

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Gheel Autism Services
<b>Centre ID:</b>	OSV-0003507
<b>Centre county:</b>	Dublin 16
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Gheel Autism Services
<b>Provider Nominee:</b>	Siobhan Bryan
<b>Lead inspector:</b>	Jim Kee
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	8
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
23 April 2015 10:30	23 April 2015 14:00
24 April 2015 09:30	24 April 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This was the first inspection of this community based residential centre by the Health Information and Quality Authority (the Authority). The inspection was unannounced and purpose of the inspection was to assess the level of compliance with the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

This inspection was of a community based residential centre based in South Dublin, run by Gheel Autism Services. The designated centre consisted of two terraced houses which had been arranged into two units, one of which was a self contained flat that accommodated two residents, while six residents were accommodated in the main house. The inspector met with residents and staff, observed practice, and reviewed documentation including care plans, medical records, policies and procedures, and staff files.

Nine outcomes were reviewed as part of this inspection, and evidence of good practice was found across all outcomes. However, the inspector found that there were aspects of the service that needed improvement. Five outcomes were found to be in moderate non compliance with the Health Care Act 2007 (Care and Support of

Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. These moderate non compliances related to the areas of social care needs, health and safety and risk management, medication management, governance and management, and the statement of purpose also required revision to comply with the Regulations.

In addition three outcomes were deemed to be substantially compliant namely; safeguarding and safety, workforce, and the aspect of residents rights dignity and consultation relating to residents' finances. The Outcome on healthcare needs was deemed to be compliant with the Regulations.

The action plans at the end of the report identifies those areas where improvements were required in order to comply with the Regulations.

**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 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

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

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

**Findings:**

The only aspect of this outcome examined during inspection related to residents' personal finances.

The inspector found that there were procedures in place for the management of residents' monies by staff, and that clear, concise records and receipts were maintained to reflect the individuals outgoing and incoming cash. However in discussions with staff the inspector found that there was no procedure or policy in place on the practice of residents contributing to staff expenses while on outings or trips, to ensure residents were appropriately safeguarded in this regard.

**Judgment:**

Substantially Compliant

**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:**

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

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

**Findings:**

Overall residents' wellbeing and welfare was seen to be maintained by a good standard of care and support. There were personal care plans and support plans available for all residents, and staff with whom the inspector spoke were very knowledgeable regarding the residents' individual preferences, interests and abilities. However, the care plans reviewed during the inspection were not sufficiently comprehensive in detailing the health, personal and social care needs of the residents. There was also limited evidence of opportunities for some residents to engage in meaningful activity, or appropriate planning to ensure goals were achieved.

The inspector reviewed a number of the residents' personal care and support plans, and noted that there was an ongoing process to update the residents' support plans in a number of areas. However at the time of inspection substantial sections of the support plans had not been completed, and within the personal care plans there was no evidence that all information was kept appropriately updated. The inspector also found that important information, such as the communication needs, was not always easily retrievable within the care plans. The personal care plan of one resident reviewed by the inspector contained no information relating to assessed health needs. The personal care plan for one particular resident identified three current goals, which were unchanged from November 2013. These goals had been reviewed, but the plan did not identify the necessary steps, or a planned timeframe to ensure these goals were achieved. The review of this resident's personal plan had no documented assessment of the effectiveness of the plan. Review of another resident's personal care plan identified a new goal from November 2014, of developing computer skills, but the plan did not provide any details as to how this goal would be achieved or the support necessary to enable the resident to progress this goal. The inspector reviewed the daily activities record for this resident, and there was no mention of any computer related activities since the goal had been identified. Other goals identified for residents included obtaining a driving license and having more family contact, but again there was no plan in place identifying the steps or timeframe involved, or of any progress to date in achieving the goals. Staff informed the inspector that one resident's long term goal was to live independently, but this information was not mentioned within the resident's personal or support plan, and there was no planning in place to outline the support required to maximise the resident's personal development with the goal of independent living.

The inspector was shown photographs of a trip to Belfast which had been arranged for one resident who had identified a trip away as one of his goals. Staff had also developed a picture book for one resident containing photos of important events and favourite activities and places. There were arrangements in place if residents wished to avail of day services, and the centre had its own transport. During the inspection residents were given the opportunity to participate in a number of activities including walking in a local park, music therapy and shopping trips, while staff also arranged for regular visits to the cinema.

The personal plans had not been made available to residents in an accessible format at the time of inspection, but the inspector was informed that work was underway to identify appropriate accessible formats were feasible.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

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

**Findings:**

There were risk management procedures and fire precautions in place in the centre that promoted the health and safety of residents, visitors and staff. However the risk management policy was not specific to the centre and did not fully identify and assess all risks within the centre. There was no documented procedure in place for responding to emergencies other than fire.

