

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Abbeyfield
Centre ID:	OSV-0002362
Centre county:	Dublin 5
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Michael Farrell
Lead inspector:	Anna Doyle
Support inspector(s):	None
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: 12 October 2016 10:00 To: 12 October 2016 18:15

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 the third inspection of the designated centre. The purpose of this inspection was to follow up on actions from an announced registration inspection carried out in the centre in November 2014 and to monitor on going compliance with the regulations.

Description of the Service:

The centre is operated by St. Michaels House (SMH) and is situated in North Dublin. It comprises of a six bedroom bungalow located, close to local shops and transport links. A service vehicle is available for residents. The centre provides care to female residents who have an intellectual disability, some of whom have mobility issues, healthcare needs and behaviours that challenge. Care is provided using the social care model of support. All residents attend day services provided by SMH.

How we gathered evidence:

Over the course of this inspection the inspector met all of the residents. Some residents were unable to tell the inspector about their views on the quality of the services been provided in the centre. One resident was supported by staff to talk to the inspector. The inspector observed practices, met with staff, reviewed documentation such as: care plans, medical records, risk assessments, policies and

procedures and fire records. The person in charge was present on the day of the inspection. The person participating in the management of the centre was present for some of the inspection. They reported to the person in charge and supported them in their role. The interim service manager and the person in charge attended the feedback meeting.

Overall findings:

Overall the inspector found that residents appeared were well cared for in the centre. Staff were observed to treat residents with dignity and respect. However, the inspector found that one resident's needs could not be met in the centre, as appropriate equipment could not be installed to meet the resident's needs. The actions from the last inspection under outcome 5, 7 and 18 were followed up on as part of this inspection. The inspector found that two of the actions had not been fully implemented since the last inspection.

The designated centre was not suitable to meet the assessed needs of one resident leading to major noncompliance identified under outcome 5. Five of the outcomes were found to be moderately compliant under health and safety, safeguarding, medication management, governance and management and workforce. One outcome under documentation was found to be substantially compliant. The action plan at the end of this report addresses the improvements required.

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):

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

Findings:

The inspector found that residents had a personal plan in place, however one of the actions from the last inspection had not been implemented and significant improvements were required in order to ensure that the designated centre was suitable to meet the assessed needs of residents.

Since the last inspection the provider had undertaken to ensure that records contained in personal plans would reflect that residents and their representatives where appropriate, were consulted about the review of the personal plan. This had not been implemented.

In addition the provider had undertaken to ensure that the assessment of need would include all residents' healthcare needs and that appropriate care would be provided to manage those needs. This action had been implemented in terms of the findings at the last inspection.

A sample of residents' personal plans was viewed by the inspector. Residents had an assessment of need in place, which had been reviewed this year. Some assessments were in the process of being updated, using a new assessment framework that was being implemented by the provider. However, there were no health action plans in place for some assessed needs in order to guide care practices in the centre.

All residents attended a day service during the day four days a week. One day each week residents had a day off from their day service in order to achieve some social care

goals. This was in line with residents wishes as one resident chose to attend day services five days a week. The inspector found some records around resident's goals for the year. For example going on holidays. However, some residents had no goals set and those that did had no formalised plan to implement and review the goal.

In addition the inspector found while residents care was regularly reviewed through staff meetings, monthly key worker reports and through staff supervision, there was no overall review of residents' personal plans in order to assess their effectiveness. For example residents had not had an annual review meeting since 2014.

The inspector found that the designated centre was not suitable to meet the needs of one resident in terms of the layout and the provision of appropriate equipment. In addition the resident themselves had requested a transfer from the designated centre as they were not happy there. The person in charge informed the inspector that a meeting had taken place on 26/09/2016 to discuss this, the minutes of this were not available to the inspector. There were records to support that the provider had been taking steps to address this issue. However, risk assessments in place stated that the lack of appropriate equipment was posing a high risk to the resident and staff in the centre.

The inspector was informed that there had been no new admissions or discharges from the centre since the last inspection.

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):

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

Findings:

The inspector found that the actions from the last inspection had been implemented and that there were systems in place to manage risks in the centre. However, further improvements were required.

Since the last inspection the provider had undertaken to ensure that fire doors were installed in the centre. This had been completed.

Fire records were available which included up to date maintenance records of fire equipment in the centre. Fire drills had been completed and no issues had been identified. Residents had personal emergency evacuation procedures (PEEP's) in place. All staff had received training in fire safety in the centre.

There was a risk management policy in place along with a health and safety statement for the centre. Incidents were recorded on an e-form and were submitted to relevant senior personnel for review. However, there was no system in place to review incidents in the centre so as to identify trends and inform future practice.

In addition the inspector viewed the control measures and information gathered in response to one incident in the centre that had been notified to HIQA and found actions had been taken in order to minimise the risk of reoccurrence. However, there was evidence that actions identified as required following the review were not always implemented. For example, manual handling assessments in relation to the use of a hoist had not been updated.

