

**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:	ORG-0008561
Centre county:	Meath
Email address:	karen.harrold@smh.ie
Registered provider:	St Michael's House
Provider Nominee:	Karen Harrold
Person in charge:	Frank Kennedy
Lead inspector:	Ciara McShane
Support inspector(s):	Siobhan Kennedy
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 January 2014 11:30	20 January 2014 19:30
20 February 2014 14:00	20 February 2014 15:00

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

Outcome 01: Residents' Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 16: Use of Resources

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over one day. This was the first inspection carried out by the Authority in this service and was a single issue inspection following information received by the Authority. The information related to concerns of low staffing levels, inappropriate mix of service users, records and documentation. The inspection did not cover all outcomes. As part of the monitoring inspection, inspectors met with service users and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medication records, risk management records and policies, rosters, staff training records and policies and procedures.

The designated centre is part of the wider organisation St. Michael's House. Amongst other supports St. Michael's House provides residential services to both adults and children, with an intellectual disability, throughout Dublin and part of the Meath area. This designated centre provided supports and accommodation to both males and females who had a range of intellectual disabilities and some with behaviours that challenge. The designated centre had capacity for five adults and had no vacancies. As some service users at the designated centre were out at Day Services, the inspection took place later in the morning into the late evening, when all service users had returned from their Day Services. On the day of the inspection there were four service users present with one service user at home with their family.

Inspectors found that while there was evidence of some good practice in the service, there were mandatory improvements required in order for the designated centre to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

The designated centre was clean, tidy and decorated in a homely manner. The staff on duty were welcoming and introduced us to one service user who resides at home for the day. The staff on duty, on the day of inspection, included the following:

Person in charge - rostered on for an administration day from 09:00 to 17:00
Social care worker (1) - sleepover duty from 11:00 to 24.00, 07:00 to 23:00
Social care worker (1) - 16:00 to 20:00
Nurse (1) - 08:00 to 20:00.

Inspectors observed staff being respectful and attentive to the service users, making cups of tea for them on their arrival home and assisting them to partake in activities of their choosing. The inspectors observed one service user playing on his keyboard and another sitting with staff members.

The inspectors found that although the designated centre had some documentation, systems, policies and procedures in place they were not all developed, relevant and used to inform practice. Service users had poor input into their service and had minimal involvement in the development of their personal plans. Risk management was found to be weak and failed to identify, record, analyse and review all areas of risk. Adverse events and incidents were not notified to the Authority in the required format and within the specified time frame in accordance with the Regulations.

The service users had no access to an advocate and the service had no advocacy programme. Complaints management, staffing and staff training also required immediate and sustained attention. These are discussed further in the body of the report and actions required are included in the Action Plan at the end of this report.

Inspectors returned to the designated centre on 20 February 2014. The person in charge and an agency nurse were on duty. The agency staff was new to the designated centre. Some staff members were on sick leave and agency staff had been allocated to cover shifts. One service user was also present who had returned from an earlier appointment accompanied by the person in charge. Inspectors received a verbal update regarding feedback given on the day of the initial inspection.

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Overall inspectors found that service users were not enabled to make choice about how they lived in a way that reflects their individual preferences. Staff reported they assisted service users with purchasing personal items such as clothing and DVD's, attend the local coffee shop and visit the local church to light a candle. However inspectors found that service users were not consulted in the daily running of the house. Service users did not participate in developing the weekly dinner menu and did not provide input to the weekly grocery shop. The lounge room in the house was recently decorated, the service users did not have input into this. Staff on duty confirmed that some service users had input into decorating their own bedrooms. Service users had no choice in deciding where they lived or their placement in the designated centre and had no say in deciding which new service users came to live in the home should a vacancy arise. The admissions of new service users was determined by the Residents Approval Committee, a central team at St. Michael's House Ballymun. The final decision is made by the chief executive officer.

The service users had no access to an advocate and the service had no advocacy programme. The person in charge did state that it had been 'mentioned' at previous meetings, with management, but nothing had been implemented to date. In additional information received, subsequent to the inspection, the provider informed inspectors that the person in charge had attended a presentation given by two members of the National Advocacy Service in October 2013.

