflect the outcome of 1 complaint for 2017.
2. Unresolved Complaints will be reviewed and progressed through the Organisation's complaints policy

**Proposed Timescale:** 09/03/2017

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Arrangements in place to meet the assessed social care needs of the residents were inadequate.

**5. Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

1. An MDT schedule and Circle of Support schedule is in place for each resident from January to ensure resident's needs are met and to promote cohesion among the MDT.
2. The position for full time basic grade occupational therapist has been advertised for the service in order to further support the current Occupational Therapy input
3. Residents needs will be reviewed within the designated centre and residents will be prioritised based on this for sensory assessments.
4. A social opportunity form has been in place from January to review and audit residents weekly social opportunities.
5. An audit of social goals and assessment were carried out on the 13/01/2017 which identified gaps. Staff were informed in relation to gaps and time frame given for social goals and assessment for residents to be completed.
6. Further training for staff in relation to social goals and assessment were scheduled on the 1/02/2017 and on the 15/02/2017.
7. Social outings for residents are assessed on a daily basis. Residents within the designated centre have complex and significant health needs, with social outings determined and planned depending on residents' well-being on the day.
8. Social outings are planned on a weekly schedule but may change depending on residents' presentation on the day and on their preference to participate in outing.

**Proposed Timescale:** 03/03/2017

**Theme:** Effective Services

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

Personal plans were not being reviewed in a timely manner

**6. 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:**

1. An audit schedule is in place from January and will continue to ensure plans are reviewed in a timely manner.
2. An MDT schedule and Circle of support is in place from January for each resident, to ensure that their needs are assessed and reviewed in a timely manner.

Proposed Timescale: Completed 23/02/17

**Proposed Timescale:** 23/02/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The design and layout of the premises was not suited to meet the needs of some of the residents living in the centre. Some bedrooms were of inadequate size for some of the residents. There was a mal odour coming from the shower room and the provision of two bathing facilities to support up to 12 residents (some with significant intimate care support needs) was inadequate.

**7. Action Required:**

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

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

1. 1 bedroom which has been identified as being inadequate size, will be assessed for possible renovating to allow the use of a hoist.
2. One resident has been identified for transfer into a larger bedroom within the designated centre
3. Requisition was sent to maintenance in relation to the mal odour in shower room, and drains have been cleaned out.
4. Cleaning schedules have been updated to ensure that the need to regularly run the water in that shower and has been communicated to relevant staff.
5. Resident files and daily notes have been relocated to office.
6. Shift leader template has been updated to ensure resident confidentiality is protected at all times
7. On January the 16th the designated centre had a new kitchen fitted. This resulted in the removal of an extending L-shaped worktop which has created accessible space for residents to utilise the kitchen.
8. An accessible bench has been ordered for our residents as part of our new kitchen design, which (once fitted) will further support residents to utilise their kitchen.

**Proposed Timescale:** 09/03/2017

**Theme:** Effective Services

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

Some of the equipment in use by the residents required review and updating

**8. Action Required:**

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

1. A position for full time basic grade occupational therapist has been advertised for the service in order to further support the current Occupational Therapy input.

A request has been made to an Occupational Therapist outside of the residential service to carry out these reviews in the interim.

2. An equipment checklist is present in each resident's IPP and will continue to be checked each month.

3. All equipment is serviced on regular basis by contractors with a record of same maintained in the designated centre.

**Proposed Timescale:** 14/03/2017

## **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:**

Systems were not in place to effectively manage risk throughout the centre.

### **9. 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:**

1. CNM's are in consultation with the quality team to devise a system that will give an appropriate overview of accidents, incidents and occurrences within the designated centre, to promote and improve trend analyses.

2. Weekly designated centre meetings include the review of accidents, incidents and occurrences within the designated centre.

3. Information in relation to trends of any incidents or accidents is discussed at team meetings.

4. Staff were communicated too regarding completing the fire register appropriately.

5. All staff have completed site specific fire training with the exception of one staff member who is currently on long term leave.

**Proposed Timescale:** 08/03/2017

**Theme:** Effective Services

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

It was not demonstrated that adequate and specific infection control procedures were in place where required.

### **10. 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:**

1. Infection control procedures for specific infection are in place with all staff aware of these and adhering to procedures.
2. Infection control check is included on daily shift leader template
3. Training for staff in relation to infection control in on-going
4. Boiler room identified as a potential risk to resident has had a lock fitted.
5. All chemical storage units are appropriately signed and locked with importance of this communicated to staff

Proposed Timescale: completed 23/02/17

**Proposed Timescale:** 23/02/2017

**Theme:** Effective Services

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

Seven of the designated centre staff had not received training in fire safety and management procedures specific to needs of residents in this centre.

