

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Meadowview Bungalows 1 & 2
Centre ID:	OSV-0004908
Centre county:	Meath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Redwood Neurobehavioural Services Limited
Lead inspector:	Andrew Mooney
Support inspector(s):	Anna Doyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From: 03 November 2017 09:30 To: 03 November 2017 19:30

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

Summary of findings from this inspection

Background to the inspection:

This designated centre was previously inspected as a new build in May 2015 and achieved a high level of compliance across all outcomes assessed. The purpose of this inspection was to monitor ongoing compliance against the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations) and to follow up on notifications submitted to the Authority. The person in charge and a clinical nurse manager from another designated centre facilitated the inspection.

How we gathered our evidence:

Inspectors visited the designated centre and met informally with residents and spoke with management, parents and two staff members. Staff supported residents by developing a social story to inform them of our presence during the inspection. The person in charge was also spoken with at length during the course of this inspection. The inspectors also viewed a sample of documentation including care plans, support plans, recording logs, and accident and incident forms. Throughout the course of the inspection inspectors also observed staff practice and residents' daily routines.

Description of the Service:

This designated centre is operated by Redwood Neurobehavioural Services Limited and is based in County Meath. There were eight residents living in the designated centre at the time of inspection. The designated centre consisted of two houses in a

campus-based setting, which was a short drive from a local village.

The provider had produced a document titled the statement of purpose, as required by regulation and this described the service provided. The designated centre aimed to provide residential support for both male and female adults over the age of 18 with intellectual disabilities. Two residents had transitioned from the service to a community based setting since the last inspection.

Provisional feedback was given during the inspection to the person in charge, the operation service manager, a clinical nurse manager, provider nominee and the chief executive officer (CEO).

Overall findings:

Overall, inspectors found that the person in charge had a very good understanding of the needs of residents and the running of the centre. Staff were observed interacting respectfully with residents' and appeared knowledgeable about residents assessed needs. Of the seven outcomes assessed healthcare needs were found to be compliant and medication management was found to be substantially compliant.

Major non-compliance was found in four outcomes: social care needs, risk management, governance and management and workforce. Safeguarding was found to be moderately non-compliant. Overall the inspectors found that staffing levels in this centre were inadequate which was impacting negatively of the quality and safety of care received by the residents.

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:

Some aspects of personal plans, support needs and services provided in the centre were made into an easy-to-read version for residents which included staff rotas, menus and social stories.

An annual review had taken place for residents in the centre that involved consultation with the resident or their representative where appropriate. However, one resident's annual review had not had been completed since April 2016. In addition, some recommendations from a case review for one resident had not been fully implemented to date.

Inspectors found that there was limited access to meaningful activities in one unit of the centre. Goals set for residents had either not progressed, were not fully implemented or were not reviewed on an on-going basis to monitor their effectiveness.

There were numerous examples where residents' goals could not be implemented due to inappropriate staffing levels or staff mix. One resident's activity timetable included a drive every day. From a review of their activities over a two month period the resident had been on a drive 12 times. Another resident's goal was to increase community access and when it was originally set in April 2017, there had been a positive increase in the resident's access. However, this had decreased significantly in recent months.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There were systems in place to protect, residents, visitors and staff in the centre. However, improvements were required to ensure that the control measures identified in some risk assessments could be effectively implemented. Inspectors also had to seek assurances around one risk identified at the inspection in relation to the temperature of water in one unit.

On a walk around of the centre, it was identified that one resident required supervision as they would often access the bath on their own and required support with controlling the temperature of the water.

Inspectors found that the temperature of the water seemed excessively hot and requested the person in charge to have this checked by maintenance. Information submitted to HIQA after the inspection found that the temperature was over the recommended levels and assurances were sought from the person in charge about how they intended to address this. These assurances were submitted.

There was a risk management policy in place along with a health and safety statement. These were not reviewed as part of this inspection.

An emergency plan along with a missing persons guide for each resident was available in the centre. The missing persons guide detailed the actions to be taken, who to contact and how to support the resident in such an event.

There was adequate means of escape, including emergency lighting, and fire exits were unobstructed. Fire fighting equipment available in the centre had been appropriately maintained.

All doors in the centre were fire doors for the containment of fire. Residents had personal emergency evacuation plans in place that outlined their support needs. Fire drills had been completed and staff were aware of the residents' needs in such an event.

