<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Redwood Extended Care Facility</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0002432</td>
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<tr>
<td>Provider Nominee:</td>
<td>Frances Gargan</td>
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<tr>
<td>Lead inspector:</td>
<td>Ciara McShane</td>
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<tr>
<td>Support inspector(s):</td>
<td>Jillian Connolly</td>
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<td>Number of residents on the date of inspection:</td>
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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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 07 January 2015 09:15  
To: 07 January 2015 18:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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**Summary of findings from this inspection**
This was the centre's first inspection. Two inspectors carried out the inspection over one day. The designated centre consisted of two units, both of which were within walking distance of a nearby village. The designated had capacity to support the needs of eight residents; on the day of inspection there were two vacancies. The designated centre aimed to provide supported living accommodation for people, both male and female, over the age of 18 years with intellectual disabilities, acquired brain injuries, mental health difficulties and/or medical conditions.

During the inspection the inspectors spoke with staff and residents, reviewed documentation including resident's personal plans and walked the premises. The inspectors found some adequate practices in place; the centre was sufficiently staffed on the day of inspection to meet the needs of those residents present and residents were found to have sufficient access to general practitioners and allied health professionals.

The inspectors reviewed eight outcomes, three of which were found to be of major non compliance and five were found to be of moderate non compliance. Improvements that were identified during the inspection included but were not limited to health, safety and risk management: safe evacuation procedures in the event of a fire, in particular at night-time, required a review as too did the risk
register to ensure all risks were highlighted and appropriate controls were in place. Deficits with the premises were highlighted more specifically the accommodation for one resident was inadequate to meet their specific needs as outlined in Outcome 6, all other accommodation for residents was found to be adequate. Improvements were also highlighted regarding medication management in addition to safeguarding and safety. The governance and management required a review to ensure that the management systems in place were safe and effectively monitored as further detailed in Outcome 14.

These failings, along with others, are further detailed in the body of the report and outlined 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:
Under this outcome the inspectors reviewed a sample of resident's personal plans. The inspectors found that each resident had a personal plan which was safely secured. Whilst the assessments and care plans were in place for the residents whom personal plans were reviewed, all had not been reviewed at a minimum annually or subsequent to an incident occurring which would have necessitated a change. For example an incident had occurred between two residents which highlighted increased vulnerabilities for them however this was not reflected in their personal plan.

Documentation within personal plans was found not always to be consistent or accurate therefore increasing the risk of timely reviews not occurring or incorrect care and support being delivered. Examples of this included incorrect ages documented across the same care plan, care plans and guidelines were not signed or dated, a resident's risk rating for a specific need differed throughout documentation in their plan; an assessment completed by an allied health professional deemed them to be of moderate risk and prescribed guidelines in line with this, however support plans had highlighted the need as high. The inspector did see however for this resident that staff on duty were following the recommendations of the allied health professional and when spoken to by the inspectors they were knowledgeable of their actual risk level.

The inspectors found that all aspects of resident's specific needs were not being met. For example for one resident living there, their bedroom did not meet their needs. The inspectors read in the personal plan for this resident they required assistance with an activity of daily living at night time. Inspectors were verbally informed that this assistance was provided by staff in the resident’s bedroom at night. The rationale for this assistance being provided in the bedroom was; if the resident exited the room at
night staff experienced challenges re-directing the resident to return to bed. This practice did not support the assessed ability of the resident or promote the dignity of the resident. The resident’s bedroom was therefore not meeting their specific needs. This resident also required a behavioural support plan to ensure staff were following consistent guidelines to ensure this need was met as further outlined in Outcome 8 and did not support good infection control.

The inspectors also saw in the review of the sample personal plans that multi disciplinary reviews occurred annually. Whilst these reviews were informative and looked at resident’s short and long term goals, they failed to connect all relevant information and needs which were pertinent to the resident. There was therefore a risk that pertinent information was overlooked of which a specific example was provided to the person in charge at feedback.

