Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Vevay Close
Centre ID:	OSV-0005052
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Company Limited by Guarantee
Provider Nominee:	John Hannigan
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Anna Doyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
17 November 2016 11:00	17 November 2016 22:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 second inspection of this designated centre. An initial inspection in 2015, was completed as a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time the designated centre was not found to be in sufficient compliance with the regulations in order for the chief inspector to grant registration. The purpose of this inspection was to follow up on the previous inspection and also to follow up on unsolicited information received identifying concerns in relation to the overall management of the designated centre.

How we gathered our evidence:
As part of the inspection, inspectors visited the designated centre, met with five residents and spoke with the person in charge and three staff members. Inspectors viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures. Over the course of this inspection resident's communicated in their own preferred manner with inspectors. Residents allowed

inspectors to visit their individual apartments and to observe their daily life in the designated centre.

Description of the Service:
This designated centre is operated by Sunbeam House Services (SHS) Limited and is based in Bray, County Wicklow. Seven residents resided in the designated centre at the time of this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose. The designated centre consisted of eight individual apartments surrounded in a courtyard.

Overall Judgments of our findings:
Eleven outcomes were inspected against and two outcomes were found major non-compliant. Outcome 8 safeguarding and safety, was major non-compliant, significant improvements were required in the management of restrictions in place and the management of displays of behaviours. Outcome 14 governance and management, was also found in major non-compliance. Inspectors found the provider had not put adequate arrangements in place. There was a lack of effective governance and management systems within the designated centre.
Seven outcomes were found to be moderately non-compliant with two outcomes substantially compliant.

The person in charge facilitated the inspection.

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

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

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

Outcome 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:
Inspectors reviewed this outcome in relation to the non-compliances identified on the previous inspection and found the actions had not been addressed in relation to complaints.

Inspectors found complaints were not processed in line with the organization's policy. On the day of inspection, inspectors became aware of a complaint made by a family member to a member of staff within the designated centre. However, when inspectors requested to view this complaint, inspectors were informed this was not documented as a complaint.

Inspectors viewed other complaints, however, the person in charge did not have access to the details of some of these despite, being the local complaints officer.

Other complaints viewed from November 2015 and March 2016 remained opened within the system in the designated centre. The person in charge was unable to identify any progress in relation to these. Steps were identified within the complaints process to be implemented however, no progress or dates were specified in relation to any progress achieved. Within other complaints viewed the process was unclear for example, review sections were blank.

Overall, inspectors found complaints were not dealt with promptly, in addition inspectors also found measures required to bring about improvements arising from complaints were not evident as insufficient information was available to staff members within the

designated centre. Both of these areas were highlighted in the previous inspection. Some of the complaints viewed had a direct impact on the day to day lives of residents in relation to the provision of meals and support with personal hygiene.

Inspectors found the oversight of resident's finances was not taking place as outlined within the organizations policy, this was discussed with the person in charge on the day of inspection.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspectors found one of the two actions identified in the previous inspection remained outstanding.

Inspectors viewed a number of written agreements including service level agreements and tenancy agreements. Inspectors found one of these did not relate to the current designated centre. Services included were specified however, staff identified some of these were inaccurate for the resident in question as the service identified were not available for this resident.

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

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-

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

Theme:
Effective Services

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

Findings:
Each resident has opportunities to engage in meaningful activity and all residents had personal plans in place. However, the progress and effectiveness of goals set were not being reviewed for some residents.

Personal plans contained social goals these included areas such as going on holidays and community activities. Other goals focused upon the overall objective of the centre to support people to live more independent lifestyles such as focusing upon activities of daily living such as to make tea independently. Some of these goals contained clear levels of progress and review however, others did not. For example, it was unclear to inspectors if actions agreed on review had been implemented or the level of progress made in relation to the specified goals. Staff members were also unable to identify progress.

The system of personal social plans within the designated centre involved personal outcome measures encompassing 23 quality of life indicators as an assessment. This plan was to be completed once every three years. The information gained during the process contributed to the development of a personal plan. This plan was to be completed annually and reviewed every six months. Inspectors viewed five residents' personal plans and these were dated in 2016.

Residents spoken with, were familiar with some of the information contained within their plans and goals they were working towards achieving. Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence of this maintained within the resident's files.

