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:	St Michael's House - Cara
Centre ID:	OSV-0002349
Centre county:	Dublin 17
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Caroline Vahey
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 April 2017 10:10	19 April 2017 19:15

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

Backround to the inspection.
This was the third inspection of the designated centre, the purpose of which was to monitor ongoing regulatory compliance. The centre was previously inspected in December 2014. Eight outcomes were inspected against on this inspection.

Description of the centre.
The statement of purpose outlined the centre provided a homely environment for residents with an intellectual disability, dementia and life limiting conditions with an aim to meet the physical, psychological and spiritual needs of the residents and supporting end of life care in a peaceful, relaxing, comfortable and dignified environment. The inspector found the service provided in the centre met the aims as set out in the statement of purpose, as well as a continuous focus to improve the experiences of residents and their families during this period of life.

How the inspector gathered evidence.
The inspection was facilitated by the person in charge and the person participating in management. The inspector spoke to three staff members during the inspection in relation to the services in place to meet the care and support needs of residents. The inspector also observed staff providing support such as facilitating activities and staff described practices such as medication management and fire evacuation procedures.

Documentation such as personal plans, fire safety records, staff training records, staff rosters and incident records were also reviewed.

Overall judgement of findings.
The inspector found the centre was in compliance or substantial compliance in seven of the eight outcomes inspected against. Residents were supported by the team to meet their assessed needs through the provision of evidenced based health and social care. There was a focus on continuous improvement and safe practices such as medication management, infection prevention and control and incident management. Care and support was delivered by a skilled and knowledgeable staff team.

One moderate non compliance was identified in Outcome 14 and related to inadequate protected time for the person in charge to manage the centre.
These findings are discussed in the body of the report and the regulations which are not been met in the action plan at the end of the report.

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

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
The inspector found residents were supported by a high standard of evidence based care and support. Assessments had been completed to establish residents' individual needs however, some improvement was required to ensure residents' social care needs were clearly documented. Residents had meaningful opportunities to engage in activities specific to their interests and activities were supported by staff cognisant of residents' wellbeing.

Each resident had an assessment of need completed and families had been involved in the assessment process. Information regarding each resident's needs was gathered at the time of admission from key sources such as family members, multidisciplinary team assessments and staff from other services. The assessment of need document set out the health and personal needs of residents however, the inspector found social care needs were not clearly documented. However, on discussion with staff, it was evident that staff knew residents' preferences for activities and social opportunities well and this formed part of the planning of activities in the centre.

Personal plans were developed outlining the care and support to meet identified health and personal needs. Plans were comprehensive and guided practice. Staff were knowledgeable on the support needs of residents and the interventions to meet both presenting and expected emerging needs. Best practice was promoted through continuous professional development, ongoing auditing of care and support and through literature reviews which in turn informed both care planning and interventions. Personal plans were reviewed at monthly intervals or sooner should the need arise. There were regular reviews of residents' needs by multidisciplinary team member also. Families had

been kept up-to-date on residents' wellbeing and family involvement was actively promoted in the centre.

Meaningful activities were planned on a weekly basis and were displayed in picture format in the main dining area. The team had recently identified a need to improve facilities in the centre for activities and upgrading of the centre had been completed with defined rooms for specific activities. The inspector observed that residents were supported to engage in their preference of activities, for example, art and crafts and beauty treatments. On the evening of the inspection a musician attended the centre to facilitate a music session. It was evident that residents enjoyed all of these activities and the staff outlined these recent improvements in facilities in the centre had a significant positive impact on residents.

The person in charge outlined process for residents transitioning into the centre and the inspector found residents were supported to move into the service. This transition and admission process was facilitated by staff support from the centre from which the resident was discharged, which had resulted in positive outcomes for each resident.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The inspector found the health and safety of residents, visitors and staff was promoted and protected. Some improvement was required in relation to a fire safety measure.

Suitable fire equipment was provided throughout the centre such as fire doors, fire alarm, emergency lighting and fire extinguishers. Records confirmed fire equipment had recently been serviced. Where required, magnetic devices had been installed to safely hold fire doors open however, the inspector found one fire door between the dining room and hall was wedged open on the day of inspection. This negated the function of this door in the event of a fire however, the inspector acknowledged that due to compartmentalisation system within the centre this risk was somewhat reduced. Daily and monthly fire safety checks were also completed.

There was adequate means of escape and exits were observed to be free from obstructions on the day of inspection. A fire evacuation plan had been developed and specified the response to take in the event of a fire. Staff were knowledgeable on the evacuation procedure and had received training in fire safety. An easy read version of

the evacuation plan was also prominently displayed in the centre. An assessment had been completed and a plan developed outlining the assistance each resident required to evacuate the building and the inspector found adequate staff resources were provided in order to complete a safe and timely evacuation.

