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:	Parkview House
Centre ID:	OSV-0002406
Centre county:	Meath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor 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:
01 February 2017 10:00	01 February 2017 19:00

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 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this designated centre. The centre had previously been inspected in 2014. The purpose of this unannounced inspection was to assess the centre's compliance with the regulations and standards as part of the Health Information and Quality Authority's (HIQA) continuous regulatory monitoring for all designated centres.

Since the last inspection a new person in charge had been appointed to the centre. They had previously been a person in charge of another designated centre with St. Michael's House.

Description of the Service

This centre is operated by St Michael's House services and is situated in a town in County Meath. It comprises of a large, well maintained, detached dormer style house. It currently accommodates four residents and one respite bed which is used every second weekend bringing the capacity of the centre to five on those weekends. All residents living in the centre and residents using respite services in the centre also have their own bedroom. The service provides supports to both male and female residents with intellectual disabilities and varying support needs.

How we gathered evidence
Over the course of this inspection the inspector met and spoke with all four residents in the centre on the day of the inspection. Some residents were unable to tell the inspector about their views of the quality of the service but the inspector observed interactions with staff and residents. A number of staff were met with and documents reviewed included: personal plans, restrictive practices and fire containment measures and evacuation procedures in the centre.

Overall judgment of our findings
Overall the inspector found residents were experiencing a good quality service but there were some areas that required improvement.

Two outcomes were found to be moderately non-complaint, Outcome 5; Social care needs and Outcome 8; Safeguarding and Safety. Improvement in support planning with regards to residents assessed social care needs was required and also safeguarding planning was required to meet the needs of some residents that required such supports.

Outcome 7; Health and Safety and Risk Management, met with Major non compliance. This related to inadequate fire and smoke containment measures in the house and evacuation procedures for residents required review.

The other five Outcomes inspected met with compliance or substantial compliance.

The findings from this inspection are contained in the report. A regulatory action plan is at the end of the report with the provider's response detailing how they will address actions given and timelines for when they will be completed.

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:
There were no actions from the previous 2014 inspection relating for this Outcome. However, on this inspection some improvements were required to ensure residents' identified social care needs were met through support and goal planning.

All residents had personal plans in place. A sample reviewed by the inspector found that an up-to- date assessment of need had been carried out for all residents living in the centre. The inspector noted the assessment of residents' social care needs was detailed and comprehensive. The assessment also included a summary of findings of what specific social care needs for residents required support planning.

Where support planning had been developed it was to a good standard and guided staff practice to meet residents' social and health care needs. Improvements were required to ensure all identified social care needs had good standard planning in place.

The inspector noted that not all social care needs identified, through the assessment process, had an associated support plan in place. For example, support planning to develop friendships, community access planning and money management planning had not been developed for residents identified with a social care need in this area.

There was evidence in residents' personal plans that goal planning and setting had occurred previously however, at the time of inspection there were no up-to-date goals set for residents and therefore no up-to-date action planning to meet residents' goals.

Residents' personal plans contained information with regards to allied health

professional assessments, reviews and intervention recommendations. Healthcare planning was maintained in residents' personal plans also. However, this needed improvement. While residents had received an annual health check not all residents' personal plans contained a copy of the doctor's assessment or recommendations and could not be located during the course of the inspection.

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

Findings:
The health and safety of residents, visitors and staff was promoted and protected in most areas within the centre however, there was improvement required in relation to the containment of smoke and fire measures in the centre. The provider was also required to ensure adequate staffing arrangements were in place to safely evacuate residents in the event of an emergency at night time when the house was at full capacity.

There was a risk management policy in place which reflected the legislative requirements of Regulation 26. A hazard and risk identification register was maintained in the centre which was continuously updated and maintained as a 'live document'.

Each resident had individual risks assessments completed which were maintained in their personal plans. These identified specific personal risks and outlined control measures to manage the risk and mitigate the likelihood the risk may occur. However, the inspector noted one safeguarding risk for a resident had not been identified and therefore risk control measures had not been outlined or documented. This is further discussed in Outcome 8; Safeguarding and Safety.

There was an up-to-date localised health and safety statement in place. Emergency planning was also in place which outlined the measures and procedures for staff to take in the event of an emergency such as a gas leak, loss of water or power and loss of heating.

Records were available to confirm that fire equipment including fire extinguishers, the fire blanket, emergency lighting and the fire alarm had all been tested by professionals within the required time frames.

All staff had completed fire training within the past year and staff spoken with had a clear understanding of the procedure to be followed in the event of a fire. Records reviewed indicated two fire drills were practiced in 2016 March and April. However, the documentation of fire drills required improvement.