There was a restriction placed on the freedom of service users, the front door was locked at all times. This is further discussed in outcome eight safeguarding and safety.

The service users were supported to go to bed when they wished and have lie-ins at weekends, this was noted while talking with staff and also recorded in service users daily notes.

There was a complaints policy in the designated centre but the practice did not reflect the policy or meet the requirements of the Regulations. The complaints policy was not in a format accessible to the service users nor was the complaints policy displayed in a prominent position in the centre. Inspectors viewed the complaints log and found that there was one complaint, in the form of a letter dated 6 January 2014. No written response, within three working days of receiving the complaint, was issued to the complainant. From the additional information requested and received by the Authority, it was confirmed that the Director of Services, contacted the complainant by phone on 22 January 2014, two days after the inspection. As required by the Regulations, all complaints should be promptly investigated. It was acknowledged, from the additional information requested and received by the Authority, ongoing phone contact, visits and other forms of support were offered to the complainant, some of which were refused.

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The designated centre did not comply with Regulation 24. There was no evidence of an admissions policy and no clear guidelines outlining the process of admitting new service users. Service users did not have an agreed written contract outlining their service provision. While service users did have a Tenancy Agreement with St Michael's House Housing Association, it was not sufficient as it failed to outline the support, care and welfare provided to the service user living at the designated centre.

The designated centre did not undertake an assessment of needs, as required by Regulation 24, prior to admission and residents are subsequently not appropriately protected from peer abuse. The person in charge stated they had no input regarding the admission of new residents, this was done through the Residents Approval Committee which was completed centrally at St Michael's House Ballymun.

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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspectors found that each service user had a personal file and that the daily and monthly notes for service users were good, clearly detailing their day, outlining any difficulties they may have had and any activities they were involved.

The inspectors found that service users were not involved in the development of their personal files nor were they in a format that was accessible to them. Significant improvements were required in relation to the personal plans to comply with Regulation 5. Each service user's personal plan did not have a comprehensive assessment of their health, personal and social care needs. After speaking with staff, inspectors formed the view that the lack of individual assessment of needs, prior to admission, had resulted in inappropriate placements and service users living with individuals whom they were incompatible with. In addition to this not all people living in the service, on a long-stay basis, enjoyed the security of a permanent home. A service user temporarily left the designated centre and returned to their family home, due to disturbances in the designated centre. The personal plan did not reflect the change in circumstances and there was no transition plan drawn up to support their needs. The person in charge did not put a formal plan in place to support the service user or their family. The Authority has requested an update on this matter. Further information received by the Authority, following the inspection, demonstrated a log of calls and offers of support made by the person in charge to the family.

Personal plans were reviewed annually but did not reflect the ongoing changes in the needs and circumstances of the service user. The inspector saw a monitoring device in one of the bedrooms, when the inspector asked about this, the person in charge stated that the service user probably did not need it for some time now and that he would review the assessment. The designated centre did not meet all needs of all service users. Some service users required a significant amount of staff resourcing and time. One service user required two staff while using transport, two staff to assist them in and

out of their chair and their bed. This resource requirement impinged on other service users such as receiving personal care in a timely manner in the morning. When the house was at full occupancy, one service user received their showers at 5pm in the evening as there were not enough staffing resources to assist them in the morning.

Two service users had a positive behaviour support plan. One service user displayed ongoing self harm, however there was no formal behavioural support plan on how the service user should be supported and protected. This service user had a daily routine plan. Inspectors formed the view from review of records, and discussion with the person in charge that the staffing levels contributed to the poor maintenance, review and updating of personal plans.

Each service user did not have a single integrated plan. All information pertinent to the service user was not kept locally. St Michael's House in Ballymun houses the minutes of the multi-disciplinary team meetings that takes place regarding an individual, communications from the GP were recorded locally in the 'working file'. Additional information received, from the provider, after the inspection stated that copies of the minutes were circulated to the designated centre.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

While there were some arrangements in place to manage risk, non compliances were identified in the risk management arrangements, emergency planning and safety statement.