Inspectors viewed a synopsis of resident's supports compiled for staff members. There was no identification of what level of staff support was to be provided or what staff were to provide this support. For example, if this related to staff members from within the designated centre or another area. Inconsistencies were also identified within what was outlined within this document and within residents plans. For example, activities such as, walks or therapeutic activities were not identified within this document. Inspectors found this document did not guide staff members effectively in relation to supporting residents social care needs within the designated centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found one of the two actions remained outstanding in relation to fire training. Inspectors found improvements were required in relation to risk management, to ensure the designated centre was suitable and safe for the number and needs of residents.

The designated centre had an organisational risk management policy in place, this included the specific risks identified in regulation 26. The designated centre risk register was currently being reviewed to accurately reflect the number of risks within the designated centre and the controls in place to address these.

Inspectors viewed residents individual risk assessments and found some of these required review. Inspectors found inconsistencies between information contained within residents files and risk assessments. This related to supports residents required from staff members and control measures in place. Inspectors found the system of risk management in place was not ensuring residents safety nor was this effectively guiding staff members. This was particularly pertinent in this centre as there was a significant reliance upon relief staff.

Inspectors viewed the fire procedure however, this document was currently under review to reflect changes within the designated centre.

Inspectors viewed five residents PEEP's (personal emergency evacuation plans) and found these required review to reflect to current needs of residents and to ensure staff were guided effectively during an emergency. For example, one plan identified staff support was required due to a sensory impairment. From discussions with staff members, inspectors were informed no support was required by this resident.

From a sample of 13 training records viewed one staff member required training in the area of fire and another staff member had not attended in the area of fire training since 2004.

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

Annual servicing was completed in December 2015 and the previous quarterly completed in September 2016.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors found the action from the previous inspection had been implemented in relation to the provision of training in the area of prevention, detection and response to abuse. In addition inspectors found there were some measures to protect residents from being harmed in place within the designated centre. However, improvements were required in relation to behavioural support plans and the use of restrictive practices.

There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided clear guidance to staff on how to manage any incident of concern arising in the designated centre. The policy provided staff with knowledge on how to recognise abuse and their responsibility in reporting it.

From speaking with some staff members inspectors found they understood their role in protecting residents and the reporting procedures if they had any concerns.

Inspectors found some measures to protect residents from being harmed were in place within the designated centre. However, improvements were required in relation to behavioural support plans and the use of restrictive practices.

There was a policy in place on the use of restrictive practices in the designated centre. Inspectors found some restrictive practices in the designated centre were not reviewed, to ensure the least restrictive practice was been implemented. Therefore, the management and monitoring of restrictions in place required significant improvement to ensure clear rationale for usage along with evidence of alternative less restrictive interventions being considered prior to implementation. If restrictions were required evidence of the least restrictive intervention being implemented for the shortest duration

of time was not evident. Inspectors also found some inconsistent information between right restrictions documents, risk assessments and personal plans. This designated centre required relief and agency staff therefore, inspectors found the safety of residents was not promoted through these inconsistencies.

Inspectors found environmental restrictions were in place however, the rationale for some of these were unclear for example, limiting the use of electrical appliances within one apartment. Inspectors requested to view evidence of why this restriction was in place. From the information provided to inspectors this was unclear nor was there evidence of a less restrictive intervention been considered.

Inspectors also found two other restrictions were implemented due to a psychological condition on the 26 December 2015. This restriction was under review since the 12 August 2016 without approval by the person in charge. Inspectors found one of the two restrictions implemented had been removed. The reason for the removal stated the psychological condition of the resident had improved. Inspectors found this system of review did not clearly outline the rationale for leaving the second restriction in place when both were implemented for the same reason.

Inspectors viewed written confirmation of a restriction in relation to a video and audio monitor the document stated this was under review on the 16 May 2016. Two members of staff identified this was not accurate as an audio monitor was used. Inspectors request clarity from the person in charge in relation to this. From the information made available to inspectors a visual monitor was identified as prescribed within the same document it also identified a neurologist prescribed a video monitor. The documents identified this was approved. Inspectors asked which of the two products were approved the person in charge confirmed this was also unclear from the records maintained within the designated centre. Inspectors also viewed minutes of meeting where a doctor agreed to a bed sensor alarm over a conference call instead of an audio monitor.

Physical restrictions in relation to a holding position for one resident was evident within documentation viewed, inspectors viewed three incidents were these were implemented. Some of the incidents viewed did not identify the duration of the intervention. Therefore, inspectors found this was not in accordance with the organisations own policy in relation to restrictive practice.