The person in charge and staff spoken with indicated they had carried out more than the two drills which had been documented however, there was no documentary record of the other third drill.

Every second weekend the capacity of the centre increased from four to five residents. Residents' personal evacuation planning indicated two residents required manual handling supports to use a wheelchair in order to evacuate. Two other residents would require specific supports and encouragement to evacuate. One waking night staff worked in the centre at all times. The inspector was not assured by the documentation maintained with regards to drills and personal evacuation planning that the provider and person in charge had adequately assessed if one staff member was adequate to ensure all residents could be evacuated from the centre at night time.

The inspector's concerns were further compounded by the inadequate fire and smoke containment measures in the centre. The inspector noted there was a lack of fire rated doors, automatic door closers and use of keys for all evacuation doors in the centre due to a risk of a resident absconding. A recent review of fire safety measures in November 2016 by the provider's own fire safety representative had also identified a number of fire and smoke containment inadequacies in the centre and had made recommendations, however these had not been addressed at the time of inspection.

The provider was required to ensure adequate fire and smoke containment measures were in place in the centre and to also assess their current systems in place to ensure residents could be safely and quickly evacuated from the centre in an emergency. Following the inspection, the inspector received an emailed update from the provider. The provider had allocated an extra staff for night time to support the increased capacity of residents for the weekend following the inspection until they could have time to assess the night time staffing requirements.

All staff had received up-to-date manual handling training and refresher training was made available to staff. Appropriate equipment was available in the centre to support staff to implement safe and appropriate resident handling and moving techniques.

Infection control measures were adequate for the centre given its purpose and function. The inspector noted the premises was maintained to a good standard of cleanliness and appropriate hand washing and drying facilities were available to both residents and staff in the centre.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
The were systems in place to safeguard residents in the centre but some needed improvement. Improvement in staff training in safeguarding vulnerable adults was required, safeguarding planning was inadequate and review of restrictive practices in the centre required improvement.

There was a policy in place on safeguarding vulnerable adults and all staff were trained in this area. However, refresher training in safeguarding vulnerable adults needed improvement. Staff had last received training in safeguarding vulnerable adults in 2014, staff had not received updated training in adult safeguarding. The staff spoken with demonstrated appropriate knowledge of abuse and what to do in the event of an allegation of actual or suspected abuse.

As mentioned in Outcome 7 of this report, the inspector noted there was a safeguarding risk which had not been adequately risk assessed and no personal risk assessment was in place to mitigate and manage the risk. Equally there was no safeguarding plan in place to support residents that required them. The person in charge and provider was required to develop a comprehensive safeguarding plan for residents that required such supports in line with the organisation's polcies and procedures for safeguarding vulnerable adults.

There was a policy in place for the provision of behavioural support to residents. Some staff had attended more formalised training in this, other staff were scheduled to commence this training the end of February.

A sample of residents' behaviour support plans were reviewed by the inspector. All residents that required a behaviour support plan had one in place which followed the principles of positive behaviour support. They had been developed by a psychologist with knowledge of the resident and their presenting issues. Support plans set out proactive and reactive strategies for staff to implement in order to support residents. Feedback from staff indicated the frequency of residents engaging in behaviours that challenge had reduced and this was further demonstrated by the reduced requirement for chemical restraint to be used to manage behaviours that challenge as part of residents' reactive strategy planning.

While there was evidence to indicate chemical restraint had reduced in the centre there was a lack of overall auditing and evaluation of other restrictive practices in the centre. Some restrictive practices that required review included the use of an audio monitor in a resident's bedroom at night. The person in charge was required to ensure a comprehensive assessment, audit and review system was implemented to ensure restrictions in the centre were reviewed to ensure they were the least restrictive and used for the least amount of time necessary.

Judgment:
Non Compliant - Moderate

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:
Not all restrictive practices in use in the centre had been notified in the quarterly notifications to the Chief Inspector.

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:
Residents were supported to achieve their best possible health.

The inspector reviewed residents' files and noted evidence which indicated residents were facilitated to access and to seek appropriate treatment and therapies from allied

health care professionals when required and in line with their assessed social and healthcare needs.

Allied health services were availed of promptly to meet residents' needs. Completed referral forms were available for review in residents' files and written evidence of allied health professional reviews, interventions and recommendations were also maintained, for the most part. For example, residents that required supports by speech and language therapist (SALT) had associated documentary planning as prescribed and recommended by the SALT. In other instances where residents required they were reviewed by physiotherapists, psychiatrists and dentists.

Residents' had access to adequate quantities and a good variety of nutritious foods to meet their dietary needs. Staff had a good knowledge of the residents' individualised plans and residents meals using fresh and frozen ingredients. Residents' were involved in selecting their daily evening meals and a weekly menu planner was located in the kitchen.