There was a vehicle in place in the centre and this had an up to date road worthy certificate. One staff member used their own vehicle to transport residents and the person in charge had records to support that this person had appropriate insurance in place. However, there were no records to support the road worthiness of this staff member's car.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were measures in place to protect residents being harmed or suffering abuse in the centre. However, improvements were required in positive behaviour support plans and the use of restrictive practices in the centre.

There was a policy in place on safeguarding vulnerable adults and all staff were trained in this area; however, refresher training had not been provided to include the HSE revised policy. Staff spoken with were clear about what to do in the event of an allegation of abuse.

There was a policy in place for the provision of behavioural support to residents. A sample of resident's support plans were viewed by the inspector, however some had not been reviewed since 2014. In addition prescribed medication used in response to behaviours that challenge was not referenced in a behaviour support plan in order to effectively guide practice.

There were a number of restrictive practices used in the centre. There was evidence to support that some of these had been reviewed. However, one chemical restraint prescribed for anxiety around medical appointments had not been referred to the service committee for approval. The inspector found that this restraint had been discontinued earlier in the year as staff stated that the resident was able to manage their anxieties when familiar staff accompanied them to medical appointments. However, the records indicated that this had not been implemented on one occasion and had caused distress to the resident.

There was one other environmental restrictive practice in use in the centre. This was discussed with the person in charge and the rationale for the use of this practice was not clear. The person in charge agreed to review this practice.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found that each resident was supported to achieve best possible health in the centre. However, some improvements were required in health support plans for residents.

A sample of personal plans viewed found that residents had an assessment of need completed, some of which were being updated. Support plans were in place for assessed needs. However, some identified health needs had no support plans in place. In addition staff made reference to declining cognitive functioning; however, there was no support plan in place in response to this concern

From the sample of plans viewed the inspector found that residents had timely access to allied health professionals in order to meet their needs.

Meal times were not observed as part of this inspection. However, residents who required assistance with meals had this documented in their personal plans.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were policies and procedures in place for safe medication practices in the centre. However, improvements were required in the disposal of medications in the centre and the guidelines in place for the administration of as required medication.

There were policies and procedures in place for the safe administration of medication. However, there was no policy on the disposal of medications in the centre. The person in charge informed the inspector of the procedure to be followed for the disposal of medications, but this was not evident in practice. For example medications that had been discontinued were stored with regular prescribed medications. The person in charge removed the discontinued medication from the medication press during the inspection.

A sample of medication administration sheets and prescription sheets were viewed by the inspector and no issues were identified. There were guidelines in place for the administration of as required medication (PRN), however some were out of date and did not contain the current prescribed medication for the resident.

The inspector found that one medication prescribed by the resident's general practitioner by e-mail, had been administered by staff from the GP prescription and had not been recorded on the resident's medication prescription sheet. This was not in line with the service medication policy.

Medications were stored in a secure cabinet in the centre. However, there was a medication fridge in the centre and this was not locked. This also contained medication that had been discontinued.

One medication error had occurred in the centre since the beginning of the year. The inspector found that this had been followed up appropriately with a nurse manager on

call.

No controlled drugs were stored in the centre.

No residents self medicated in the centre. There was information contained in residents file where the prescribed medications and their uses had been made into an accessible format for residents.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that there was a defined management structure in place. However, improvements were required so as to ensure that the quality of care provided in the centre was being continuously reviewed.

There was a defined management structure in place. The person in charge reported to a service manager, who reported to the provider. A person participating in the management of the centre had recently been appointed; they supported the person in charge in their role. They were interviewed as part of this inspection and were found to be knowledgeable of the residents needs and aware of the regulations.

The person in charge was present on the day of the inspection. Their fitness had been assessed at the last inspection of the centre. The inspector found that the person in charge had a very good knowledge of the residents needs in the centre. They were allocated protected time on a weekly basis in order to complete administrative functions.

An interim service manager had been appointed to the centre. The inspector found that a meeting had recently been held between this person and the person in charge. However, prior to this there were no records available of meetings held between the person in charge and the service manager.

There had been no quality review of the centre and an annual review had not been completed. There were records to indicate that some quality and care practices were being reviewed. For example health and safety audits were being completed monthly and medication was audited on a weekly basis. In addition, the interim service manager informed the inspector at feedback that a quality enhancement plan had been formulated for the centre in order to ensure that actions identified from meetings, audits and HIQA inspections of the centre were being followed up on. A copy of this was submitted to HIQA after the inspection.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector found that the skill mix in the centre was suitable to meet residents' needs. However, there were insufficient staffing levels on duty some days in order to meet residents social care needs.