Accidents, incidents and near misses were not all identified, recorded and investigated or learning gained from them. Numerous incidents and accidents involving service users acting out against other service users and staff had not been recorded in a formal way and were not notified to the Authority as required by the Regulations. Arrangements to ensure that risk control measures were proportional to the risk identified, and that any adverse impact may have on the service users quality of life, had not been considered. Risk management in the designated centre was found to be insufficient.

Environmental risk assessments were lacking, the front door was locked at all times discussed further in Outcome eight and there was a partition door, with a sliding bolt on it, separating the kitchen from the eating area within the kitchen. Staff interviewed

stated it was there to prevent service users coming into the kitchen while food was being cooked. However, there was no risk assessment, outlining the control measures and rationale, in place for this. Although there were some individual risk assessments, all elements of the service users' safety and well being, identifying any risks with controls to proportionately manage these risks, were not carried out for each service user.

There was no emergency plan in place to guide staff in the event of emergencies such as a power outage, loss of water, flooding or any other natural disaster. The safety statement was a generic St Michael's House safety statement and not specific to the designated centre. Further information received from the provider, subsequent to the inspection, outlined two sections of the safety statement that were specific to the centre.

There were regular fire drills, fire equipment was serviced as required and daily checks were carried out to ensure that fire exits were not blocked and that fire equipment was in place and had not been tampered with. The break-glass units had been moved to a height so that only staff could reach as one service user had a history of breaking these when unhappy.

The emergency pull chord in one of the bathrooms was tied up. In the event of an emergency the service users would be unable to reach the chord.

There was a medication policy in place. The inspectors observed records demonstrating weekly medication audits of all medication. The audit records viewed by the inspector demonstrated that medication was unaccounted for. While medication errors were recorded, the person in charge failed to sufficiently investigate the reasons for it happening and therefore, no controls were put in place to prevent it from re-occurring.

Staff were aware of infection control procedures. The inspectors observed appropriate personal protective clothing in bedrooms, bathrooms and the kitchen. A staff informed inspectors of the procedure for cleaning the hoist and sling for a service user and also the laundry procedures should there be an outbreak of infection. Each service user had their own colour coded towels in addition to their own bed linen. The staff followed Hazard Analysis and Critical Control Points (HACCP) guidelines in the kitchen where food was prepared and stored. The inspectors viewed the daily records demonstrating records of temperatures of food, fridges and freezers.

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

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were some arrangements in place to safeguard the young adults at the designated centre however, these were not all compliant with the Regulations.

Physical and environmental restrictions were in operation. The person in charge confirmed that when two service users were involved in an altercation one of them was locked into a room to remove them from the company of the service user. This practice was outlined in one of the service users behavioural support plans but there was no risk assessment in place for this. The positive behaviour support policy within St. Michael's House states that the practice of seclusion is prohibited and that all forms of restraint should be approved through the organisation's positive approach monitoring group. The person in charge confirmed that the front door was kept locked at all times to prevent one service user from absconding. This service user had not absconded for a year and the practice of locking the door had not been reviewed. Additional information received from the provider stated that the resident attempted to abscond nine months previous. On the day of inspection there was no available risk assessment in place for this restrictive practice in terms of, the absconding, or in the event of a fire or emergency evacuation. This practice had also not been submitted to the organisation's positive approach monitoring group as stated in the behaviour support policy.

The person in charge confirmed that staff 'gently' hold down the hand of one service user to protect them from self harm, there was no risk assessment in place for this. Inspectors spoke with staff and formed the view that not all service users that required a behavioural support plan had one. Inspectors viewed the two behavioural support plans that were in place. The behavioural support plans in place were developed by St Michael's House Senior Clinical Psychologist.

Not all service users were protected from abuse at all times. It was documented in daily notes that service users hit out at other service users. Where this was witnessed by staff the service users were separated. These incidents were not all formally recorded, investigated, analysed or actions put in place to prevent it from reoccurring.