Meals prepared and cooked during the inspection smelt appetising and were presented nicely. Residents had adequate space to sit in the dining area for their meals and adequate support was given by staff to residents as 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:
Overall there were appropriate and safe medication management systems in place. However, improvements were required in relation to the storage of refrigerated medication.

There were policies and procedures for the safe administration of medication in the centre. Medications were administered by all staff. Non nursing staff were trained in safe administration of medication and were afforded refresher training in this area to ensure their skills were up-to-date and in line with safe medication management policies and practices of the organisation.

Medications were stored in a locked cupboard and there was a fridge available for

medication if required. However, there was no lock on the medication fridge. The fridge also required defrosting and no temperature checks were recorded to ensure medications were stored at the correct temperature at all times.

Staff spoke with demonstrated they understood the procedure in place for the disposal out-of-date and soiled medications and showed the inspector the receptacle medications and used bottles were disposed of. When required a company collected the disposal box and issued an invoice receipt which the person in charge kept on file.

A sample of medication prescription sheets and medication administration sheets were viewed by the inspector and were found to contain the appropriate details. This included where medications should be crushed or in liquid form. Residents had individual medication plans in place that detailed the supports required.

Stock checks of residents' medications were calculated once a week and documented on a stock taking chart. The inspector noted these stock takes were up-to-date for all residents.

There were no controlled drugs prescribed in the centre.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
Management systems in the centre in the main were adequate and provided appropriate reporting structures and on-call support to staff and residents. Some quality review systems required improvement.

Since the last inspection a new person in charge had been appointed to the centre. The person in charge was fulltime in their role and had the necessary qualifications and experience to meet the needs of the role. They were knowledgeable of the residents and were in a process of settling into their new role in the centre having worked as a

person in charge for another designated centre some years previously.

There was a clearly defined management structure in place. The person in charge reported to a service manager, who in turn reported to the provider nominee.

Regular meetings between the person in charge and the service manager occurred. The person in charge informed the inspector that she felt very supported by the governance and reporting system and found the on-call arrangements very beneficial.

The person in charge held regular staff meetings in the centre. Minutes of these meetings were recorded and available for staff to read following the meetings. These meetings were important as they discussed residents' needs, staffing and rosters, upcoming events, changes in policies and kept staff up-to-date on system changes or policy changes within the organisation.

An unannounced quality and safety review had been completed in October 2016 by a representative on behalf of the provider; in this case it was the regional manager. The inspector reviewed the audit and found it was comprehensive and reviewed many areas with regards to the quality of service residents were receiving identifying a number of key areas which if addressed would bring about improvements in the centre, for example the audit identified key training in behaviours that challenge was required.

An action plan was documented at the end of the audit, however, there was no time line documented and therefore it did not provide the auditor or the person in charge with a time frame to measure improvement by.

An annual report had been drafted and the inspector reviewed this during the course of the inspection. It was a comprehensive document and took into consideration feedback from residents and where the centre was doing well and what it could do better. However, it had not been signed off and therefore had not been issued to residents and their representatives or families.

The person in charge had developed some auditing systems to improve practices in the centre. For example, they had developed a hygiene/infection control management system in the centre which had proved effective. The inspector noted the premises were hygienic and well maintained on this inspection. Resident's bathing facilities were maintained to a high standard of cleanliness.

The person in charge however, was required to expand her auditing system to other key quality indicators to ensure quality and standards were high in other areas. For example, medication management audits had been carried out in the centre but not with enough frequency to ensure practice was appropriately reviewed, medication management audits available on the day of inspection were for January and November 2016 only.

Restraint practices in the centre required more comprehensive auditing and review. No restraint register was in place and while a review had occurred recently with an allied health professional it was not documented in such a way so as to plot improvement or evidence a reduction in the use of restraint. Personal planning for residents was not audited and therefore was not compliant with the regulations as was found on this

insepction.

Judgment:
Substantially Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Staff working in the centre were supported to meet their continuous professional development needs in order to meet the needs of residents.

There was a planned and actual rota in place. There were two staff available in the centre in the morning and evenings. One waking night staff are available at night. The person in charge informed the inspector that extra staffing resources could be allocated to the centre if residents wished to go out in the evening or to attend appointments.

The person in charge had begun to implement a staff supervision and support meeting and at the time of inspection had completed two meetings with staff. The staff roster also indicated the dates she had scheduled for other staff working in the centre to receive supervision.

There were no volunteers working in the centre at the time of inspection.

Staff personnel files were not reviewed as part of this inspection however, the inspector did request copies of all staffs' Garda vetting. These were made available to the inspector during the course of the inspection. All staff had received vetting.