Inspectors viewed a behavioural support plan dated 10 November 2015 outlining a number of recommendations. These related to staffing and regular familiar staff providing care delivery to avoid displays of behaviour that challenges. Another recommendation suggested consideration to a one staff team approach. This document had a review date inserted for 09 September 2016. Inspectors asked the person n charge who had reviewed this document however, this information was unavailable as the document was unsigned. There was also no evidence of review of the interventions in place to identify if these were effective in the management of the residents displays of behaviours that challenges. Another resident required a behavioural support plan since 12 August 2016. Inspectors requested to view this document. The person in charge was unaware if this plan had been completed, following a review of the residents file the person in charge confirmed this was yet to be completed. Inspectors found the system of reviewing and implementing resident's behavioural support required

improvement. As all staff members were not effectively guided consistently in the delivery of support to residents in relation to displays of behaviours that challenges from plans viewed.

From a sample of 13 staff members training records viewed two staff members required training in relation to the management of displays of behaviours.

Intimate care plans were in place for residents however, some of these required updating to reflect current practice within the designated centre in relation to the provision and delivery of care.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Inspectors found improvements were required in relation to the written report provided to the Chief Inspector at the end of each quarter to include all occasions on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

Findings:

Each resident was supported to achieve best possible health. However, improvements were required in the information contained in resident's healthcare plans.

The healthcare needs of residents were completed via a plan entitled 'my health development plan'. From this a care plan and/or support plan was developed. Inspectors viewed five resident's plans. However, some healthcare conditions were not identified. Inspectors found interventions were in place for some healthcare conditions. However, some of these conditions were not identified within a health assessment. Inspectors also found a lack of input from a dietitian for a specific condition in relation to the foods provided. Inspectors found there was a review system in place for goals set however, this review did not access the effectiveness of the interventions in place.

Inspectors found healthcare plans contained generic information not relevant to residents. For example, the document stated staff teach me personal care, eating well, being more active, smoking, alcohol and drug intake. Some of these documents were signed by the resident themselves. Inspectors discussed this with the person in charge and some of these areas were not relevant to residents.

Inspectors viewed some epilepsy plans in place and found theses were not detailed enough to guide staff members in effective delivery of care in relation to seizure management.

Some residents and staff members spoken with were familiar with some of the healthcare interventions in place and discussed these with inspectors.

Residents had access to a G.P. (general practitioner), all residents had received an annual review, including phlebotomy tests as required for some residents due to medication prescribed.

Regarding food and nutrition inspectors found residents participating in mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices. Residents participated in cooking and or meal preparation in accordance with their own preferences and abilities.

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

implemented.

Findings:
Inspectors found one of the two actions from the previous inspection remained outstanding. Improvements were also required in relation to p.r.n. medicine (medicine only taken as the need arises).

Inspectors found policies and procedures were in place for the safe management of medications. This related to the administration, transcribing, storage, disposal and transfer of medicines dated 01 September 2016. Medication was recorded when received.

Inspectors found staff members were not guided effectively in the administration of some p.r.n medications for example, when two or more medications were prescribed for the same purpose. No guidance was available to staff in relation to which medication to administer or if both medications could be administered. Staff members spoken with were unsure if both medications could be administered.

Some medication plans in place were not reflective of the current medication prescribed for residents.

One medication was labelled incorrectly with 10mgs specified however, the medication was 5mgs. Inspectors found this practice was not in accordance with evidence based practice or in line with the organizations administration of medications policy.

Inspectors found some short term medication were not discontinued within the resident's administration sheet. Other administration sheets were found to be up-to-date and showed staff administered and signed for medication.

Inspectors crossed checked the balances of some medication and found these to be accurate.

Staff signatures were present within the signature bank.

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

There was a system in place for recording, reporting and reviewing medication errors.

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

Findings:
Two of the three actions from the previous inspection had been achieved, in relation to appointing a person in charge and completing an annual review. However, inspectors found significant improvements were required within the overall governance and management structure in place within the designated centre as identified on the previous inspection.

In the context of the findings on this inspection, the management arrangements in relation to the person in charge did not ensure effective governance, operational management and administration of this designated centre. The person in charge was responsible for two designated centres along with a day service. The person in charge did not have sufficient knowledge in relation to the assessed needs of the residents, was not able to access relevant documentation such as accurate staff training records, staff supervision records and the review of incidents and accidents within the designated centre. The person in charge did not take reasonable measures to ensure oversight of resident's finances. Key workers were assigned responsibility for maintaining oversight of residents balances and expenditure, however, there was no auditing or checks in place to ensure compliance to policy. The organisational policy on managing residents finances stated the person in charge must complete audits or residents financial transactions.