The staff team have not received recent training to assist them respond to behaviour that challenged. This will be discussed in further detail in Outcome 16.

The inspectors acknowledged additional information received highlighted case conferences that staff were involved in and the clinical input received at some staff meetings.

The inspectors were unable to ascertain if the service users felt safe. Staff were observed interacting with the residents in a respectful manner. Staff talked knowledgeably about the service users.

Finances were not reviewed on this inspection.

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Staff were not maintaining detailed records of all incidents and accidents. Schedule 3 of the Regulations states that records should be kept on any occasion where restrictive procedures were used in respect of the service user, the reason for its use, the intervention tried to manage the behaviour, the nature of the restrictive procedure and its duration. Schedule 3 also states any incident in the designated centre where a service user suffers abuse or harm should be recorded detailing all aspects of the incident, those involved and those who witnessed it. The staff told inspectors there was not enough time to record all incidents and accidents.

There were numerous incidents and accidents that were required and should have been notified to the Authority as required by Regulation 31. To date the Authority has received no notifications from this designated centre.

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspectors found that there was insufficient staff, in the designated centre, to meet all needs of all service users. Staff reported service users required various levels of

support. Four service users required full assistance with most activities of daily needs and one service user required more verbal prompts than full assistance. However, inspectors were unable to confirm this as there were no assessments of needs in their individual care plans.

On review of rosters and discussion with staff, inspectors formed a view that there was insufficient staff on duty in the mornings. The person in charge stated that there were insufficient staff numbers to allow for records and personal plans to be updated. It was also stated staff meetings occur infrequently due to low staff numbers. Records viewed by inspectors showed that staff meetings did not frequently occur, not all personal plans were updated and not all accidents and incidents that occurred were formally recorded. The morning routine, assisting services users up from bed and providing personal care, was unorganised. Due to the personal care support needs of the service users, it was reported by the person in charge, that often service users were 'walking up and down the hall' waiting for staff to become free to assist them.

In 2011 the staff compliment was decreased in the designated centre to 8.5 whole time equivalent. The person in charge confirmed that this was not done through any formal process of assessing the needs of the service user and the designated centre. The person in charge confirmed that the provider was aware of the current staffing level.

The person in charge informed inspectors that a staff member was rostered two days a week, 4pm to 8pm, to assist the service users with activities. Inspectors reviewed two rosters spanning over eight weeks and this shift was only rostered on seven occasions. The person in charge stated that if annual leave or sick hours occurred the activation hours were used to supplement these gaps. This therefore reduced the opportunities for service users to engage in activities.

There were a number of service users with limited verbal communication, staff communicated by recognition of gestures or a selection of pictures , albeit limited, for one service user. No assistive technology devices were used to aid communication.

The designated centre was equipped with televisions, DVD players, radios, jigsaws and other games that the service users are interested in. A garage, at the back of the designated centre was converted and housed an activities and chill out room for the service users. It housed an exercise bike, a treadmill, a game console and a television amongst other items. Inspectors were told this room was utilised when there was enough staff on duty to do so.

The designated centre had sufficient transport, it had one vehicle. One service user required two staff at all times when using the vehicle.

Considering the complex needs of the service users and the high number of incidents read in the file of one service user alone, staff were not appropriately skilled in reacting to behaviour that challenged. The inspector observed, from 11 staff training records, insufficient training, provided to staff, regarding behaviour that challenged. Three staff had received no training on behaviour that challenged while eight staff had expired training in this area. All staff signed a Policy 'Best Practice in Behavioural Support' in July 2012 and a briefing session was provided. Inspectors also noted, from viewing the 11

staff training records, that six staff had no training on Safeguarding Service Users and five staff required additional training as their previous training had expired. A staff member who was interviewed stated that they last received training on Safeguarding Service Users four years ago during their induction programme and it had not been refreshed since.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Ciara McShane
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:	ORG-0008561
Date of Inspection:	20 January 2014
Date of response:	21 February 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents' Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The service users are not consulted with all decisions about his or her care and support.

Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

- Each person will be supported by their key-worker to make decisions about his/her care and support. This will be done by the key-worker keeping the person informed of upcoming meetings, discussions and appointments and supporting the person to understand and participate in what is discussed and agreed in relation to their care and

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

wellbeing. (Immediate)

- The person in charge will ensure that parents and family members are actively involved in supporting their family member to participate in all aspects of their care. (Immediate)

- The person in charge will make a referral for each resident to the Speech and Language Therapy Department for a communication assessment to be completed by end March 2014. This will assist key-workers in helping people make meaningful decisions about their life.

- Residents will be involved in reviewing their existing Personal Plans along with key-workers and any other relevant people in their lives over the next 3 months.

Proposed Timescale: 30/06/2014

Theme: Individualised Supports and Care

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

The service users were not consulted and did not participate in the running of the designated centre.

Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

- Weekly House Meetings with all residents will commence 16th February 2014 to involve people in participating in and making choices about routine daily living in the designated centre. Menu planning, shopping, housework and activities will be discussed. A record of people's preferences will be kept and used to inform meals, outings and activities etc for the week ahead.
- Key-workers will use pictures, symbols and objects of reference, which are known to the residents, to help people be involved in the running of the designated centre.
- The person in charge will ensure that expressed preferences of residents in relation to day to day living, e.g. choice of clothes, food, outings and activities, spending their own money, holidays and visits home will be met as far as is practicable.

Implemented immediately and is on-going.

Proposed Timescale: 12/03/2014

Theme: Individualised Supports and Care

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

The designated centre did not carry out a needs assessment for each service user.

Action Required:

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the

nature and extent of the resident's disability and assessed needs and his or her wishes.

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

- The person in charge will collate the information from the process of assessment of need carried out prior to admission and include it in each person's Personal Plan. This will include areas such as day service, social interests, family contact, medical, mental health, choices and preferences, support needs for personal care areas, hobbies and interests, means of communication and goals for the future.

Proposed Timescale: 31/05/2014

Theme: Individualised Supports and Care

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

The complaints procedure was not in a format accessible to all service users.

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

- The person in charge will display an accessible version of the Complaints Policy. (Completed)
- The person in charge and key-workers will support people to understand the complaints procedure at a house meeting and how they can complain about issues that affect them within the designated centre. (31st March 2014)

Proposed Timescale: 31/03/2014

Theme: Individualised Supports and Care

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

The service users had no access to an advocacy service.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

- The National Advocacy Service has been invited to the designated centre to meet residents and staff to explain their role in providing independent support to people should they need or want it.
- A representative from the National Advocacy Service met staff in the designated centre on 5th March 2014 and will meet the residents on 7th April 2014.
- The person in charge has distributed information from the National Advocacy Service to all parents and families of people living in the designated centre.

Proposed Timescale: 12/03/2014

Theme: Individualised Supports and Care

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

The complaints procedure was not displayed in a prominent position in the designated centre.

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

- The person in charge will display a copy of the organisation's Complaints Policy in a prominent position and ensure that all families and service users are aware of it's contents and how they can bring forward any complaint or concern. (Completed)

Proposed Timescale: 12/03/2014

Theme: Individualised Supports and Care

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

Complaints were not addressed promptly. The complainant letter was received on 6 January and a phonecall, acknowledging the letter, was not made until 22 January, by the Director of Services, after the Authority carried out their inspection.

Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

- All future complaints will be dealt with in accordance with the organisation Complaints Policy and investigated promptly.

Proposed Timescale: 12/03/2014

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

There was no admissions policy in place.

Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in

accordance with the statement of purpose.

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

- A draft Admissions Policy is now available to govern and manage both internal and external admissions to residential centres 25/03/2014
- An Admissions Policy will be completed in its entirety by December 2014

Proposed Timescale: 01/12/2014

Theme: Effective Services

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

The service provider or person in charge did not undertake an assessment of needs prior to admission and service users were subsequently not appropriately protected from peer abuse.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

- All future assessments of need will take account of the need to protect residents from abuse by their peers.
- Reported instances of peer abuse among current residents will be reviewed by the person in charge, relevant clinicians and staff, service users and families and appropriate measures will be put in place to protect people from peer abuse.

