

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002397
Centre county:	Dublin 14
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Declan Ryan
Lead inspector:	Linda Moore
Support inspector(s):	Valerie McLoughlin
Type of inspection	Announced
Number of residents on the date of inspection:	4
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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:

03 February 2015 11:00

To:

03 February 2015 19:40

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

This service comprises one six bedded community house, five of the rooms are for residents use, four residents currently reside there.

Inspectors met with management, residents and staff members over the inspection. Inspectors observed practice and reviewed documentation such as personal care plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and residents meetings.

As many of the residents at the centre are out during the day, part of the inspection took place in to the evening, when residents had returned from their day activities.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met. The centre was clean and had a warm, hospitable atmosphere and inspectors found that the residents were comfortable and confident in telling the inspectors about their home.

While evidence of good practice was found, a considerable number of areas of non compliance with the Regulations were identified. Inspectors had concerns about fire safety and the provider took action on the day of the inspection to address the issues

raised. There was not enough staff on duty at times to meet the needs of residents.

Other areas for improvement included risk management practices, governance arrangements and access to training. The non compliances are discussed in the body of the report and included in the action plan at the end of this 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):

This was the centre's first inspection by the Authority.

Findings:

This service was provided to four residents ranging in age from 25 to 29. Two residents were independent with mobilising, while two required assistance at times. All residents attended a day service and required supports with health, personal and social care needs.

In general, inspectors found that aspects of resident's wellbeing and welfare was being maintained. The documentation in use appeared cumbersome for staff and required improvement. Inspectors were not able to ascertain if residents social care needs were met as all residents did not have a personal plan in place and where resident had these plans there as no system of review in place.

Inspectors found that personal plans was not consistently in place for all residents. While staff told inspectors that the residents had achieved many goals in 2014, this was not documented and staff were not aware of resident's goals. Residents plans were not developed in an accessible format for use by the residents. The personal plans that were in place contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests.

There was a lack of evidence to show if the goals set in 2014 had been realised and if they improved the lives of residents.

While residents had access to the multidisciplinary team as required, a comprehensive assessment with multidisciplinary involvement was not completed. Relatives said that

that any assessment or plans were discussed with them.

Residents had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. One resident had a part time job which they enjoyed and others were facilitated to attend courses outside of their day services if they wished.

Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly. This was confirmed when speaking with relatives.

The person in charge and staff were committed to promoting the rights of residents.

Residents gave examples of how they were involved in the running of the centre for example emptying the dish washer, hovering and doing laundry duties and assisting to keep their bedrooms clean. There were regular house meetings where residents made decisions and asked staff for support.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. Staff were observed interacting with residents in a respectful manner, consulting with them and seeking their views.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the provider had put sufficient risk management measures in place; however, they needed to be significantly improved. For example, risks associated with fire safety. The systems for the identification, assessment and management of risk required improvement. Inspectors were not entirely satisfied that staff took a proactive role in the management of all risk in the centre. The risk management policy did not meet the regulations and therefore could not be implemented.

Staff had not received training in risk management and were not knowledgeable in this

area.

Inspectors read the Health and Safety Statement and found it was not specific for the location. It did not include all risks associated with the premises.

There were some risk assessments completed but these had not been reviewed. Staff were not knowledgeable in the development of the risk assessments for example, there were no additional control measures recorded to mitigate the risk. All risks were also not included, such as staffing levels and fire safety, for example.

Residents did not have missing person profiles, and there were no risk assessment completed to guide this.

The person in charge and management team undertook a review of the recorded incidents on a monthly basis; however inspectors found that all incidents of falls or behaviours were not recorded. Inspectors noted from a review of residents files, that some resident had unexplained bruising, while staff said they monitored this, there was no evidence of any analysis or follow through of the cause of the bruise. Therefore this information could not be analysed to improve the service and this was a missed opportunity to share any learning for the period.

Inspectors found that where the incident reports were completed, they did not include the preventative measures and the staff did not have access to the necessary information following an incident to effect change. Inspectors noted that investigations were not always completed following an incident in the centre and did not ensure that the learning had taken place and improvements implemented as a result.

The risk management policy was included in the safety statement; it was generic and did not guide practice. While it included some of the aspects of the Regulations, it did not comprehensively include the practice in place for identification, recording, investigation and learning from serious incidents. The policy also did not include the specific risks required by the Regulations including self harm. The person in charge spoke of a review of the health and safety in the centre which was carried out in 2013 but the report and action plan could not be located.