While training and refresher training was available to staff the person in charge did not have a staff training schedule for the year. The inspector was informed the staff training schedule was not available due to issues with the IT system for the centre.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002406
Date of Inspection:	01 February 2017
Date of response:	22 March 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:
While residents had received an annual health check not all residents' personal plans contained a copy of the doctor's assessment or recommendations and could not be located during the course of the inspection.

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 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
The PIC will ensure that all residents Personal Plans will contain a copy of the doctors assessment and recommendations following annual health checks.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no up-to-date goals set for residents and therefore no up-to-date action planning to meet residents' goals.

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

Please state the actions you have taken or are planning to take:
• The PIC will support Key-workers to identify up to date goals for each Resident and develop actions plans to meet these goals.
• The PIC and Key-worker will review the goals on a quarterly basis of each Resident and again at the Residents' Wellbeing Meeting which is on an annual basis.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all social care needs identified, through the assessment process, had an associated support plan in place.

3. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
• On behalf of the Registered Provider the PIC and Key-workers will ensure that all associated Support Plans are in place in relation to identified Social Care needs.

• The PIC will establish a review process on a quarterly basis with Key-workers to

review and revise Support Plans in place.

Proposed Timescale: 30/04/2017

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 provider was required to ensure adequate fire and smoke containment measures were in place in the centre

4. 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:
• On behalf of the Registered Provider the PIC and Service Manager will meet the Technical Services Manager and Organisations Fire Officer to review recommendations made in Nov 16 and agree a plan of work to address fire safety inadequacies.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was required to assess their current systems to ensure residents could be safely and quickly evacuated from the centre in an emergency.

5. 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:
• On behalf of the Registered Provider the PIC has reviewed and revised all Personal Evacuation Plans.
• A night time evacuation was completed on 6th Feb 17 where all 5 residents were evacuated safely by one staff member in under three minutes.
• Allied Health Care Professionals have identified equipment to assist the night evacuation of one person.
• The equipment identified has been purchased and Allied Health Care Professionals, Occupational Therapy and Physiotherapy, will provide guidelines and training to the staff team to support the correct usage of equipment.

Proposed Timescale: 13/04/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was required to ensure assessment, audit and review system was implemented to ensure restrictions in the centre were reviewed to ensure they were the least restrictive and used for the least amount of time necessary.

6. 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:
• On behalf of the Registered Provider the PIC and Senior Psychologist reviewed all restrictive practices in the Designated Centre on 8th Feb 17.
• The PIC has established a new system to assess, review and audit all restrictions on a quarterly basis.
• One restriction highlighted in the course of the Inspection (audio monitor) was removed immediately.
• The PIC and staff team are working on the reduction of other restrictions in the centre in a bid to reduce or remove them completely in the near future and discuss this at the monthly staff meetings.

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:
Staff had last received training in safeguarding vulnerable adults in 2014. Staff had not received updated training in adult safeguarding.

7. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The PIC has arranged for refresher Safeguarding Training for all staff which will be completed by end of June 17.

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge and provider was required to develop a safeguarding plan for those residents that required such supports in line with the organisation's polcies and procedures for safeguarding vulnerable adults.

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

Please state the actions you have taken or are planning to take:
• On behalf of the Registered Provider the PIC has developed a Safeguarding Plan for the resident in consultation with the Designated Officer.
• The PIC, Service Manager and relevant Clinicians will review this Plan on 30th March and amend accordingly.

Proposed Timescale: 31/03/2017

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:
Not all restrictive practices in use in the centre had been notified in the quarterly notifications to the Chief Inspector.

9. 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:
The PIC will include all restrictive practices in future quarterly notifications to the Chief Inspector.

Proposed Timescale: 31/03/2017

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:
Improvements were required in relation to the storage of refrigerated medication.

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

Please state the actions you have taken or are planning to take:
• The PIC has requested a suitable lock to be fitted to the fridge used to store medication.
• The PIC and staff team will record the temperature of the medication fridge daily to ensure that the temperature is at 5 degrees or below.

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:
The auditing system required review.

There was no time line documented in the action plan for the six monthly provider led audits, therefore it did not provide the auditor or the person in charge with a time frame to measure improvement by.

11. 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:
On behalf of the Registered Provider the PIC and Service Manager will include time lines in the Action Plans of future Quality and Safety Audits carried out every 6 months.

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:
An annual report had been drafted but it had not been signed off and therefore had not been issued to residents and their representatives or families.

12. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual

review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector. **Please state the actions you have taken or are planning to take:** The Registered Provider will sign off the Annual Report so that it may be available to residents and their families.
Proposed Timescale: 31/03/2017