The inspector reviewed records of fire drills in the centre. Drills had included simulated night time drills and all residents had been evacuated within a satisfactory timeframe. Where issues arose actions had been developed with most actions complete on the day of inspection. One action regarding the fire door between the hall and dining room was not appropriately responded to by the provider and remained an issue as previously mentioned.

There was a policy relating to risk management and risk management plans were in place for the specified risks as per Regulation 26. Risks had been identified throughout the centre and risks assessments specified the control measures in place to manage these risks. Site specific and procedural risks assessments included a broad range of areas such as storage and use of oxygen, manual handling, food safety, infection control and medication administration. Individual risks assessments were also developed specific to each resident's needs, for example, manual handling and falls and measures were outlined in plans to minimise these risks. A picture signage system was used to highlight falls risks. Measures were in place to prevent accidents in the centre such as the use of assistive manual handling devices and handrails fitted throughout the centre to aid mobility. Staff had received training in manual handling.

The inspector reviewed incident records for the preceding three months. Incidents had been recorded and post incident reviews had been completed to identify trends and follow up actions. Measures had been taken following incidents to prevent reoccurrence, for example, additional staff resources had been allocated for supervision purposes and where required reviews had been completed with the multidisciplinary team.

There were procedures to respond to emergencies such as loss of water, loss of power and fire and the arrangements for alternative accommodation formed part of this plan. Emergency equipment was provided to respond to medical emergencies in the centre and first aid provisions were also available. St Michael's House service had also developed an emergency response plan which specified contingency arrangements, for example, staffing arrangements, assistive equipment and accommodation.

The centre had policies relating to incidents where a resident goes missing.

There were policies and procedures relating to health and safety such as waste management, food safety and fire safety and there was an up-to-date health and safety statement. Food safety measures were discussed with the catering staff and the inspector found satisfactory food safety measures were in place to protect residents and staff. For example, fridge and freezer temperatures were recorded, and cooking, cooling and reheating records were maintained for all meals prepared in the centre.

The inspector observed good practice to promote the prevention and control of infection. Personal protective equipment such as gloves, shoe covers and disposable aprons were provided. Hand washing and hand sanitising equipment was provided

throughout the centre and the inspector observed staff implementing appropriate and regular hand hygiene practices. There was a dedicated clinical room which had a defined area for procedures relating to aseptic techniques and a separate area relating to contaminated material.

Judgment:
Substantially Compliant

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 measures were in place to protect residents and residents were provided with emotional and therapeutic support to meet their identified needs. Improvements were required in the use of some restrictive practices to ensure these practices were identified and implemented in accordance with the centre policy and best practice. Some improvement was also required in behaviour support planning to ensure a consistent approach.

There was a policy on the prevention, detection and response to abuse. Staff had been provided with training in safeguarding however, some improvement was required to ensure refresher training was provided. Staff spoken to were knowledgeable on the types of abuse and the response to take should a safeguarding concern arise. Staff members spoken with stated they felt residents were safe in the centre and staff were observed to have a warm, patient and friendly approach with residents. There were no safeguarding concerns on the day of inspection. The inspector reviewed records of two residents' finances for a three month period and found measures were in place to safeguard residents' finances. There was complete accounts kept of all monies spent on behalf of residents and financial audits were completed on a monthly basis. Safeguarding also formed part of the six monthly unannounced visit by the provider.

Residents were supported with their emotional needs and support was also provided through regular psychiatry and psychology reviews. The inspector reviewed two plans outlining the support for residents with behavioural needs and found some improvement was required to a plan, outlining the prescribed therapeutic responses, to ensure a consistent approach. The inspector spoke to two staff members regarding behaviour

support interventions and found staff were knowledgeable on these proactive and reactive strategies and on the circumstances for the use of prescribed interventions.

There were some mechanical and environmental restrictive practices observed to be in use in the centre. Mechanical restraints had been assessed prior to their implementation with regards to the risks and rationale for use, and their use was recorded and regularly monitored. The inspector observed a number of doors leading out of the centre to be locked and this was discussed with the person participating in management. The reason for these restrictive practices was clear and proportionate to the described risks however, their use had not been applied in accordance with the centre policy and the Regulations. For example, these practices had not been referred to the service committee for restrictive practices, did not have any associated risk assessments, and there were no plans developed setting out the circumstances for use or the plan in place to reduce these practices should the opportunity arise.