**Judgment:**
Non Compliant - Major

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**Outcome 06: Safe and suitable premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The designated centre consists of two units both of which each have capacity for four residents. The inspectors found, for the most part the designated centre, was fit for purpose. Each resident had their own bedroom, one of which was ensuite and the remainder of the residents shared bathroom facilities. The units were, for the most part well maintained and decorated. There were some pictures in areas of the designated centres and resident’s artwork was displayed. The kitchens were spacious and well equipped however one of the kitchens required improvements, a number of items including the oven, dishwasher and the presses required cleaning. There was also dry food stuff, opened and unsealed, in the presses. In addition there was food stuff in the fridge that had been opened and not labelled thus increasing the risk of residents eating food stuff which should no longer be consumed. This is further outlined in Outcome 7.

The inspector saw that the designated centre had large gardens for residents to spend time should they wish, one was equipped with a smoking gazebo for residents, however a significant number of disposed cigarettes were strewn on the back yard. The same back yard had an unused shower tray and shower door disposed behind the oil tank, this required attention. The risk associated with the strewn disposed cigarettes and oil tank will be further outlined in Outcome 7.
Staff, in one of the units, had sleepover facilities which were found to be insufficient. Staff in this unit slept in the lounge room on a portable mattress; this required a review to ensure that staff on sleepovers had appropriate sleepover facilities. This unit also had instances where staff, at times, had two consecutive sleepover shifts.

Aspects of Schedule 6 of the Regulations were found to be inadequate. Storage in the designated centre was evident as being problematic. The inspectors saw a cabinet where multiple items had been inappropriately stored. In one of the drawers’ items such as creams, antibacterial sanitizer, stationary, vacuum cleaner accessories, a broken oxygen mask amongst other redundant items were stored together. In addition as detailed in Outcome 5 due to the specific needs of one resident the layout and allocation of bedrooms did not support the independence and dignity of residents and required a review.

The pathway of a unit was found to be unsafe. On departing the premises the inspectors found the outside of the unit to be in near darkness, although there was an outside light, the pathway leading to and from the house was significantly dark. The path was also narrow with a stream running alongside it in the absence of protective railings. Residents living in the house had mobility difficulties, one of whom had been identified as at risk of falls. Increased lighting and a safety rail was required. At feedback the person in charge told the inspectors that the resident who was at risk of falls had been instructed to carry a torch for safety while using the path in periods of darkness.

**Judgment:**
Non Compliant - Major

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**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:**
During the inspection, the inspectors reviewed fire safety for one of the units. The inspector saw some safe systems in place however improvements were required. The designated centre had fire extinguishers which were found to be within their service period. The inspectors spoke with staff and residents regarding evacuation in the event of a fire. The staff explained that if a fire occurred at night-time the waking night staff had the keys, this was seen as a risk as the waking night staff was the sole person with access to the keys of the unit. In addition there were no break glass units at the emergency exit points. Therefore the system of key holding at night time required a review to minimise risk. There were also no running persons signage to highlight the emergency exit points. As outlined in the centre’s risk register, which was in draft form, there was a keypad mechanism on the side gate which was the sole side entrance of the unit and therefore posed as a risk in the event of a fire. The time-frame for this to be addressed had been documented as December 2015, for such a significant risk this
completion date for the replacement of the keypad was too long. The resident spoken with stated they had not participated in a fire drill since residing at the centre, however they told the inspector they would escape via the nearest exit point. In sample documentation subsequently reviewed by the inspector the resident had been marked as absent for the fire drills. The inspector found that the centre conducted frequent fire drills, one of which had been recently conducted at night-time. There was little detail recorded on the drill sheets reviewed by the inspectors; the date of the drill and the length of time it took to evacuate were recorded. However, the number of residents, the time of day, which residents were present or any comments/concerns were not documented. The inspector asked the staff member if this information was present anywhere else in the centre. The staff member could not source the information for the inspectors while at the centre. Subsequently at feedback the person in charge stated this information was available at the centre. Post inspection the information was made available and reviewed by the inspector which they found to be adequately detailed. This is further outlined in Outcome 17.