Inspectors found that there was an emergency plan in place to guide staff in the event of such emergencies as power outages or flooding. All staff spoken with were knowledgeable of the plan.

Residents who could talk to inspectors commented that they felt the centre was safe and secure there was a staff member in the centre at all times.

Fire safety

Inspectors had concerns about aspects of fire safety, which may have placed residents at risk. Inspectors found that there were inadequate arrangements in place for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to a safe location. This was addressed immediately when raised with the provider during the inspection.

Inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and fire drills were carried out by staff at suitable intervals as defined by the Regulations. However inspectors found that while these drills had been completed, the learning from the drill had not taken place and adequate arrangements were not in place for the evacuation of all residents from the centre. A review of the fire drill records and in discussion with staff, they told inspectors that not all residents were willing to leave the centre when the fire alarm was set off and they did not have enough staff on duty at night time to support residents to leave the centre or move to safe location and maintain their safety.

Fire equipment had been serviced.

Improvements were also required with regards to other elements of fire safety. Inspectors observed fire doors been held open with door stoppers during the inspection.

Fire procedures were displayed throughout the centre. While there were personal evacuation plans for residents, they did not include the mobility and cognitive understanding of residents or address the issues raised at the fire drill.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However, these needed to be improved. This included the management of behaviours that challenge and the use of restrictive practices.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff except one had received training and this

was planned.

Inspectors reviewed the centre's policy on the prevention, detection and response to elder abuse and found that this policy overall gave guidance to staff on the types of abuse and included the procedures for reporting alleged abuse and the procedures to follow when investigating an allegation of elder abuse. However they were not comprehensive to include the process to follow to maintain the resident safely and to include the management of the staff at whom the complaint was made against.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. A resident told inspectors they were safe and this was confirmed with relatives. Relatives said they could tell a number of staff if they had any problems or concerns.

The management of residents with behaviour that challenged was not fully effective at all times. Inspectors observed an incident of behaviour that was challenging during the inspection and other residents in the centre appeared distressed. Residents records showed that other incidents had occurred including, but not restricted to, one resident targeted other residents in the centre. Staff had referred the resident for psychiatry review.

There was a policy on the management of behaviours that challenged, which, did not guide practice, this only included the development of the behaviour support plans but did not give any other guidance to staff. Staff told inspectors that they did not feel they had the resources or skills to manage a residents new behaviours. Due to the lack of knowledge and support in this area, staff described a practice whereby they lifted one resident off the ground during an incident of behaviour that was challenging, this practice may have placed the resident and staff at risk of harm. Training had been provided in this area and the management informed inspectors that additional support in this area would be provided to staff.

All residents who engaged in behaviour that was challenging did not have a behaviour support plan in place to guide staff which conflicted with the policy. While one resident had a behaviour support plan, it did not guide staff on the management of all behaviours.

Overall restrictive practices were used infrequently in the centre. Staff did not use medications to manage resident's behaviour. However, Inspectors found that the processes needed to be improved in line with the Regulations. Staff had not received training in restrictive practices and said they would welcome this. Staff confirmed and inspectors saw that staff used gates in two areas to restrict residents movement. Records showed and staff told inspectors that these restrictive practice were used the absence of staff, for supervision purposes. As these were used in the absence of staff, they may have placed residents at risk.

Staff told inspectors that they had concerns with the use of the gate at the bottom of the stairs and this was used when there was only one staff member on duty who was upstairs with another resident. The use of this gate conflicted with the recommendations of the physiotherapist and occupational therapist for one resident.

There was no documentary evidence to demonstrate who initiated the restrictive practice. There were no risk assessments in place to include the alternatives that were tried prior to its use. There was no record maintained of the frequency of its use in all instances. The person in charge said this had been reviewed at the positive approach committee, but there was no record of the decision. There was no care plans in place for all restrictive practices in place.

Inspectors found that there was no policy in place on the use of restrictive procedures in line with the Regulations.

Judgment:
Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there were appropriate arrangements in place to support residents' health care issues as they arose. Inspectors reviewed the care plans for residents and found that they had access to a general practitioner, including an out of hour's service. There was evidence that residents accessed other health professionals such as the physiotherapy, dietician and speech and language therapist services if required.

While staff told inspectors that health assessments were completed annually, they were located off site and therefore did not provide any information for staff in the care of residents. While there were care plans in place, these did not address all health issues, such as falls management. Residents who had fallen, did not have a falls care plan in place and were not reviewed following all falls.