The inspector found that there were times during the week when there were insufficient staffing levels in the centre. One resident required two staff in order to meet their assessed needs. However, with the exception of one evening during the week, there was only two staff on duty at all times. This impacted on other residents social activities. For example, the inspector was informed that on some occasion's staff and residents were required to return from social activities so as two staff members were available to support this resident.

In addition, there was a risk assessment in place in response to one resident not having access to social activities due to lack of familiar staff on duty. While the person in charge informed the inspector that every effort was made to ensure that this was addressed, the over reliance on agency staff in the centre meant that this was not always facilitated. For example in a four week period in July and August 2016, 234 hours had been filled by agency or relief staff.

The inspector was informed that this had recently been addressed and that two new

part time staff had been appointed and another part time staff post had been advertised. On viewing a planned roster for a four week period in October and November 2016, the inspector found that the use of agency and relief staff would decrease as 106 hours were requested for this period.

An up to date schedule of training was not available on the day of the inspection. Some staff had recently completed training in the centre. The person in charge agreed to submit these to HIQA after the inspection. On review some gaps were identified. These included:

- No refresher is training in safeguarding vulnerable adults in line with the HSE policy.
- Three staff had not completed medication training.
- Two staff had not completed refresher training in first aid and a number of staff required training in positive behaviour support. However, the inspector was informed that some staff were completing refresher training in First Aid and positive behaviour support in the coming weeks.

Supervision for staff was in place. Staff spoken to said that they felt supported in their role and that the person in charge was available to them to discuss concerns at anytime. A sample of staff supervision meetings were viewed. Examples of issues discussed included training needs, teamwork and residents' needs.

There was a nurse on call available 24hours a day in order to provide support to staff around nursing needs.

Personnel files were not reviewed as part of this inspection and the inspector was informed that there were no volunteers employed in the centre.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspector found that two of the actions from the last inspection had been implemented and one still required improvement. No other aspect of this outcome was inspected.

Since the last inspection the provider had undertaken to ensure that a resident's guide and a directory of residents were available in the centre that included all of the relevant requirements under Schedule 3 of the regulations. The inspector found that both of these actions had been implemented.

In addition the policies and procedures required under schedule 5 of the regulations were to be available in the centre. This had been completed with the exception of the policy on the provision of information to residents which was still under review by the service.

Judgment:

Substantially 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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002362
Date of Inspection:	12 October 2016
Date of response:	25 November 2016

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:

There was no evidence that residents or their representatives were involved in their personal plans.

1. Action Required:

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

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

conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, 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:

Residents consulted re; family involvement since inspection, those who wish family involvement, these families have received letters inviting their participation. Copies of these letters are in residents files for viewing.

All residents will be involved in the development of their personal plan.

Proposed Timescale: 30/10/2016

Theme: Effective Services

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

Personal plans were not reviewed so as to appropriately assess their effectiveness.

2. Action Required:

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

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

A Personal Goal Tracker is now in place to assess the progress of identified goals for each person. Support plans are reviewed monthly to establish skill development.

Proposed Timescale: 30/10/2016

Theme: Effective Services

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

One resident who was been monitored due to a changing need had no support plan in place to show how this should be implemented or who was responsible.

3. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

A referral for a review of guidelines has been made to the relevant department and Behaviour guidelines have been reviewed by the Psychologist. The person in charge and key worker will follow up with the relevant people to ensure a robust support plan,

is in place to identify additional supports and will be monitored to reflect changing needs.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Some residents had no goals set and those that did had no formalised plan to implement and review the goal.

4. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

A Personal Goal Tracker is now in place to assess the progress of identified goals for each person. Support plans will be reviewed monthly to establish skill development.

All staff will receive onsite training regarding development of Personal Plans on 17/11/16.

Evaluation of the support plans will take place monthly and feedback to the clinic team re; changing needs

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

The designated centre was not suitable in order to meet the assessed needs of one resident.

5. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

- The resident in question has already been referred to Residential Approvals Committee to support a transition to more suitable accommodation.
- Review by manual handling trainer scheduled for the Monday the 5th Dec to provide support and guidance to staff .
- Recent O.T assessment carried out { on alternate premises} on 18th Nov to establish

residents suitability for placement, O.T dept felt that the residents needs would be met from a manual handling view point with the addition of a tracking system.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

Some residents' personal plans did not contain health support plans for their assessed needs.

6. 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:

Completion of transfer of all documentation to the new format including health support plans drawn up to reflect residents needs will be completed by the 31/12/2016

Proposed Timescale: 31/12/2016

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:

There was no record available to show that a staff member's car who used it to transport residents was roadworthy.

7. Action Required:

Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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

A copy of NCT cert and evidence of Indemnity by Insurer is now held on site.

Proposed Timescale: 13/11/2016

Theme: Effective Services

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

There was no system in place to review incidents in the centre so as to identify trends and inform future practice.