The organisational risk management policy, corporate risk register, service and care provision risk register and the draft Gheel health and safety risk register were reviewed by the inspector and found that although comprehensive, they did not address all necessary hazard identification or assessment of all risks within the designated centre itself. There was no register of risks maintained in the centre that covered all matters as set out in Regulation 26, and there were no risk assessments available for the recent installation of a portable pre fabricated wooden structure at the back of the centre, for the varying floor levels in the upstairs hallway, or for the gate at the top of the second steep stairway which lead to one of the emergency exits.

There were policies in place that addressed the unexpected absence of a resident, aggression and violence, and self harm. The inspector reviewed individual risk assessments that had recently been incorporated into residents' support plans. The person in charge outlined how all serious incidents or adverse events involving residents were recorded on the incident management software system to ensure appropriate investigation, review and identification of any necessary learning. The health and safety statement was being revised at the time of inspection and the inspector was shown the draft version.

The fire evacuation procedure and all residents' personal evacuation plans were easily accessible in the front hall of the main house. The fire evacuation plan was not displayed in the flat. Fire drills were conducted on a monthly basis and staff spoken to

by the inspector were confident that all residents could be safely evacuated from the centre in the event of a fire. Internal monthly fire safety checks were documented, and records confirmed that the fire alarm and emergency lighting system had been serviced recently.

There was no emergency plan in place within the centre that detailed procedures to be followed in the event of loss of electricity, heating or water or in the event of a flood or other emergency situations other than fire. The person in charge confirmed that arrangements were in place with a local hotel if evacuation of the centre was necessary.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

The inspector found that measures were in place with regard to the safeguarding of residents. The only issue of concern for the inspector related to the information available regarding behaviour support for some residents.

There was a policy on and procedures in place for, the prevention, detection and response to abuse, and staff had up to date trust in care training on this issue. Intimate care plans were in place for residents who required support with personal care. All observed interactions between staff and residents were respectful, demonstrating a consent based approach by offering choices to residents in relation to daily living tasks and activities. Residents could lock their bedroom doors if they wished, and the two residents in the self contained unit had a separate front door with their own front door keys.

The person in charge confirmed that there were no restrictive practices in operation within the centre at the time of inspection. A positive wellbeing approach to managing behaviours of concern policy was in place for the provision of behavioural support. Staff were knowledgeable of managing behaviour considered to be of concern or challenging, including de-escalation and intervention techniques, and to minimise such behaviours by

maintaining a low arousal environment. There was information on challenging behaviour included in some residents' care plans, but the inspector found no indication as to when it had been last updated, and further to this the information had not been incorporated into a behaviour support plan to provide sufficient guidance to staff.

**Judgment:**

Substantially Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

The inspector found that the residents were supported to access health care services, and that staff supported residents on an individual basis to achieve and enjoy best possible health. The inspector did identify deficiencies in documentation relating to the health care needs assessments of some residents and this is detailed under Outcome 5.

The inspector reviewed a number of the residents' care plans and found that residents' health care needs were met with regular access to a general practitioner (GP), and other allied health care professions such as dental, podiatry and psychology services. Records of monthly body weights and blood pressure checks were available in some of the care plans. There were also records of the end of life wishes of some residents documented within the care plans. The inspector observed staff actively encouraging one resident to take responsibility for their own medical needs and to attend the GP. Staff spoken to by the inspector confirmed that residents were encouraged to make healthy living choices, including healthy eating and exercising.

Residents were consulted on an individual basis regarding food choices within the centre, although there were no formal arrangements in place to document residents' preferences or maintain records of menus. Within the main house staff facilitated mealtimes and cooking although residents were involved in food shopping. Staff provided assistance to the two residents in the flat to prepare food and meals as necessary. Staff were knowledgeable of residents' individual food preferences.

**Judgment:**

Compliant

## **Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

### **Theme:**

Health and Development

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

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

### **Findings:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However the inspector found deficiencies relating to certain medication management practices, including the information provided on the prescription sheet, use of PRN (as required) medicines and audit of practice within the centre.

Medicines were supplied by a retail pharmacy business, and were appropriately dispensed in individual 'pouches'. Medicines were stored securely within the centre, and staff had received training on the safe administration of medicines. One resident had been assessed for the self administration of medicines.

The Inspector found that dates of opening had not been marked on certain prescribed creams and liquid medications, to indicate their subsequent expiry dates. The inspector also reviewed a number of prescription and administration sheets and identified a number of issues including:

- The prescriber's name, and residents' dates of birth were not clearly and consistently indicated on the prescription sheet (Drug prescription record/sheet)
- The allergy section on the prescription sheet was not always completed to indicate any allergies to medicines, or stating no known drug allergy
- The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines, and in some cases only the times of administration were ticked.
- not all medicines were prescribed generically were appropriate and had been prescribed by proprietary brand names. However the medicines being administered to residents were generic brands, and this discrepancy between the names of the prescribed and administered medicines has the potential to cause confusion, and lead to medication errors.
- There was no evidence of regular review of the residents' medication.