**11. Action Required:**

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

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

Staff identified not having received site specific training have now received that training, with the exception of one staff who is on long term leave and will complete training prior to their return to the designated centre

Proposed Timescale: Completed 13/02/17

**Proposed Timescale:** 13/02/2017

**Theme:** Effective Services

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

The evacuation plans required review In order to be assured that the procedures in place were effective and took into account the residents needs for assistance at night time.

**12. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

1. All resident evacuation plans have been reviewed and updated to reflect step by step, the support residents would require in event of evacuation.

2. On the 8/02/2017 the fire and safety officer attended the designated centre. A review was carried out of the designated centre's day and night evacuation plan. Amendments were made to site specific evacuation plan, details of this were communicated to all staff in the designated centre.

3. The CNM met with fire and safety officer to assess adequacy of drills and their frequency.

The fire and safety officer documented the review for the designated centre and confirmed that the drills were adequate & effective. Details of this document are attached to action plan.

4. All new staff will be trained on the site specific evacuation plan for this designated centre as part of their induction process

5. Night simulation evacuation drills will continue on a scheduled basis.

6. The PIC in conjunction with CNM's will continue to review training records and schedule follow up training as required.

Proposed Timescale: Completed 10/02/17

**Proposed Timescale:** 10/02/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Residents did not have adequate access to relevant multidisciplinary supports for the implementation and review of behavioural support plans.

**13. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

1. An MDT schedule and Circle of Support schedules are in to encourage and promote better outcomes for residents.

2. Residents and their representatives will continue to be consulted in relation to personal planning and use of restrictive interventions

3. Behaviour Support plan for identified resident is now in place.

4. CNM's have carried out audit of IPP's with outcomes and actions communicated to staff

5. Restrictive interventions are reviewed in line with policy by committee every three

months

6. Safeguarding training was scheduled for week of the 20/02/2017, four staff attended same. A further date has been scheduled for the 27th February when the remainder of staff requiring refresher training will receive same.

**Proposed Timescale:** 27/02/2017

**Theme:** Safe Services

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

Systems for oversight of residents' finances did not sufficiently safeguard residents finances

**14. 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:**

Two financial audits will be carried out each year within the designated centre. One of these audits will be carried out by a Manager external to the designated centre.

**Proposed Timescale:** 24/04/2017

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

There was a delay in sourcing appropriate medical treatment for a resident.

**15. 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:**

An internal investigation will be carried out to determine the foreseeability of the rapid deterioration of the resident's condition and any delay in medical treatment.

**Proposed Timescale:** 09/03/2017

### **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The person in charge was also the director of care and support for the entire campus. He was also the person in charge for two centres. The person in charge did not have the capacity to effectively manage or monitor this centre.

**16. 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:**

1. The position of Person in Charge for this designated centre will be re-advertised
2. There are now two CNM1's placed in the designated centre.
3. Each CNM1 has been allocated 24hrs Protected per week.

**Proposed Timescale:** 09/03/2017

**Theme:** Leadership, Governance and Management

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

The systems of governance and management in place were not adequate in ensuring the centre was being effectively monitored and to ensure that residents' needs were consistently being met.

**17. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

1. The position of Person in Charge for this designated centre will be re-advertised
2. Two CNM1's are in place in the designated centre.
3. Each CNM1 has been allocated 24hrs Protected per week.

**Proposed Timescale:** 09/03/2017

**Theme:** Leadership, Governance and Management

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

The actions arising from unannounced visits and audits of the centre were not being addressed in a timely manner

**18. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the

designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- 1 The annual review of the designated centre for 2016 will be completed.
- 2 The position of Person in Charge for this designated centre will be re-advertised
- 3 Two CNM1's are in place in the designated centre.
- 4 Each CNM1 has been allocated 24hrs Protected per week.
- 5 Weekly meetings include a review of the designated centres Quality Enhancement Plan to ensure identified actions are being addressed in a timely manner

**Proposed Timescale:** 09/03/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There were gaps identified in staff training such as site specific fire training and safeguarding.

**19. 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:**

1. PDR's and supervision schedule is in place
2. All staff have received site specific fire training have, with the exception of one staff who is on long term leave.
3. Safeguarding training was scheduled for week of the 20/02/2017, four staff attended same. A further date has been scheduled for the 27th February when the remainder of staff requiring refresher training will be scheduled.

**Proposed Timescale:** 27/02/2017

**Theme:** Responsive Workforce

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

The supervision process required review in order to support staff development

**20. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately

supervised.

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

- 1 PDRs and supervision schedule is in place for 2017
- 2 Staff have been prioritised for PDRs and supervision

Proposed Timescale: Completed 25/02/17

**Proposed Timescale:** 25/02/2017