The inspectors reviewed the personal emergency evacuation plans for residents, which had been completed with residents and found these to be, for the most part, adequate documents. One of the personal evacuation plans stated that the resident required a wheelchair to evacuate, however on further investigation it was deemed that this was not required as staff could support them for short distances. The personal emergency evacuation plan was therefore inaccurate and required to be updated.

The inspectors found a risk register, which was in draft form, was maintained in the designated centre. Generic and centre specific risks had been identified however some improvements were identified as not all risks were highlighted for example it did not acknowledge the absence of break glass units or running person signage for fire prevention and the disposed cigarettes beside the oil tank and the risk of ignition had also not been outlined.

The storage of food as highlighted in Outcome 6 required a review to ensure that any associated risks were identified and outlined in the risk register and appropriate controls put in place. This was also necessary regarding the area of infection control, as outlined in Outcome 5. A commode was in use, as an intervention to support a resident at night. This was not in line with the assessed needs of the resident and therefore an unnecessary risk was present.

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:
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Under this outcome the inspectors reviewed resident’s behavioural support plans and restrictive practices. From the sample of personal plans reviewed the inspector saw that residents had some behavioural support plans in place to guide staff assist, support and interact with residents in a positive way and one which was the least restrictive. The behavioural support plans reviewed, for one resident, were transparent however they had not been reviewed since July 2013. The inspectors also saw instances where residents required behavioural support plans but these were not yet developed, for example one of which had been noted as being identified as required in May 2014 but at the time of inspection this behaviour support plan had not been developed. Also another resident who, due to their behaviours, was unable to use certain facilities at certain times during a twenty four hour period, however there was no behaviour support plan in place to guide staff to support this resident.

While reviewing a resident's personal plan the inspectors also found that restrictions had been highlighted regarding windows and doors being locked to prevent a resident absconding. This correlated with the risk assessment that had been completed for this resident as reviewed by the inspector. However on the day of inspection, doors and windows were unlocked and opened whilst the resident was present. Staff told the inspectors these restrictions were no longer required however the documentation did not reflect this. With regards to restrictions, the inspector saw outlined in the personal plan of one resident they were to sign a contract each time they wished to independently leave the centre. The multi disciplinary team deemed the resident to be vulnerable subsequent to an assessment which resulted in the contract being developed. This same resident had also sent letters, to the person in charge, as evident in their personal plan, requesting an increase in independent access. This limitation was not documented as a restrictive practice. At feedback the person in charge stated that this was no longer the case and the resident left the centre independently. The inspector saw this resident leave the centre independently on numerous occasions during the inspection. Although this was positive their personal plan had not been subsequently updated to reflect this and a risk was present that unfamiliar staff may impose the guidelines regarding the contract, as documented in their personal plan.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspectors found that residents had regular access to general practitioners and allied health professionals such as occupational therapy and physiotherapy. Residents also had regular access, where required, to psychology and psychiatry. Specific healthcare needs had been identified and the inspectors saw care plans in place to support these needs. However some required a review as all pertinent information was not outlined within them or connected to specific healthcare needs that were interlinked. For example a resident had an epilepsy care plan in place, however all controls such as their medication requirements and the need for aids such as crash mats were not outlined in this plan. It was also not linked to their falls care plan which they had in place. This required a review to ensure that healthcare needs were holistically addressed and all controls and supports in place for a resident to meet their specific needs were outlined in their care plan. The information within the epilepsy care plan was also incorrect as it stated that the resident had one to two seizures a year, from a review of documentation the inspectors saw that the resident had twelve seizures in 2014.

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 inspectors reviewed the management of medication in one of the units and found improvements were required. Medication storage was appropriate, the inspector saw that medication was locked in a unit and only staff on duty had access to this. The inspector reviewed the prescription and administration sheets for one resident. The inspector found that improvements were required regarding the prescription of medication to be administered. The inspector saw that seventeen medications on the prescription sheet had been discontinued however best practice regarding maintenance of prescription sheets was not adhered to.