Inspectors found that all incidents were reviewed by the person in charge and there was evidence that they were also reviewed at multidisciplinary team meetings. For example, trends were identified relating to one resident and this had been reviewed and support mechanisms had been implemented for the resident. However, some control measures identified for residents' could not be implemented due to staffing levels in the centre and some risks identified were not risk assessed in a timely manner and the controls in

place were limiting a residents' access to the community.

There were infection control guidelines in place. There were no known infection control risks in the centre on the day of the inspection. Standard infection control precautions were in place which included hand sanitising gels, hand washing facilities and appropriate personal protective equipment was available. The centre was observed to be clean on the day of the inspection.

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:

Inspectors found that there were systems in place to protect residents in the centre, however significant improvements were required to ensure that safeguarding plans were being implemented. It was also found that intimate care plans required review as did the use of restrictive practices in the centre.

The provider and person in charge responded to allegations of abuse in a timely manner and reported it to the relevant authorities. Inspectors found that a recent allegation had been responded to and actions had been taken to address this. For example, supervision of staff practices was being increased at night in response to some allegations.

However, inspectors found that safeguarding plans in response to behaviours of concern could not at times be effectively implemented due to inadequate staffing arrangements in the centre. For example two staff were required to support one resident as a measure outlined in a safeguarding plan, however it was confirmed that this arrangements may not always be implemented due to inadequate staffing levels.

Residents had intimate care plans in place that indicated they required support with personal intimate care. However, the document did not outline their personal preferences and the actual supports they needed. For example intimate care plans stated full assistance was required in certain areas of personal care but insufficient

details were provided as to how this should be delivered.

Residents had up-to-date positive behavioural support plans in place that were reviewed in a timely manner. Staff spoken with understood how to support residents using these plans. There were monthly multidisciplinary meetings in place to support the implementation of these plans. Of a sample of documentation viewed, staff were provided with relevant positive behavioural support training and de-escalation techniques. However, inspectors identified an on-going issue in relation to maintaining a resident's privacy, which was had not been fully addressed at the time of this inspection.

A rights restriction committee was held regularly and is attended by the psychologist, person in charge and other relevant personnel.

Inspectors observed a number of restrictions within the designated centre. These included environmental restrictions such as a kitchen door being locked throughout the day and the front door being locked when staff were not available to supervise residents. While these were recorded and submitted quarterly to HIQA, it was not clear that all alternative measures were considered before these restrictive procedures were used. Inspectors could not ascertain if these restrictions were only used for the shortest duration necessary. Other environmental restrictions were observed, such as residents' personal belongings being locked in presses. These were risk assessed but had not been identified as restrictions and had therefore not been included in quarterly returns. Inspectors viewed documentation relating to physical holds being used to support residents to their bedrooms. These restrictions had been documented in incident report forms as manual handling techniques but again were not reported to HIQA as required.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents were supported to achieve good health in the centre.

From a sample of plans viewed inspectors found that an assessment of residents' healthcare needs had taken place. Healthcare interventions were in place to guide staff practice and these were reviewed monthly by staff. Staff spoken with, were aware of the residents' healthcare needs.

Hospital passports were in place that outlined the residents' support needs should they require hospital stay.

Residents' had access to a range of allied health professionals to support them which included a psychologist, dietitian and occupational therapist. Regular multi-disciplinary meetings were held to review supports in place.

Interventions were in place for residents who required specialised diets. While some conflicting information was recorded on the resident's plan, staff were clear about their support needs and this was also observed in practice.

Residents' meals were prepared by staff in the centre. Menus were displayed in pictorial form on the notice board in the dining room and were supported at resident forum meetings to plan meals.

Although both kitchen doors were locked in the centre, inspectors observed residents being offered snacks and drinks during the inspection.

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:

There are written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, improvements were required in the administration of one resident's medication to ensure best practice.

Medications were primarily administered by nursing staff in the centre, with the exception of one 'as required' medication prescribed. Healthcare assistants had received training in this area and the training records reflected this.

Medications were stored securely in the centre and unused or discontinued medication was stored separately from regular medications in the centre. A fridge was available in the centre for medication if required. Temperature control records were maintained for this on a daily basis.