There was a care plan for a resident with epilepsy, however, if followed would have placed the resident at risk as appropriate interventions would not be delivered in a timely manner. Improvements were required in the management of behaviour that is challenging, see outcome eight.

Nutrition

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for

residents to interact with each other and staff. There was a central dining room which was decorated to a high standard.

Weights were recorded on a monthly basis or more frequently if required, however there was no record maintained when a resident refused to be weighed. Therefore this may not be addressed.

Where modified consistency diets were recommended this was adhered to by staff.

Inspectors found that there was an ample supply of fresh and frozen food, and residents could make themselves a snack at any time. Photographs of foods for prompting were kept in the kitchen for residents to use to assist them in deciding what they wanted for dinner

The person in charge and staff had arranged weekly meetings for residents in the centre as another way of supporting residents to communicate their views. Inspectors reviewed the minutes and notes of some of these meetings and residents also told inspectors that they used the meetings to make decisions on what they wanted to eat during the week. Residents went food shopping with staff as needed.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

The medication management policy did not meet the requirements of the regulations. It did not contain information on prescribing, administration or management of controlled medications. While there were policies on transporting medications between units, storage, audit and disposal of medications they had not been reviewed and updated since 2009 and did not guide practice. For example, storage of medication policy stated that some medications must be stored in a separate locked temperature controlled fridge reserved specifically for medications. There was no medication fridge on site.

Staff were trained to administer medications and inspectors found they were knowledgeable about safe administration of medication. However, there were no records of competency assessments maintained on file. Inspectors reviewed the prescription record and medication administration records for residents and found that the documentation was complete. Where medications were prescribed as required (PRN)

the maximum dose and the reason for its use was prescribed, for example paracetamol for pain relief.

All residents medications were reviewed three monthly by the doctor. When any medication was discontinued the medication chart was rewritten to promote safety of drug administration.

Inspectors observed that the medication storage cupboard was in the kitchen. The keys were kept with the staff member and the double locked cupboard was used solely for the purpose of medication storage.

Where residents had medical conditions there were guidelines about how these were to be managed, and emergency medications prescribed. Staff spoken to were very clear of what action they would need to take, and who was responsible. However, the prescription and the protocol in place were not the same and inspectors were concerned that this could result in poor outcomes for residents.

Some residents went home on a regular basis, and there were arrangements in place for sending the correct medication with the resident.

While there was a procedure in place for counting and recording the number of medications administered and remaining, inspectors found that a comprehensive audit of medication management practice was not carried out. As a result "near miss" errors and medication errors may not be detected.

Staff collected medications from the pharmacy weekly or twice weekly as required and there was a system in place for recording all medications taken from the pharmacy.

Staff told inspectors that the pharmacist was available to provide advice as required, for example in relation to what drugs may be crushed as prescribed, or alternatively provided in powder format.

There were no medications that required strict control measures (MDAs) in place during the inspection. There was a system in place for checking the balance of sedative medications at the end of every shift. This was also supervised by the person in charge regularly.

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):

This was the centre's first inspection by the Authority.

Findings:

The provider had established a management structure, and the roles of managers and staff were clearly set out and understood. This was outlined in the statement of purpose. Inspectors found that while there was a person in charge of the centre, the post did not meet the requirements of the Regulations.

The person in charge was supported by the provider and service manager who reports to the acting chief executive to assist her to deliver a good quality service. The person in charge and service manager meet monthly and there were also cluster meetings where all persons in charge met monthly. The minutes were reviewed by inspectors.

The person in charge also holds regular staff meetings with all staff to discuss any issues that arise.

The person in charge was appropriately qualified and had continued her professional development. She had sufficient experience in supervision and management of the service. She told inspectors she had read the requirements of the Regulations and Standards and was actively trying to update her knowledge. She had attended training on the requirements of the regulations. She had very clear knowledge about the needs of each resident. She had completed a management course.

However inspectors found that the person in charge carried out her role in addition to carrying a caseload. She was rostered as part of the staff complement and while she was provided with one day per week for administration she did not have the opportunity to engage in the governance of the centre on a consistent basis.

The person in charge did not have the opportunity to engage in auditing, review of personal plans, review of medication practices or to complete supervision with staff, these issues are discussed throughout this report. Deputising arrangements for the person in charge were recently appointed.