Intimate care plans were also developed and specified the support provided to ensure residents' needs were met while also maintaining their privacy and dignity.

Judgment:
Substantially Compliant

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 residents' healthcare needs were met.

Residents' healthcare needs had been assessed by healthcare professionals such as a general practitioner, registered nurse, psychiatrist, physiotherapist and occupational therapist and healthcare plans were developed based on these assessments. Plans were detailed guiding the practice in the provision of healthcare interventions and the inspector found these plans were implemented in accordance with recommendations made. Residents had been provided with appropriate equipment to meet identified and emerging needs.

There was a dedicated multidisciplinary team comprising a range of professionals, as previously outlined, as well as a speech and language therapist and a social worker. The team met of a monthly basis and there were regular onsite reviews of the residents' healthcare needs. For example, the general practitioner attended the centre twice a week, the centre was staffed by registered nurses and there were timely and ongoing

reviews with multidisciplinary team members. The team also provided support and advice to residents' family members, for example, support with changing needs.

Residents were supported during times of illness and a staff member outlined care interventions recently initiated for a resident during a period of illness. Arrangements were in place to support residents presenting with a change in healthcare symptoms and the person participating in management described these arrangements, as well as links with an external palliative care service provider in order to inform best practice. The inspector found the planning of end of life care considered the needs and wishes of the individual resident and of their family. The centre was laid out in a manner that ensured the privacy and dignity of the resident was maintained and that families were supported during this end of life period.

The inspector discussed the provision of food with the catering staff on the day of inspection. Food was prepared on site and the staff member described the individual dietary needs of residents as per their assessed needs. The food provided was varied and nutritious and records were maintained on the food offered to the residents. A menu plan was displayed in picture format in the dining room outlining the choices available. There were also snacks available should residents wish to choose.

The inspector observed a meal time which appeared to be a positive and social time for residents. The advice of a speech and language therapist formed part of nutritional plans where required.

Judgment:
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 residents were protected by the centres' procedures on medication management. Some improvement was required to ensure the label on medications matched the prescriber's instructions.

The inspector reviewed medication records for four residents. Prescription and administration records were complete, for example, the name, dose and route of medications were documented, residents' details were specified and the general practitioner name was recorded. Medications requiring crushing had been prescribed by a doctor. PRN (as required) medication specified the circumstances under which these

medications should be administered and the maximum dosage in 24 hours was documented. While most medication labelling was accurate, the inspector identified the details on the label of one medication was not in accordance with the prescriber's instructions.

Medications were administered by registered nurses.

Medications were stored in a locked trolley. Controlled medications were securely stored and accurate stock and administration records maintained as per guidance set out by the Nursing and Midwifery Board of Ireland.

Out of date of unused medication was disposed of in medication waste bins, managed by a clinical waste company.

The inspector reviewed records for medication errors in 2017 and found the arrangements were in place for review and learning from adverse medication incidents. Medication practice was audited regularly and this centre was part of a national pilot project for reviewing clinical nurse practices including a comprehensive review of medication management. An account was kept of all medications received into the centre.

Medications were supplied by a community pharmacist.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found effective management systems were in place to support the delivery of safe and quality services in the centre. There was regular auditing of practices in the centre. Improvement was required in the support for the person in charge to manage the centre.

Overall the inspector found residents were provided with a consistent and quality

service, and this was audited on an ongoing basis. There were a variety of audits completed such as financial audits and health and safety checks. The person participating in management with support from the director of nursing had recently rolled out a national pilot for auditing nursing practice specific to intellectual disability services. This monthly audit reviewed practice such as medication management, care planning and the environment. The actions arising from this audit formed part of supervision reviews for nurses working in the centre, facilitated by the person participating in management. The person in charge facilitated supervision for health care assistants and catering staff approximately three times a year.

An annual review of the quality and safety of care and support had been completed for 2016 by the service manager on behalf of the provider. The review had considered the views of residents and their representatives and of staff members. Actions were developed following the review and the inspector found these actions were complete by the day of inspection. Six monthly unannounced visits had been completed and where issues were identified actions were implemented.

There were staff meetings held on a six to eight weekly basis and incorporated reviews of residents' needs, health and safety issues, new admissions to the centre. Practice development also formed part of staff meetings in areas such as wound care and pain assessment. Since the last inspection, decisions regarding admissions to the centre were made at multidisciplinary team level reviews. The person in charge and the person participating in management were part of this team along with other allied healthcare professionals and meeting were scheduled monthly. The inspector was satisfied these arrangements ensured the person in charge was part of this decision making process.