All of the learning from the review of an incident in the centre had not been implemented into practice.

8. Action Required:

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

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

A tracker system is now in place to review incidents in the centre so as to identify trends and inform future practice.

Proposed Timescale: 30/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was no rationale in place around one restrictive practice in the centre.

One restrictive practice had not been referred to the service committee for approval.

9. 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 first restrictive practice mentioned above has been removed.

Referral to Positive Approaches Management Committee (PAMG) was sent on 28/10/16 regarding the other restriction mentioned. Their response will inform us regarding future practice.

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Some behaviour support plans had not been reviewed since 2014.

One resident who had been prescribed medication in response to behaviours that challenge did not have this referenced in their behaviour support plan in order to guide practice.

10. 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:

Behaviour Support plans that were out of date have been referred to the psychology department for review

All prescribed medication in response to behaviours that challenge will be referenced in their corresponding behaviour support plan.

Proposed Timescale: 30/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Some residents had no health action plans in place around some assessed needs.

11. 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:

Support plans including health action plans will be reviewed and any outstanding supports will be referred to the relevant Health Care Professionals which will address identified needs.

Proposed Timescale: 30/11/2016

Outcome 12. Medication Management

Theme: Health and Development

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

There was no policy on the disposal of medications in the centre.

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:

Policy on the disposal of medication is now in the centre and has been read and signed off by staff.

Proposed Timescale: 30/10/2016

Theme: Health and Development

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

Unused and discontinued medication was stored with regular medications on the day of the inspection.

13. Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

A quarterly Audit of Medication Management was carried out on 13/11/16 by the Person in Charge.

A tri monthly audit will be completed in the centre by the Person in Charge.

All unused and discontinued medication has now been removed from the centre.

Proposed Timescale: 13/11/2016

Theme: Health and Development

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

One medication prescribed by the resident's general practitioner by e-mail, had been administered by staff from the GP prescription and had not been recorded on the resident's medication prescription sheet. This was not in line with the service medication policy.

Some PRN guidelines in place did not contain the correct information about prescribed medications as recorded on the prescription sheet.

14. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

PRN guidelines have been amended to reflect changes by the residents doctor to their prescribed medication and recorded on their Medication Adminstrating Sheet (MAS) . Refresher training for staff in the administration of medication has been completed on the 14/11/2016.

Proposed Timescale: 14/11/2016

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:

There were no records of regular meetings being held with the person in charge and the service manager since the last inspection.

15. 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:

Copies of supervision meetings between the Person in Charge and the Service Manager are now held in the centre

Proposed Timescale: 30/10/2016

Theme: Leadership, Governance and Management

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

An unannounced quality and safety review had not been completed in the centre since 2014.

16. Action Required:

Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

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

A unannounced Quality and Safety Audit was carried out on the 25/10/16

Proposed Timescale: 25/10/2016

Theme: Leadership, Governance and Management

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

An annual review had not been completed for the centre since the last inspection in 2014.

17. Action Required:

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

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

Annual review for 2015 has been completed

Proposed Timescale: 15/11/2016

Theme: Leadership, Governance and Management

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

There was no supervision in place for the person in charge in the centre.

18. Action Required:

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

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

Monthly supervision is now scheduled with Person in Charge and Service Manager
A record of these meeting will be kept in the centre

Proposed Timescale: 20/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There had been an over reliance on agency/relief staff in the centre.

19. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Roster review scheduled for 21/11/16

Proposed Timescale: 21/11/2016

Theme: Responsive Workforce

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

There was insufficient staffing available at certain times during the week in order to meet residents assessed social care needs.

20. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

An additional staff is available one evening per week. The above mentioned roster review will identify any additional supports that may be required.

Proposed Timescale: 21/11/2016

Theme: Responsive Workforce

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

Staff had not completed refresher training in safeguarding vulnerable adults.

Some staff had no safe administration of medication training completed.

Some staff required refresher training in positive behaviour support.

Some staff required refresher training in first aid.

21. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- All Staff have completed training in safeguarding vulnerable adults. Refresher training is scheduled for 2017.
- The three staff who completed Initial Training during 2013 are scheduled to complete refresher training on January 20th and 27th 2017 in line with the unit roster.
- One staff who completed Initial Training in July 2014 will complete refresher training via an online module prior to her expiry date in July 2017 and will complete formal refresher training during 2018.
- All other staff training in this area continues to be in date until 2018 and 2019 but will be given access to refresher training if the need is identified.

Safe administration of medication training completed on 18/10/16

One staff member is scheduled to attend the final First Aid refresher training (for this centre) on 30/11/16

Proposed Timescale:**Outcome 18: Records and documentation**

Theme: Use of Information

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

The policy on the provision of information to residents was not available in the centre.

22. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Policy on the provision of information to residents will be available by the 31/1/2017

Proposed Timescale: 31/01/2017