Proposed Timescale: 30/04/2014

Theme: Effective Services

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

Each service user did not have an agreed written contract which deals with the support, care and welfare of the service user including details of the service to be provided to the service user.

Action Required:

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

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

- A contract will be developed for all future service users moving into the designated centre in line with the requirements of the Regulations.
- In the interim the Provider Nominee, along with the Regional Management Team, will develop a provisional contract for each resident.

Proposed Timescale: 30/06/2014

Outcome 05: Social Care Needs

Theme: Effective Services

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

Each service user's personal plan did not have a comprehensive assessment of their health, personal and social care needs.

Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

- The person in charge will ensure that a comprehensive assessment of the health, personal and social care needs of each resident is collated and included in their Personal Plan.
- The person in charge will ensure that this assessment is completed prior to any future admissions to the designated centre.

Proposed Timescale: 30/05/2014

Theme: Effective Services

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

Service users were not actively involved in the development of their personal plans and do not own them.

Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

- The person in charge and key workers will review each resident's Personal Plan with them, in consultation with parents and/or family members and in line with the resident's wishes.
- The person in charge will ensure that Personal Plans are in an assessable format to help residents understand what is in them and that they have had full participation in their development.

Proposed Timescale: 30/06/2014

Theme: Effective Services

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

Personal plans were not reviewed in a timely manner to reflect the changing needs of the service users.

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:

- The person in charge will set review dates for each person's Personal Plan in the designated centre.
- Where circumstances have changed for a resident a review will be arranged to reflect the change in the Personal Plan.

Proposed Timescale: 12/03/2014

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:

Accidents, incidents and near misses were not all identified, recorded and investigated or learning gained from them.

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 person in charge will ensure that all future accidents, incidents and near misses are identified, recorded and investigated in a timely manner.
- The person in charge will review all such incidents at staff meetings and with relevant clinicians with a view to prevention in the future and learning from past incidents.

Proposed Timescale: 19/04/2014

Theme: Effective Services

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

Risk management was not robust, analysed or reviewed within effective time-frames. Risk management in the designated centre did not cover all aspects of the designated centre where risk was observed. There were no robust plans or procedures in place for responding to emergencies other than fire. The emergency pull chord in the downstairs

bathroom was tied up, therefore ineffective in the case of an emergency. Although there were risk management procedures in place to audit medication, it did not sufficiently identify the reasons for the drug errors and therefore no controls were in place to prevent it re-occurring. There was no centre specific safety statement.

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 person in charge, with the support of the provider nominee, will review the risk management systems in the designated centre with the help of the organisation's Health and Safety Officer. (30th April 2014)
- The person in charge will review the existing risk assessments and complete additional ones to cover all aspects of risk in the designated centre. (30th April 2014)
- The person in charge will draw up plans for responding to emergencies other than fire to include flood, loss of power or water or other natural disasters. (30th April 2014)
- The emergency chord in the downstairs has been rectified. (Completed)
- The person in charge will review the local management of drug errors and include a review procedure with staff members in order to prevent future errors and gain learning from the past. (30th April 2014)
- The person in charge will attend refresher risk assessment training on 13th March 2014. Application will be made to the training department to accommodate other staff members on future risk assessment training.

Proposed Timescale: 30/04/2014

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:

All staff did not have up-to-date training in the area of supporting people with behaviour that challenges.

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:

- Staff in the designated centre will receive training in Positive Behaviour Support, which is delivered by the Open Training College. Dates of this training begin in April/May 2014 and September/October 2014.
- The person in charge and relevant clinicians will discuss appropriate training for staff members in the designated centre in relation to de-escalation and intervention techniques. (27th March 2014)

Proposed Timescale: 31/10/2014

Theme: Safe Services

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

Each service user that required a behavioural support plan did not have one.

Action Required:

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

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

- All service users that require a behavioural support plan have one.
- The person in charge will ensure that review dates are included in each behavioural support plan.