The person in charge was employed on a full time basis and had an average of 12 hours per week protected time. The inspector discussed with the person in charge their duties and responsibilities however, the inspector found the person in charge did not have adequate protected time to fulfil their administrative functions. While the person in charge outlined a review of the nursing structures in the service was underway and protected time would form part of this review, this had yet to be completed on the day of inspection.

There was a clearly defined management structure. Staff reported to the person in charge and in their absence the person participating in management. Staff members told the inspector that both the person in charge and the person participating in management were supportive and provided good leadership.

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

Findings:
The inspector found there were sufficient staff with the relevant experience and qualifications to meet the assessed needs of residents and residents received continuity of care. Some improvement was required to ensure staff were provided with refresher training.

The centre was staffed by nurses, care staff and catering staff and the inspector found staff were deployed in such a manner as to ensure there were sufficient staff on duty at all times. The skills mix of nurses and care staff, including registered nurses in intellectual disability and registered general nurses ensured the diverse needs of residents such as social, health and communication needs were met. The inspector found staff were knowledgeable of the specific needs of residents and of the support required to meet the identified and expected emerging needs.

Since the last inspection, additional catering staff had been provided at weekends to ensure continuity of this aspect of service provision.

The staff were observed to interact with residents in a sensitive and caring way, engaging with residents in a positive and relaxed manner.

Planned and actual staff rosters were maintained indicating the staff on duty during the day and at night time.

The inspector reviewed records of staff training. Staff had been provided with mandatory training in fire safety, safeguarding and manual handling however, some staff had not attended refresher training in safeguarding. Staff had been provided with additional training in infection control, food safety, hand hygiene, risk management, diabetes and subcutaneous fluid administration.

There were no volunteers in the centre.

Judgment:
Substantially Compliant

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

policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The inspector found policies outstanding from the last inspection were in place including communication with residents, monitoring and documentation of nutritional intake, the creation of, access to, retention of, maintenance of and destruction of records. The policy on the provision of information to residents was developed by the service and due to roll out in the coming week.

The inspector reviewed the centre policy for the use of CCTV however, this policy was not reflective of changes of practice in the centre.

All records pertaining to residents were found to be securely stored.

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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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002349
Date of Inspection:	19 April 2017
Date of response:	01 June 2017

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Social care needs were not clearly set out in the assessment of need document.

1. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The PIC will review and revise all assessments of need, to ensure that the Social care needs of each resident are clearly reflected. This will be discussed at the centre staff meeting in June, and the PIC will introduce a system to ensure regular monitoring of assessments of need and associated support plans.

Proposed Timescale: 31/07/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of a wedge to hold open a fire door negated the function of that door in the event of a fire. The issue in relation to the functioning of the magnetic device on this fire door had not been appropriately responded to by the provider.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has contracted the installation of 625 UEM hold-open, swing-free, door mounted units on both sets of double doors. These will be installed on June 29th subject to delivery of special order units

The designated centre has 24 hr waking staff, in order to respond quickly and efficiently to any emergency situations which may arise.

Proposed Timescale: 29/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of some environmental restrictive practices had not been applied in accordance with the centre policy and best practice.

3. 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 Registered Provider will ensure that all environmental restrictive practices will be applied in accordance with the centre policy and best practice.

Proposed Timescale: 31/07/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to a plan outlining the prescribed therapeutic responses, to ensure a consistent approach

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

Please state the actions you have taken or are planning to take:
The PIC will ensure that prescribed therapeutic responses are included in the PBSP, in collaboration with the staff and clinicians who develop the plan of care. The PIC will introduce a system whereby this will be reviewed at least quarterly.

Proposed Timescale: 30/06/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate support was not given to the person in charge to manage the centre in terms of protected time.

5. 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 comprehensive nursing structure review was commissioned by the Registered Provider and carried out by the Director of Nursing. Recommendations from the report include increasing protected management time.

The recommendations were submitted to the registered provider for consideration on April 28th, and will be further considered at the workforce planning committee on May 25th.

Subject to the approval of the Registered Provider, and in line with available resources the recommendations will be implemented.

Proposed Timescale: 30/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not been provided with refresher training in safeguarding.

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

Please state the actions you have taken or are planning to take:
The PIC has liaised with the Provider's Training Manager to request refresher safeguarding training who all staff members who have not yet received it.

This training has now been scheduled for all outstanding staff.

Proposed Timescale: 31/08/2017

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 centre policy on CCTV had not been updated to reflect a change in practice

7. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The Registered Provider has revised and updated the centre's policy on the use of CCTV to ensure that it is reflective of changes in practice.

Proposed Timescale: 31/05/2017