From a review of a sample of medication prescription sheets, administration sheets and medications stored in the centre, inspectors found that the practices in place were in line with best practice. For example, all medications were labelled correctly and the labels corresponded with the prescription sheets and the maximum dose was outlined for 'as required' prescribed medications on the prescription sheets.

However, inspectors found that the preparation and administration of one resident's medications was not in line with manufacturer's guidelines and there was no medication plan in place, to indicate that the prescribing doctor was satisfied with this method of administration.

There were measures in place for the investigation of and learning from medication errors in the centre. For example, all medications errors were reported to senior personnel at the time and followed up with medical intervention and or advice if required. Control measures were then implemented which included further training for staff if required.

Inspectors were informed that a pharmacist also completed medication audits in the centre every month, the findings of which were forwarded to the person in charge. These records were not viewed as part of this inspection.

The majority of medications were dispensed in blister packs from the pharmacist. All of the blister packs were checked for accuracy when they were delivered to the unit by nursing staff. Other medications stored in their original packaging were audited every week by nursing staff to ensure accuracy.

Inspectors were informed that there were no controlled medications stored 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:

This inspection found that there was a clear management structure in place which identified the lines of authority and accountability in the centre. There was a full-time person in charge in place who was a suitably skilled, qualified and experienced manager. However, taking into account the cumulative findings of this report the inspectors were not assured that the current systems of governance and management in place were effective in ensuring a safe or appropriate service to the residents. The person in charge had responsibility for another designated centre and was also responsible for the transition of a number of residents to a new designated centre. Furthermore, due to the inadequate staffing arrangements in place a sample of rosters informed the inspectors that the person in charge had to provide regular frontline cover which was impacting on her capacity to fulfil her role effectively.

Inspectors viewed a number of centre specific audits covering areas such as care plans, finance, adult protection and health and safety. There were monthly schedules in place and they were being completed. Inspectors also viewed team meeting notes and saw that these were being held regularly. Numerous topics including complaints were discussed. However, there was no evidence that learning from accidents and or adverse incidents occurring in the centre were discussed at these meetings.

There was an annual review of the quality and safety of care in the designated centre completed in September 2016. It had evidence of consultation with residents and their representatives. The review noted a number of quality improvements were required. For example one resident's family had indicated that they would like to see a more varied range of activities provided by the centre. This was then highlighted and noted as a quality improvement area by the provider. However, at the time of this inspection this action had not been addressed and the range of activities on offer from the centre had not been improved upon. There were still very limited activities being offered by the centre.

There was evidence that the provider had arranged unannounced visits to the centre in line with their regulatory requirements and a report on the safety and quality of care and support within the centre was completed by April 2017. This report highlighted a number of quality improvements needed and actions to address same. For example as a result of consultation with families it was noted that additional recreational activities were required. However, and as stated above, the range of meaningful activities on offer from the centre remained inadequate.

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):

No actions were required from the previous inspection.

Findings:

The staffing levels and skill-mix in the centre at the time of the inspection were not in line with the statement of purpose for the centre and there were limited contingencies in place to cover staff leave and vacancies. Inspectors found that this was contributing to negative outcomes for residents as demonstrated in this report. Improvements were also required in the actual rota maintained in the centre.

The person in charge informed inspectors at the opening meeting that there had been a large turnover of staff in the centre since March 2017. In addition, a number of staff were on specified leave at the time of the inspection. Inspectors acknowledge that this was outside the control of the provider and that the provider had been attempting to recruit staff for the centre over the last number of months.

Notwithstanding this inspectors found that while the person in charge had been highlighting this as a concern to the provider and attempts were made to ensure that staffing levels were consistent in the centre on a daily basis, this was not always possible as there was limited availability of replacement staff in the centre. This was confirmed by staff, the person in charge, and the staff rota viewed by the inspectors.

In addition, from a review of the rota inspectors found that some days, only one nurse was available between the two units. On some evenings the staffing in one unit was reduced to two staff from 5pm to 8pm. Nurses were replaced by healthcare assistants.

This was discussed with the provider on the day of the inspection and inspectors were informed that four new staff had been recruited for the centre, one of whom was due to commence on 16 November 2017.

In addition to this, inspectors found that staff supports outlined in some residents' personal plans required two staff or a specific staff profile in order to support them. This could not be fully implemented as the required staff were not always available in the centre. Again this was confirmed by staff, observed on practice on the day of the inspection and evident on the staff rota.