Inspectors observed that the person in charge had a person-centred approach with residents and staff through her open and friendly interaction with them. She demonstrated strong leadership and good communication with her team. She was frequently observed meeting with residents and staff and ensured good support to all. This was confirmed by relatives.

There was a system in place to review the quality and safety of care in the designated centre. These could be improved by including measurable outcome goals, where the benefits of improvements could be identified, verified and monitored.

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):

This was the centre's first inspection by the Authority.

Findings:

While the staff were observed to be very caring and passionate about the care they provided, inspectors were not satisfied that the staff number, skill mix and supervision was sufficient or appropriate to meet the needs of residents at all times.

Staff told inspectors and this was reviewed in the residents records that restrictive practices were used in absence of supervision which placed residents at risk. Inspectors found that there was one staff member on duty from 07:00 to 09:00 am and a gate was placed at the bottom of the stairs in the absence of staff to prevent a resident from climbing the stairs. The risks associated with the use of this stairs was discussed under Outcome eight.

Residents records confirmed that one resident at high risk of falls was to receive supervision at all times and this could not be provided due to the staffing levels. There was insufficient staff on duty at night to safely evacuate residents as previously discussed.

Staff files were not reviewed on this inspection.

Training records held in the centre outlined the current training for all staff up until 2015. Many of the staff had received training on the Regulations and National Standards in 2014. All mandatory training was provided. There was no training plan for 2015. Inspectors noted that staff had not received training in risk management or restrictive practice and additional training in behaviours that were challenging was also required.

Staff meetings took place regularly; however there was no formalised supervision of staff in place. The nurse manager was not available to supervise the care delivered. This is discussed under outcome seven and 14.

There were no volunteers working in the unit.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

This was the centre's first inspection by the Authority.

Findings:

The designated centre did not have all of the written operational policies as required by Schedule 5 of the Regulations and while there were policies as discussed in the report, they did not guide practice. Staff were not familiar with the content of policies. They attributed this to not having the time to read policies. This includes the risk management policy, protection policy, behaviour that challenges, restrictive practice policies.

No other aspect of this outcome was viewed on inspection.

Judgment:
Non Compliant - Moderate

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:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002397
Date of Inspection:	03 February 2015
Date of response:	02 March 2015

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:

A comprehensive assessment with multidisciplinary involvement was not completed.

Action Required:

Under Regulation 05 (1) (b) 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC will review all completed Assessment of Needs with the staff team on March 23rd 2015. This review will indicate multidisciplinary support needs for each resident. The PIC will arrange meetings with the relevant clinicians to review, revise and update the assessments of needs.

Proposed Timescale: 20/04/2015

Theme: Effective Services

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

Personal plans was not consistently in place for all residents

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:

The PIC will review all completed 2014 Personal Plans and will agree with the staff team a system for personal planning for 2015. One Personal Plan will be completed each month and priority will be given to any plans which were not completed at the time of inspection. Personal plans will be available for review by inspectors.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

There was no system for the regular reviews of the plans to take place.

Action Required:

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

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

The PIC will ensure that the progress and effectiveness of each Personal Plan is reviewed and discussed at monthly staff meetings. Minutes of the staff meetings will be available for inspection. A formal review of the plan will be carried out with each Service User every three months. The Key Worker will maintain records of these reviews, and these will be available for inspection.

Proposed Timescale: 23/03/2015

Theme: Effective Services

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

Residents plans were not developed in an accessible format for use by the residents.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

All 2015 Personal Plans will be developed to ensure that the necessary information regarding the choice, tracking and management of Service Users' goals is in an accessible form.

Proposed Timescale: 30/06/2015

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 risk management policy did not meet the requirements of the Regulations.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The Registered Provider has developed a Risk Management Policy. The Policy includes arrangements for the identification, recording and investigation of, and learning from serious incidents or adverse events involving residents.

The PIC will implement the Risk Management Policy in the designated Centre. The Policy will be available for review by inspectors.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The emergency plan did not include all emergencies as required by the Regulations.

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:

The PIC will implement a system for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Missing person's profiles and risk assessments will be completed as part of this.

Proposed Timescale: 16/03/2015

Theme: Effective Services

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

There was insufficient arrangements in place for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to a safe location.

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 the day of the inspection the Registered Provider arranged for additional staff to be present in the Designated Centre at night to assist with the evacuation of all Service Users in the Designated Centre.

A series of fire drills have taken place, and will continue to take place for a period of six weeks to assess levels of Service User compliance with evacuation procedures.