The inspectors also found out of date medication, one which was dated October 2014, stored in the medication press. The staff spoken with told the inspector that returned medications were returned to the pharmacist. There was no documentation to corroborate that medication had been returned to the pharmacy or recorded as being received by the pharmacist. This required a review to ensure the system of returning medication was safe and transparent.
The inspector spoke with a staff member regarding identifying medication from the blister pack, the staff member while able to identify some of the tablets was unable to identify all the medication. There was also no identity cards in the unit for some of the medications. The person in charge told the inspector that the clinical nurse manager has responsibility for ensuring new tablets have corresponding identification sheets, this gap in governance and management of medication had not been realised. The person in charge stated this would be added to the audit schedule. This is further outlined in Outcome 17.

**Judgment:**
Non Compliant - Moderate

### 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 staff team at the designated centre consisted of staff nurses and health care assistants. Management systems were found to be in place; staff meetings were held throughout the year, the inspectors reviewed minutes for a meeting which was held in September 2014. Staff told the inspector they were supported by a clinical nurse manager should they require support and that they saw the person in charge occasionally. Staff told the inspectors they received annual appraisals, however the inspector found that staff did not receive supervision throughout the year, this is further outlined in Outcome 17. Staff were offered and had availed of debriefing, for example post significant incidents that had occurred at the centre. Staff were aware of who the person in charge was as too were the residents whom the inspector spoke with. A deputy person in charge had been identified.

The person in charge, at the time of inspection, was progressing elements of the governance and management systems in the designated centre to ensure that improvements were made to areas such as the audit schedule and quarterly reports. The inspector saw these efforts highlighted in a revised audit schedule which the person in charge was in the process of implementing.

However, based on the cumulative findings evidenced throughout this report including but not limited to the absence of staff supervision, the absence of relevant behavioural support plans, gaps in medication management, the risk relating to evacuation in the event of fire in one of the units and incorrect information documented throughout
personal plans. Inspectors concluded that the management systems in place did not ensure that the service provided was safe and effectively monitored as required by Regulation 23 (1) (c).

**Judgment:**
Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The inspectors found on the day of the inspection the staffing levels were appropriate to meet the needs of the residents present however improvements were identified regarding staff knowledge.

The inspectors found there was a roster in place which reflected the staff on duty on the day of inspection. Further development was required regarding the roster to ensure it was maintained efficiently so that the role of staff were identified in addition to an explanation of the abbreviations made available on the roster. Staff told the inspectors they received annual appraisals; the inspector found that staff did not receive supervision throughout the year.

During the inspection a number of staff were spoken with by the inspector. Through conversations with the inspector, as outlined in Outcome 7 and 12, it was evident that staff required additional training and instruction regarding a number of areas such as further information to identify all medication within the blister packs, maintenance of care plans to ensure they were reflective of resident’s actual needs in addition to knowledge regarding the location of pertinent information within the designated centre such as the fire drill log book. Further oversight was required regarding the supervision of staff to ensure that duties and responsibilities were being adhered to such as replenishing of tablet identification information being made available to all staff once new medication was received and documentation recorded in personal plans, for example, was accurate and current.

Staff at the centre had received training. Staff spoken with by the inspectors stated should they require additional training a request was made to the training department and usually it was granted. Post inspection the inspector reviewed training documentation and found that not all elements of mandatory and necessary training were up-to-date. Ten staff members required a refresher, or in some instances to be
retrained, in the Professional Management of Violence and Aggression (PMAV). One staff member who worked in one of the units, where only one staff member was present at night time, had not received training in PMAV since 2006 with another staff member had not received it since 2011. This staff member worked in a unit where incidents and accidents occurred frequently.

**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:**

Ciara McShane  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<td>07 January 2015</td>
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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:
As outlined in the body of the report all elements of personal plans were not reviewed at a minimum annually or subsequent to a change in needs.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessment, by an appropriate health care professional, of the health, personal and 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 and appropriate members of the MDT have reviewed Personal Plans to reflect changes in the needs and circumstances for residents.

Proposed Timescale: 21/01/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements to meet all identified needs of residents required improvement to ensure that:

- Information within personal plans was accurate and that it was evident whom and when guidelines and assessments were developed.

- Pertinent information relevant to residents was highlighted and documented as part of resident's multi disciplinary review and not overlooked.