Proposed Timescale: 12/03/2014

Theme: Safe Services

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

Physical and environmental restrictive practices were in place in the absence of robust risk assessments demonstrating the necessity for the restrictive practice, all other controls trialled, a review of the practice and in the absence of input from the service user or his/her representative.

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 person in charge will ensure that all restrictive practices are risk assessed in the designated centre. (Immediate)
- The person in charge will refer all restrictive practices in the designated centre to the organisation's positive approach monitoring group. (Completed)
- The person in charge will ensure that where a restrictive practice forms part of a behavioural support plan that this is risk assessed and a review date is included with a view to reducing or removing the restriction over time. (30th April 2014)
- The person in charge will discuss restrictive practices with all staff and relevant clinicians supporting the designated centre at regular meetings, usually held at 6-week intervals. (30th April 2014)

Proposed Timescale: 30/04/2014

Theme: Safe Services

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

Service users were not protected, at all times, from abuse caused by other service users.

Action Required:

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

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

- The provider nominee along with the person in charge, residents, staff members, families and relevant clinicians will promote a safe environment for all those living in the designated centre. (Completed)
- Where there are safety concerns between residents i.e. one resident causing abuse to another, the person in charge will ensure that individual safeguards are put in place. (Immediate)
- The person in charge will ensure that appropriate risk assessments are in place where safety of residents may be compromised. (31st March 2014)
- The person in charge will ensure that all staff members are aware and understand the organisation's policy and procedures in relation to safeguarding of service users. (Immediate)
- The person in charge will ensure that all concerns and/or allegations of abuse are reported to the organisation's Designated Person, who manages all reports of concerns or allegations of abuse or neglect made in the organisation. (Immediate)

Proposed Timescale: 31/03/2014

Theme: Safe Services

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

All incidents and accidents of abuse have not been investigated and appropriate actions put in place.

Action Required:

Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

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

- The person in charge will ensure that all incidents, allegations or suspicions of abuse or neglect are reported appropriately both internally i.e. within the policy and procedures of the organisation and externally i.e. as per the statutory regulations.
- The person in charge along with residents, staff and family members, relevant clinicians and service manager will discuss instances of abuse in the designated centre and agree appropriate actions to prevent future occurrences.
- The person in charge will ensure that such incidents are investigated and/or assessed

in a timely manner.

Proposed Timescale: 12/03/2014

Theme: Safe Services

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

All staff did not have up-to-date training in safeguarding service users.

Action Required:

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

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

- 10 staff members will receive Safeguarding Service User Training between 12th March and 14th April 2014.
- The person in charge will ensure, with the assistance of relevant people i.e. Service users and/or family members, key-workers and relevant clinicians that appropriate guidelines are written up and implemented to promote the safety and wellbeing of all residents in the designated centre.

Proposed Timescale: 14/04/2014

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The designated centre had not notified the Authority of any incidents.

Action Required:

Under Regulation 31 (1) you are required to: Maintain a record of all incidents occurring in the designated centre.

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

- The person in charge will ensure that all incidents in the designated centre are reported in line with the organisation's policy and procedures.
- The provider will ensure that all incidents/notifiable events are reported to the statutory authority in a timely manner as per the Regulations.

Proposed Timescale: 12/03/2014

Theme: Safe Services

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

The designated centre had not notified the Authority of any incidents to date regarding abuse to a service user.

Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

- The person in charge will ensure that all incidents of abuse of a service user in the designated centre are reported appropriately and in line with the organisation's policy and procedures.
- The provider will ensure that the statutory authority is informed as per requirements of the Regulations.

Proposed Timescale: 12/03/2014

Outcome 16: Use of Resources

Theme: Use of Resources

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

There were insufficient staffing resources to meet all the needs of all the service users at all times.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

- The provider nominee and person in charge will arrange a review of the roster and current shift patterns with a view to moving staff to those times of the day when people have greater needs and need more staff support.
- In the interim 32 hours will be put back into the roster as of 21st March 14.
- Future staff requests for reduced hours of work and or requests for continuation of parental leave will be considered in light of the needs of residents in the designated centre.

Proposed Timescale: 30/04/2014