There was a planned and actual rota maintained in the centre. However, it was not clear who covered shifts some days on the actual rota. This was discussed with the person in charge.

Staff training records were submitted after the inspection and on review the inspectors found that all staff had completed mandatory training. Additional training provided to staff included training in person-centred planning, food hygiene and health and safety.

Staff spoken with felt supported in their role and said that they received supervision from the person in charge.

There were no volunteers employed in the centre.

Personnel files reviewed as part of this inspection were found to contain the requirements of the regulations.

Judgment:

Non Compliant - Major

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:

Andrew Mooney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Redwood Neurobehavioural Services Limited
Centre ID:	OSV-0004908
Date of Inspection:	03 November 2017
Date of response:	15 January 2018

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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

There was limited access to meaningful activities in one unit of the centre

1. Action Required:

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

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

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

Resident's meaningful activities have been monitored and documented since our inspection and residents from Bungalow 1 & 2 have been out on community outings on 209 occasions from 01 Dec 17 to 07th Jan 18. Each resident has been on community outings which are evidenced in their progress notes.

These outings include bus trips to:

Naul /Skerries/Balbriggan/Dundalk/Drogheda/Swords/Slane, walks around local parks, walking to the local shop, going to the book shop, swimming, going to McDonalds, going for ice-cream, horse-riding. Outings and activities also includes any preferences of the residents may choose.

Additional hours from members of the activation team are in Meadowview on Tuesdays from 9-5 and Thursday 10.30-13.30. They support residents in being members of the community and help with any community based goals.

Audits will continue to capture all social trips that take place. Activity schedules are in place for residents.

Proposed Timescale: 15/01/2018

Theme: Effective Services

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

One resident's plan demonstrated that the resident had not had an annual review since April 2016.

2. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

This annual review had been carried out on 25th April 2017 but had not been filed in the care plan. This document is now present.

Proposed Timescale: 15/01/2018

Theme: Effective Services

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

Recommendations from a case review had not been implemented to date.

There were numerous examples where residents' goals could either not be implemented due to inappropriate staffing levels or staff mix.

3. Action Required:

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

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

Personal Plans have been updated to reflect recommendations from case reviews.

All residents' goals have been reviewed since the inspection. Key workers are being mentored regarding the development of SMART goals with residents. There has been in house training presented to staff on the role of the key worker and guidance in SMART goal development – this took place on 10th January 2018 and further dates have been organised. With improved staffing levels and additional hours from the Community Activation team goals are now being progressed.

Proposed Timescale: 30/01/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

One risk identified on the day of the inspection had not been appropriately risk assessed and assurances had to be sought from the provider and person in charge.

Some control measures outlined in residents risk assessments could not be implemented due to staffing levels and skill-mix not been in place.

One identified risk for a resident had not been reviewed in a timely manner and this was impacting on the resident's access to their community.

4. 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:

All risk assessments have been reviewed and are up to date and are available for inspection.

- A temperature regulated valve has been fitted into the water in the bathroom and weekly checks of the temperature of water is being carried out by maintenance and is logged in the Millmount book.
- A staff member has been allocated as Health and Safety representative for the houses.

- The risk assessment template is under review and we are trialling a new template. The head of psychology has conducted a risk audit.
- Risk assessments will be brought to the Rights Review committee to be signed off.

Proposed Timescale: 15/01/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Individual behaviours were being inappropriately managed and this was negatively impacting on other residents.

5. 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:

Training is provided in Positive Behaviour Support (PBS) by our PBS specialist. Staff are also required to complete 3 day training in the professional management of aggression and violence. All new staff who join the service are provided with this training within a 3 month timeframe. New staff are scheduled to receive this training before 03/03/2018

One residents Positive Support Plan has been reviewed by the MDT around inappropriate behaviours and supports put in place.

Proposed Timescale: 30/03/2018

Theme: Safe Services

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

It is not clear that alternative measures are considered before a restrictive procedure is used. When restrictions are used it is not clear they were used for the shortest duration necessary. Inspectors were told and observed that a Kitchen door was locked and residents did not have access to this kitchen area.