Inspectors were unable to determine how frequently this person was present in the designated centre nor did the staff rota identify this to other staff members. Inspectors were informed this person in charge had taken on the role in a temporary capacity and another person had been recruited to commence in the role in a number of weeks.

Inspectors did identify there was a clearly defined management structure in place within the organization and staff members were familiar with these individuals. Inspectors viewed minutes of the person in charge attending the senior management team meeting. This was dated 25 October 2016. Areas discussed related to the whole organization including an organizational update, financial update and policy update in relation to the complaints policy.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings). However, these meetings were not available for review within the designated centre.

An annual review of the quality and safety of care in the designated centre was

completed, this was dated 19 February 2016. Inspectors found this document did not meet with regulations as consultation with residents and their representatives was not evident.

The provider had nominated a person to conduct visits to the designated centre at least once every six months and produce a report. The last unannounced visit was conducted on the 06 October 2016. The action plan for this report was not yet completed. Inspectors requested to view the previous report, However, inspectors also found no action plan was evident for this within the designated centre.

Inspectors viewed minutes of staff meetings within the designated centre some of these were held in conjunction with another designated centre. Since July four meetings had been conducted two of these pertained to this designated centre only. The person in charge attended two of the staff meetings. Inspectors found lack of clarity in relation to the progress of items discussed at team meetings as some items were not followed through within the minutes. Other areas discussed within meetings were not reflective of current practice within the designated centre. For example, supervision discussed on the 18 July 2016, it was identified another person in charge of a different designated centre was to continue supervising staff members in this designated centre. The person in charge of this designated centre did not have access to the supervision records of the staff members working within the designated centre.

Inspectors were informed this had changed and supervision was conducted by the deputy manager of the designated centre however, the person in charge did not have access to these. Inspectors found no evidence was evident between this staff member and the person in charge in relation to ensuring effective governance of staff supervision. Therefore, inspectors were unable to establish how the person in charge had effective oversight in relation to this process.

Inspectors were unable to view any audits conducted by the person in charge within the designated centre for example, in the area of medication management. Therefore, inspectors found improvements were required in the local management systems in place to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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:
Inspectors were unable to determine if sufficient staff numbers with experience were deployed to meet the assessed needs of the residents within the designated centre. Improvements were required in relation to the staff rota and staff training. Staff training was identified during the previous inspection and remained outstanding on this inspection.

Accurate training records were not available within the designated centre these were subsequently provided following inspection. From the sample of 13 staff members records viewed, inspectors found six staff members required first aid training and one staff member required refresher training as previous training was dated 2005. Safe administration of medication training was required by one staff member and refresher training was required by three staff members. Epilepsy and the administration of rescue medication refresher training was required by one staff member.

Inspectors viewed the proposed and actual staff rota and found significant improvements were required. Inspectors found the rota did not reflect practice within the designated centre. Staff members were present from another designated centre at periods when this designated was short staffed as staff members worked between locations. Staff names, role, along with hours worked were not reflected within the rota. Inspectors were informed staffing numbers depended on the numbers of residents. Inspectors cross referenced this information received against the actual rota and found gaps evident. Where the actual complement of staff was one less than required. In addition the need for familiar staff was documented within several residents files, as a control measure to displays of behaviours that challenge. Inspectors found this was not reflected in practice as agency staff members were regularly required to work within the designated centre. Inspectors also found the staffing numbers contained within the statement of purpose was not accurate.

Inspectors found what level of support residents required from staff members was unclear within the designated centre. Inspectors requested this information however, the document provided did not outline this.

Staff files were not reviewed as part of this inspection as these are held within the organizations head office off-site these were reviewed as part of the previous inspection.

There were no volunteers within the designated centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

Findings:
The action from the previous inspection had been achieved. Inspectors viewed documentation in relation to the recording of the dosage of medication for one resident in place within the designated centre.

Inspectors viewed the directory of residents which did not include all the information as specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example the date of admission was not present for all residents.

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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee
Centre ID:	OSV-0005052
Date of Inspection:	17 November 2016
Date of response:	13 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Oversight of resident's finances was not taking place as outlined within the organizations policy.