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

Please state the actions you have taken or are planning to take:
A MDT review meeting was held on the 21st January 2015 and a comprehensive review of all residents was carried out. The PIC and appropriate members of the MDT have reviewed Personal Plans to reflect changes in the needs and circumstances for residents. Guidelines and assessments in place have been signed by the appropriate people.

Proposed Timescale: 21/01/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not equipped to meet a specific identified need for one resident as seen by the inspectors during the inspection.

Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Following the MDT meeting on the 21st January 2015 the commode has been removed from the resident's bedroom on a trial basis. An Environmental review has been carried out and the necessary amendments have been made. Family consultation has taken
A Support Plan is in place to support this resident’s night time needs and the trial is currently being carefully monitored.

**Proposed Timescale:** 21/01/2015

### Outcome 06: Safe and suitable premises

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The pathway leading to and from the unit required a review to ensure that residents could safely navigate to and from the unit.

**Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
Individual risk assessments regarding access to and from the house have been completed for each resident living in this centre. The service will liaise with the landowners who share the laneway to once again highlight the associated risk and make a request to reinstall the lighting and railings.

**Proposed Timescale:** Risk Assessment completed on 12th January 2105. Then awaiting feedback from Landowners to decide the next stage.

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A number of improvements were identified during the inspection:

- A shower door and shower base was disposed off in the back garden.
- Numerous disposed cigarettes were strewn in the back garden.
- The kitchen in one unit required cleaning in particular the oven, top of the dishwasher and the exterior of the presses.

**Action Required:**
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

**Please state the actions you have taken or are planning to take:**
The shower door and shower base were disposed of on 8th January 2015. The cigarette butts were also removed on the 8th January 2015 and all residents and staff have been provided with information regarding the importance of using appropriate designated areas for smoking. A deep clean of the kitchen was carried out on the 8th January 2015. Cleaning schedules are in place to ensure compliance in this area.
**Proposed Timescale:** 08/01/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Storage in one of the units required a review, in particular relating to the contents of a filing cabinet.

A review was required of the layout of allocations of bedrooms within the designated centre to ensure the needs of residents were being met.

**Action Required:**  
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:  
Following the MDT meeting on the 21st January 2015 the commode has been removed from the resident’s bedroom on a trial basis. An Environmental review has been carried out and the necessary amendments have been made. Family consultation has taken place. A Support Plan is in place to support this resident’s night time needs and the trial is currently being carefully monitored. Additional storage is being sourced.

**Proposed Timescale:** Commode removed following MDT meeting on 21st January 2015, The Support Plan is being reviewed weekly. Additional Storage expected by 28th February 2015

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**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:  
Although there was a risk register maintained in the designated centre it did not identify all risks such as those highlighted in the body of the report.

**Action Required:**  
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:  
The service accepts that the Draft Risk Register did not identify all risk. This is now finalised and is live within the Centre. Staff are guided by the Risk Management policy for the identification and management of risks for the centre.

**Proposed Timescale:** 12/01/2015  
**Theme:** Effective Services
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</thead>
<tbody>
<tr>
<td>The measures outlined to address the risk of the side gate required review as the identified date was too far out.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

**Please state the actions you have taken or are planning to take:**
The PIC has finalised the Draft Risk Register, timeframes have been allocated in line with the identified risk rating as per risk management policy.

**Proposed Timescale:** 12/01/2015
**Theme:** Effective Services

<table>
<thead>
<tr>
<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The use of a commode required a review to minimise the risk of infection being spread.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
Following the MDT meeting on the 21st January 2015 the commode has been removed from the resident’s bedroom on a trial basis. Because the commode has been removed, then Infection is not an issue. An Environmental review has been carried out and the necessary amendments have been made. Family consultation has taken place. A Support Plan is in place to support this resident’s night time needs and the trial is currently being carefully monitored.

**Proposed Timescale:** 21/01/2015
**Theme:** Effective Services

<table>
<thead>
<tr>
<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The systems to manage an emergency evacuation in the event of a fire required review as there were no running persons’ signage or break glass units at the centre and the procedure of the night staff holding the keys in the absence of break glass units posed as a significant risk.</td>
</tr>
</tbody>
</table>

The personal emergency evacuation plan for one resident required to be updated as the
information contained within was incorrect.

**Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
The centre accepts the findings of the Inspector. Break Glass units have been fitted on 13th January 2015, Emergency Lighting (Running Person Signage) has been installed on the 4th February 2015. The personal emergency evacuation plan was reviewed and updated on the 8th January 2015.

**Proposed Timescale:** 04/02/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The side entrance of one unit was secured by keypad controls this posed as a risk to staff and residents trying to exit should there be a fire.

**Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
A review of the fire system has been carried out and the centre has installed a new fire system. The gate at the side entrance of the building has been fitted with an automatic release system which is connected to the fire panel. Therefore in the event of the fire alarm activating the gate will automatically release open. The system is fully operational from 12th February 2015. Prior to the installation of the measures as outlined above, there continued to be free egress via both the front and back doors from the building in the event of a fire.

**Proposed Timescale:** 12/02/2015

**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:
Not all residents had behavioural support plans where required.

Information pertaining to resident's behavioural support needs, including the use of restrictions, was incorrect and not the most up to date information regarding their behavioural support needs.
**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 service has developed a behaviour identification checklist for the centre to complete and will be reviewed through the Clinical Psychology Department and where appropriate an assessment will commence to inform any required plans.

**Proposed Timescale:** 20/02/2015

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The care plans to address the specific needs for some residents required review to ensure they effectively guide staff in supporting residents meet these needs. For example the epilepsy care plan for one resident was inaccurate and lacked information to guide staff to support the resident meet all aspects of their specific need.

**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 PIC and appropriate members of the MDT have reviewed and updated personal plans to reflect the healthcare needs of the residents.

**Proposed Timescale:** 21/01/2015

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**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 prescription practices regarding the administration of medications required review as outlined in the body of the report.

**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 service accepts the findings of the Inspector. The PIC has put in place appropriate practice relating to the prescription and administration of medication.

**Proposed Timescale:** 12/01/2015

**Theme:** Health and Development

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

The system regarding the storage and returning of unused and out of date medication to the pharmacist required a review to ensure the system was safe and in line with best practice.

**Action Required:**

Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

The service accepts the findings of the Inspector. The PIC has put in place appropriate systems regarding the storage and returning of unused medications.

**Proposed Timescale:** 12/01/2015

**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 management systems in place required a review as they did not ensure that the service provided was safe and effectively monitored

**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:**

A Clinical Service Manager has been appointed. This will allow the PIC to ensure that supervision is effective by facilitating regular Review and Audit of the centre to ensure evidence based best practice.

**Proposed Timescale:** 16/03/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As outlined in the body of report further development was required in relation to the roster.

- It was unclear what role the staff member fulfilled
- Abbreviations were used in the absence of a key to explain them

**Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
The service has moved to a “Time Management System” (TMS) for developing Staff Rosters.
A planned and actual roster is maintained within the centre with no abbreviations listed, the role of the staff member will be added to the TMS by 23rd February 2015.

**Proposed Timescale:** 23/02/2015
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although staff had sufficient access to training, as outlined in the body of the report training relating to PMAV was not up-to-date.

Further instruction regarding medication management was also required.

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

**Please state the actions you have taken or are planning to take:**
The PIC and relevant members of the MDT, are carrying out a review of Mandatory Training requirements. Dates have been allocated for Medication Training and PMAV training.

**Proposed Timescale:** 31/03/2015
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although staff received annual appraisals there were no mechanisms in place for staff to receive formal supervision.
All staff had not completed their duties and responsibilities as outlined in the report which the person in charge had also failed to identify for example updating of personal plans as required, highlighting any deficits to their managers and the deficits regarding medication management had also not been highlighted.

Staff members, on the day of inspection, were unable to locate pertinent information, relating to fire drills, at the designated centre.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
A Clinical Services Manager has been appointed. This will allow the PIC to ensure that supervision is effective by facilitating regular Review and Audit of the centre to ensure evidence based best practice.

**Proposed Timescale:** 16/03/2015