Additional personal equipment was sourced for one Service User to assist with evacuation.

The Registered Provider will organise a full review of evacuation procedures after the six week period, to determine if additional staff /changes to the built environment/ changes to Service user evacuation Plans are required.

The outcome of the review will be implemented. Date and minutes of the review will be available for inspection.

Proposed Timescale: 20/03/2015

Theme: Effective Services

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

Inspectors observed fire doors been held open with door stoppers during the

inspection.

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 practice of keeping fire-doors open is specifically linked to the prevention of challenging behaviour for a Service User. The Registered provider will arrange a multidisciplinary review, including Psychology, Technical Services and Fire Safety Personnel, which will take place to resolve this issue.

Proposed Timescale: 06/03/2015

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:

Staff told inspectors that they did not feel they had the resources or skills to manage the new behaviours.

Action Required:

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

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

The PIC will organise staff training in the management of behaviour that is challenging, including de-escalation and intervention techniques. This tailored training will focus on specific behaviours (both new and old) in the Designated Centre. A record of staff attending the training will be available for inspection in the Designated Centre.

Proposed Timescale: 20/04/2015

Theme: Safe Services

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

Restrictive practices needed to be improved in line with the Regulations.

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 organise a review of the two restrictive procedures in the Designated Centre to ensure that they are in line with National Policy and Evidence Based Practice. Minutes of the review will be available for inspection.

Proposed Timescale: 20/03/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Evidenced based care was not delivered in epilepsy management, falls management and behaviours that is challenging.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

The Registered Provider will support the PIC to ensure that appropriate health care plans are compiled for each resident, in consultation with relevant clinicians, having regard to each resident's personal plan. These plans will be available for inspection.

Proposed Timescale: 31/03/2015

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 medication management policy did not meet the requirements of the regulations and was not in line with best practice guidelines.

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:

The Medication Management Policy has been updated to reflect the requirements of the regulations.

The Policy has been printed and included in each individual Service Users' medication administration folder.

A SAM trainer will carry out SAM training with the staff team.

Proposed Timescale: 20/04/2015

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 person in charge did not have the opportunity to engage in the governance of the centre on a consistent basis.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The PIC will be supported by the Registered Provider, to be rostered for additional management time, to ensure that the management systems in place will safely and appropriately meet resident's needs.

These systems will be consistent and regularly monitored by the registered Provider, this will take place at monthly management meetings between the PIC and the Registered Provider's representative. The minutes of these meetings will be available for inspection.

Proposed Timescale: 31/03/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staff number and skill mix was insufficient to meet the needs of residents

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:

The Registered Provider will carry out a full review of staff numbers and skills mix, to establish what is required to meet the needs of each resident. Minutes of this review will be available for inspection. The roster review will take account of fire safety, restrictive practices and the clinical and care needs of each resident.

<p>Proposed Timescale: 30/04/2015</p> <p>Theme: Responsive Workforce</p> <p>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect: Staff did not have access to all necessary training to meet the needs of residents.</p> <p>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.</p> <p>Please state the actions you have taken or are planning to take: Staff training will be scheduled to address all outstanding staff training needs. Refresher training will be scheduled as required to meet all mandatory and statutory requirements.</p> <p>Safe guarding training was completed for all staff on 23/2/15.</p> <p>Positive Behaviour support training will be delivered to the staff team by the Psychologist on 23/3/15.</p> <p>Training records will be available for inspection.</p>
<p>Proposed Timescale: 31/03/2015</p> <p>Theme: Responsive Workforce</p> <p>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect: There was no formalised supervision of staff in place.</p> <p>Action Required: Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.</p> <p>Please state the actions you have taken or are planning to take: The PIC will commence formalised supervision of all front line staff, using a template which has been developed by the HR department. The minutes of these meetings will be available for inspection.</p>
<p>Proposed Timescale: 31/03/2015</p>

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 designated centre did not have all of the written operational policies as required by Schedule 5 of the Regulations and while there were policies as discussed in the report, they did not guide practice. Staff were not familiar with the content of policies.

Action Required:

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

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

The Registered Provider is developing a Policy on:

- (a) Risk Management - to be completed by 31/3/15
- (b) Restrictive Practice - to be completed by 30/6/15

The PIC will organise for additional staff training on the implementation of Positive Behaviour Support Guidelines in the Designated Centre.

Proposed Timescale: 31/07/2015