1. Action Required:

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

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
A review of the oversight of resident's finances has been conducted. Going forward and in line with organisational policy a monthly review of resident's financial records will be conducted by the PIC.

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Insufficient information was available in order for staff to bring about any improvements following a response to complaints.

2. Action Required:
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The outcome of complaints and any learning identified will be discussed at staff team meetings. Complaints will be a standing item on team meetings to encourage discussion and awareness amongst the staff team.

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some complaints were not processed in relation to the organizations policy.

3. 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:
All future complaints will be processed in line with the organisations complaints policy.

Proposed Timescale: 13/02/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some written agreements in place were not reflected of the services provided within the designated centre.

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

Please state the actions you have taken or are planning to take:
A review of written agreements will be conducted for the designated centre. All written agreements will be amended to reflected services provided in the designated centre.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found one agreement did not related to the current designated centre.

5. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
This agreement will be updated to reflect the resident's placement in this designated centre.

Proposed Timescale: 30/04/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some reviews of personal plans did not assess the effectiveness of each plan.

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

circumstances and new developments.

Please state the actions you have taken or are planning to take:
All future reviews of Personal Plans will assess the effectiveness of the plan. This will be clearly documented in the review notes.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found inconsistent information was contained within the synopsis of supports and residents person plans in relation to activities.

7. 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:
A review of the of the synopsis of supports and personal plans will be conducted. Any inconsistencies will be removed.

A clear working document outlining the assessed supports required by each resident will be generated.

Proposed Timescale: 28/02/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment, management and ongoing review of risk required review for some residents.

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 comprehensive review of how risks are assessed, managed and reviewed will be conducted. This will include individual and location risks.

Individual Risk assessments will be completed by keyworkers, the PIC and in

collaboration with residents and/or their representatives.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations required review. As some PEEP's did not reflect the current support requirement of residents.

9. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
A review of all residents Peeps will be undertaken with Keyworkers and the PIC. Any deficits identified will be rectified. Any changes will be communicated to the team via e-mail and at the next staff meeting 27/02/2017.

Proposed Timescale: 27/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From a sample of 13 staff members training records one staff member required training in the area of fire and another staff member had not attended training since 2004.

10. 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:
A comprehensive review of the staff training needs has been conducted.

A training needs analysis has been devised, which highlights training deficits & upcoming training needs. Any training identified has been booked and staff are scheduled for ongoing refresher training.

Proposed Timescale: 13/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recording of physical restrictions for one resident was not in accordance with evidence based practice.

11. 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:
A restrictive practice log will be created. It will document,
- The date
- Time
- Duration
- Resident Unique identifier
- Type of restriction
- Description of restriction
- Staff involved

This log will be reviewed weekly by the PIC and used to generate NF39 notifications.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some behaviour support plans did not effectively guide staff to assist them to respond to display's of behaviours and support resident to manage their displays of behaviours.

One resident required a behavioural support plan. This was not available for staff to guide their practice within the designated centre.

12. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
All current behaviour support plans will be reviewed to assess do they effectively guide staff in responding to behaviours that challenge. Where deficits are found, the plans will be developed with a team based approach and in line with organisational policy.

A behaviour support plan will be devised in cooperation with the resident's team to

guide staff in their practice in the designated centre.

Proposed Timescale: 31/03/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From a sample of 13 staff members training records viewed two staff members required training in relation to the management of displays of behaviours.

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

Please state the actions you have taken or are planning to take:
A comprehensive review of the staff training needs has been conducted.

A training needs analysis has been devised, which highlights training deficits & upcoming training needs. Any training identified has been booked and staff are scheduled for ongoing refresher training.

Proposed Timescale: 13/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the use of environmental restrictions to ensure a clear rational for use with regular reviews.

Lack of evidence to ensure every effort to identify and alleviate the cause of residents' behaviour were being made within the designated centre.

Evidence of alternative measures being considered before a restrictive procedure was used and that the least restrictive procedure, for the shortest duration necessary was used for some residnets was not present within the designated centre.

14. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
All environmental restrictions will be reviewed.

This review will clearly outline the rational for the restriction. It will also clearly demonstrate evidence what alternative measure were considered. Any restriction used will clearly demonstrate it's the least restrictive option being used for the shortest duration.

How behaviours are manged will be reviewed and the use of positive behaviour support plans will promote the least restrictive environment possible.

Proposed Timescale: 13/03/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some intimate care plans were in place required updating to reflect current practice within the designation centre.

15. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
All intimate care plans will be reviewed by Keyworkers. This review will reflect current practices and the wishes of residents and/or their representatives.

Proposed Timescale: 13/03/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some of the environmental restrictions were not included within the written report provided to the Chief Inspector at the end of each quarter.

16. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
A restrictive practice log will be created. It will document,
• The date

• Time
• Duration
• Resident Unique identifier
• Type of restriction
• Description of restriction
• Staff involved

This log will be reviewed weekly by the PIC and used to generate NF39 notifications

Proposed Timescale: 28/02/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some healthcare plans contained generic information.

Some healthcare interventions were not identified within a healthcare assessment.

Some reviews of healthcare interventions did not access the effectiveness of the interventions in place.

Some epilepsy plans required improvement to effectively guide staff in relation seizure management.

17. 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:
Any nonspecific generic information will be removed from healthcare plans

Healthcare assessments will be amended to reflect all healthcare interventions being used.

All future reviews of healthcare interventions will include assessment of the effectiveness of the intervention in place.

All epilepsy plans will be reviewed in conjunction with the appropriate healthcare professional and developed to effectively guide staff in relation to seizure management.

Proposed Timescale: 28/02/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence of a dietician review was not present within the designated centre.

18. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
Where a dietician is required to support the assessed needs of a resident, evidence of their ongoing intervention and review will correlated. The outcome of each review will be clearly recorded.

Proposed Timescale: 13/02/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No guidance was available to staff in relation to the administration of some p.r.n medications .

Some medication plans in place were not reflective of the current medication prescribed for residents.

One medication was labelled incorrectly.

Some short term medication was not discontinued within the resident's administration sheet.

19. 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:
A review of all medication plans and supports will be conducted.

Where further guidance is required in the administration of PRN medication, this will be developed and recorded in the residents Medication Folders.

All Medication plans will be updated to reflect the current medication prescribed for residents.

When delivered, each residents medication will be checked to ensure it is labelled correctly. This will be recorded on the medication sign in sheet.

Any short-term medication needing to discontinued will be discontinued by the residents GP on the resident's medication administration sheet.

Proposed Timescale: 28/02/2017

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:
Inspectors found the person in charge was in charge of more that one designated centre and was unable to ensure effective governance, operational management and administration of the designated centres concerned.

20. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The person in charge at the time of this inspection was only as an Acting Role, there is now a full time permanent Person in Charge of this location. Further changes to downsize the cluster have also been made and should be completed by end of March as interviews will be held on16th Feb 2017.

Proposed Timescale: 31/03/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge of the designated centre did not have training in regard to the needs of residents within the designated centre.

21. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

A new PIC has been appointed since this inspection. This PIC has completed all necessary training to support residents within the designated centre.

Proposed Timescale: 13/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review of the quality and safety of care and support in the designated centre did not consult with residents and their representatives.

22. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The 2016 annual review of quality and safety will clearly demonstrate how residents and their representatives were consulted with.

Proposed Timescale: 30/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management system in place did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

23. 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:
The Person in Charge will ensure the service provided is safe, appropriate to residents needs and consistent.

This will be achieved through,
- Regular dialogue with residents and their representative's.
- The PIC will conduct monthly audits to monitor the service effectively.
- Regular reviews of resident's plans will be overseen by the PIC.
- Risk assessment will be reviewed regularly
- The centre risk register will be updated regularly.

Proposed Timescale: 30/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangement in place to support, develop and performance manage all members of the workforce required improvement to ensure the person in charge was aware of staff members reviews in relation to the quality and safety of the service they delivered.

24. 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:
A supervision schedule will be devised to provide support to staff at regular periods, in line with the organisational policy. This supervision will be conducted by the Person In Charge.

Proposed Timescale: 28/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Accurate rota's in relation to the planned and actual staff rota were not maintained within the designated centre

25. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
Planned and actual rosters are now kept in the Designated Centre

Proposed Timescale: 13/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff required training and other required refresher training.

26. 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:
A comprehensive review of the staff training needs has been conducted.

A training needs analysis has been devised, which highlights training deficits & upcoming training needs. Any training identified has been booked and staff are scheduled for ongoing refresher training.

Proposed Timescale: 13/02/2017

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 directory of residents did not include all the information as specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

27. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
The directory of residents will be reviewed and amended to include all information as specified in paragraph 3 of schedule 3 of the Health Act 2007.

Proposed Timescale: 31/03/2017