6. 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:

PIC, CNM, and the MDT have completed work on an auditing tool on the rights and restrictions for each resident and will be reviewed by MDT ensuring the least restrictive practice is used.

Proposed Timescale: 15/01/2018

Theme: Safe Services

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

Residents care plans did not sufficiently detail the supports required to assist them with their personal intimate care

7. 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 residents have intimate care plans in place. These are reviewed and updated regularly by the PIC. All new staff to the unit are familiarised with all care plans including Intimate care plans and communication needs.

Referrals have been sent to SALT to assist with easy read documentation which will be completed by 28/02/2108.

Proposed Timescale: 28/02/2018

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:

The preparation and administration of one residents medications was not in line with manufacturers guidelines and there was no medication plan in place, to indicate that the prescribing doctor was satisfied with this method of administration.

8. Action Required:

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

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

Our prescribing doctor has documented that this method of medication administration is

appropriate for this resident.

Proposed Timescale: 15/01/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The Person in Charge was responsible for more than one designated centre. As a result of a number of staff vacancies the Person in charge did not have adequate protected time to fulfil the role of Person in Charge.

9. 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:

We have revised our governance arrangements with a view to enhancing them across the service. With regard to Meadowview there will be a PIC in place for each designated centre rather than 1 PIC for the 2 centres.

1. Staff recruitment which was underway at the time of the inspection have resulted in the employment of 6 new Direct Support Workers (DSW) employed on a full time basis and 1 relief (DS W). An additional CNM has also commenced employment on a full time basis. Recruitment is ongoing to fill vacancies and we have a relief panel in place. Long service staff are employed on each unit to ensure continuity of care and we employ a key working model.
2. Rosters have also been reviewed to ensure maximum utilisation of resources across the centre.
3. As part of our Enhanced Governance structures we have identified two Provider Representatives one of whom will have responsibility for the campus and one for the community. This will provide oversight and support for the PIC on an ongoing basis and will highlight areas which need to be addressed and ensure appropriate measures are taken to deal with any issues.
4. We will also have one whole time equivalent PIC for the centre. Currently there is one PIC for two centres.
5. In addition , as part of these revised governance arrangements, an experienced manager was appointed on the 2nd January as a compliance and Quality Assurance Specialist which will considerably improve the audit oversight function.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

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

Despite identifying areas of concern in the unannounced inspection there was a lack of an effective plan to address concerns regarding the standard of support provided. For example the need for additional recreational activities was identified but on inspection there was still a very limited amount of activities outside the designated centre being offered or facilitated.

10. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

Actions from report April 2017 are completed. The 6 monthly unannounced inspection was carried out on 01/11/2017 and report finding had not been typed up prior to inspection on 03/11/2017. This is now complete.

We have reviewed the in-effectiveness noted in the findings and there is now a plan in place to tighten up governance in this area.

Proposed Timescale: 15/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was a high turnover of staff in the centre in recent months resulting in insufficient staffing levels some days and unsuitable staff mix in order to support residents in the centre.

11. Action Required:

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

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

Staff recruitment was underway at the time of inspection and since there have been 6 new Direct Support Workers (DSW) employed on a full time basis and 1 relief (DSW). There has been a CNM employed full time. Recruitment is continuous and ongoing. Long service staff are employed on each unit to ensure continuity of care and we employ a key working model.

Staff rosters have been reviewed to Maximise the utilisation of staff resources. There is a robust training and induction so new staff have a good understanding of the

residents.

Proposed Timescale: 15/01/2018

Theme: Responsive Workforce

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

The contingencies in place to cover staff leave in the centre were not sufficient so to ensure consistency of care for residents.

12. Action Required:

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

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

Unfortunately, at the time of the inspection there were a number of staff who had to be placed on administrative leave at short notice which aggravated the staff shortages.

Please see action 11 to see the outcome of recruitment.

A relief panel is in place and staff are offered overtime. Recruitment efforts have been intensified and are ongoing.

A night nurse superintendent role has also been put in place on the campus.

Proposed Timescale: 15/01/2018

Theme: Responsive Workforce

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

The actual rota in the centre did not outline all of the staff that worked in the centre everyday.

13. 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:

We have implemented a new roster template which will allow for clarity, roster planning and visibility of staff working. Any relief staff/staff redeployed will be visible on shift.

Proposed Timescale: 15/01/2018