The PRN medicines on a number of the prescription sheets were also reviewed, and the indication/conditions for use and the maximum dose to be administered in 24 hours were detailed. However the inspector was not satisfied that there was sufficient guidance available to support staff in administering these medicines, as there were no detailed instructions or protocols available outlining when the medicines were to be administered, the time interval between doses, any specific monitoring necessary or actions to be taken if the resident failed to respond to the medication.

Staff informed the inspector that medication errors were recorded on the incident

management software to ensure effective review and appropriate response to such incidents. An audit of medication administration was planned for the centre, but the audit system in place at the time of inspection was not sufficiently comprehensive to ensure effective monitoring of medication management practices within the centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The inspector reviewed the statement of purpose, that had been updated in November 2014 and found that the document did not contain all of the information as specified in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults with Disabilities) Regulations 2013.

The statement of purpose set out the values and aims of the centre, and detailed the services to be provided for residents. The information on the facilities provided had not been updated to reflect the recent installation of a pre fabricated portable wooden building at the back of the centre. The organisational chart included in the statement of purpose did not clearly identify the person in charge or the provider nominee. There was insufficient information provided within the statement of purpose regarding the arrangements made for consultation with, and participation of, residents in the operation of the designated centre.

**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:**

There was a clearly defined management structure in place and staff were familiar with the reporting mechanisms. The centre was managed by a suitably qualified, skilled and experienced person in charge who had been appointed in January 2015. The inspector was informed, and observed during the inspection that a quality improvement plan was underway within the service. However, the inspector had concerns regarding the management of individual assessments and care planning as detailed in outcome 5.

The inspector reviewed the report compiled following the unannounced visit conducted by the provider nominee in September 2014, which was based on the Authority's 18 outcome inspections. This report had identified a number of issues that required follow up to ensure that the service was providing appropriate standards of care and support. The report did not contain a plan to address all of the issues identified, and some of the actions were still outstanding at the time of inspection, including the guidance necessary for administration of PRN medicines as outlined in outcome 12. Gheel autism services had also commissioned an external consultancy to conduct a gap analysis performed against the Authority outcomes and standards in early 2015, but there was limited evidence of the extent of consultation with residents and/or their representatives within the centre, or that a copy of this review had been made available to residents.

The person in charge was deemed to be suitably qualified and experienced, and provided leadership and support to the staff. The person in charge had a long working history within Gheel autism services, and was currently the clinical coordinator, and was involved in the running of a day service. The provider nominee and person in charge provided assurances that sufficient support was available to the person in charge to ensure good governance, operational management and administration of the centre on a regular and consistent basis. Regular staff meetings were held in the centre, and the person in charge also attended monthly person in charge management meetings, and senior management meetings that included the provider nominee.

**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 inspector found that the levels and skills mix of staff were sufficient to meet the needs of residents at the time of this inspection.

The inspector observed that staff on duty during the inspection were familiar with the needs of the residents, and provided care in a considerate and respectful manner. Staff rosters were reviewed, and there were two staff on duty at all times in the centre, with regular relief staff available to ensure continuity of care. However the roster did not indicate the full names of the staff as no surnames were included on the roster. The roster did not detail the actual hours worked by the staff, and the hours worked by the person in charge were also not included on the rosters. The person in charge detailed plans to recruit further staff on a part time basis to provide support to the two residents in the self contained unit.

Staff were supervised on an appropriate basis, and one of the full time staff acted as location coordinator within the centre and was involved in the daily management of the centre, and acted as manager in the absence of the person in charge. The person in charge had conducted three supervision meetings with staff since January 2015, and intended to conduct a minimum of two of these meeting per year as per policy. Staff had up to date mandatory training in place.

Staff files reviewed during the inspection met the requirements of Schedule 2 of the Regulations.

**Judgment:**

Substantially Compliant

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Jim Kee  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Gheel Autism Services
<b>Centre ID:</b>	OSV-0003507
<b>Date of Inspection:</b>	23 April 2015
<b>Date of response:</b>	26 May 2015

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

There was no procedure or policy in place on residents contributing to staff expenses while on outings or trips, to ensure residents were appropriately safeguarded in this regard.

**Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably

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

practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

A staff social fund has been established within the Designated centre and all staff have been informed of the new procedures at their Team meeting on the 19th May 2015. A review of the Service User Finance Policy which will include arrangements for staff while supporting service users in the community will take place.

**Proposed Timescale:** 31/07/2015

**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:**

Personal plans for some residents did not contain any information related to assessment of their health needs.

**Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and 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 provider nominee has arranged for additional training to be provided as required to staff regarding the implementation of the Support Plan which includes the assessment of health needs. The assessment of all service users Health needs will be completed by the end of June.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

The goals/objectives stated in some residents' personal plans did not identify the necessary steps, or a planned timeframe to ensure these goals were achieved.

**Action Required:**

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

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

A new form has been developed by the Practice Development Project Manager to guide staff on the identification of steps as they relate to an overall goal and the timelines for achieving the goal.

**Proposed Timescale:** 15/07/2015

**Theme:** Effective Services

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

The reviews of residents' personal plans did not include assessments of their effectiveness.

**Action Required:**

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

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

The annual review structure will include the assessment of the effectiveness of the Support Plan.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

The personal plans in place for certain residents did not outline the supports required to maximise the resident's personal development to enable independent living.

**Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

All Support Plans in the designated centre will be audited by the PIC. The PIC will work with Keyworkers to ensure that all supports required to maximise the resident's personal development to enable them to live independently are addressed.

**Proposed Timescale:** 15/07/2015

**Theme:** Effective Services

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

The residents' personal plans were not available in an accessible format.

**Action Required:**

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

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

The service user accessible format of the Support Plan which is called a Person Centred Plan will be developed for all the residents in this designated centre.

**Proposed Timescale:** 30/08/2015

**Theme:** Effective Services

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

The personal and social care needs of some residents relating to identified objectives/goals within their personal plans was not provided.

**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:**

The specific Support Plans that contained these gaps have been addressed by the PIC with the related Key Worker. All Key Workers are currently updating their Support Plans to ensure all personal and social care needs are documented.

**Proposed Timescale:** 30/08/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The risk management policy was not specific to the centre and did not fully identify and assess all risks within the centre.

**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 Health and Safety Risk Register and the Care and Support Risk Register will be complete by the end of June. These documents will identify all the specific risks in this designated centre. The Corporate risk register is complete.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

There was no emergency plan in place within the centre that detailed procedures to be followed in the event of loss of electricity, heating or water or in the event of a flood or other emergency situations apart from fire.

**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 emergency plan has been reviewed to include the detailed procedures to be followed in the event of loss of electricity, heating or water or in the event of a flood or other emergency situations apart from fire.

**Proposed Timescale:** 30/05/2015

**Theme:** Effective Services

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

The procedures to be followed in the event of fire were not prominently displayed within the self contained flat.

**Action Required:**

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

The emergency plan is now available within the self-contained flat.

**Proposed Timescale:** 15/05/2015

## 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:**

Information included in residents' personal plans on challenging behaviour did not indicate when it had been last updated, and further to this the information had not been incorporated into a behaviour support plan to provide sufficient guidance to staff in managing such behaviour.

**Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

All residents who require a behaviour support plan will have them completed by the end of July. All plans will have a review date and will provide guidance to staff on ways to manage behaviours of concern.

**Proposed Timescale:** 30/07/2015

## Outcome 12. Medication Management

**Theme:** Health and Development

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

The Inspector found that dates of opening had not been marked on certain prescribed creams and liquid medications, to indicate their subsequent expiry dates.

**Action Required:**

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

A full medication audit took place on the 26th May 2015. All actions from the audit will be managed through the same electronic system that monitors incidents within the organisation.

The issue relating to the labelling of creams and liquids was also addressed at the Team Meeting of the designated centre on the 19th May 2015.

**Proposed Timescale:** 26/05/2015 and ongoing

**Proposed Timescale:** 26/05/2015

**Theme:** Health and Development

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

A review of a number of prescription and administration sheets identified a number of issues including:

- The prescriber's name, and residents' dates of birth were not clearly and consistently indicated on the prescription sheet (Drug prescription record/sheet)
- The allergy section on the prescription sheet was not always completed to indicate any allergies to medicines, or stating no known drug allergy
- The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines, and in some cases only the times of administration were ticked.
- not all medicines were prescribed generically were appropriate and had been prescribed by proprietary brand names. However the medicines being administered to residents were generic brands, and this discrepancy between the names of the prescribed and administered medicines has the potential to cause confusion, and lead to medication errors.
- There was no evidence of regular review of the residents' medication.

**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:**

A new audit system has been developed by the Practice Development Project Manager. This audit system has been presented to the Management Team for approval on the 18th May 2015. A Medication Audit schedule has been set and will be complete by the end of August 2015.

**Proposed Timescale:** 30/08/2015

**Theme:** Health and Development

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

There was insufficient guidance available to support staff in administering PRN (as required) medicines, as there were no detailed instructions or protocols available outlining when the medicines were to be administered, the time interval between doses, any specific monitoring necessary or actions to be taken if the resident failed to respond to the medication.

**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:**

All PRN medications prescribed will have documentation included in the individuals Support Plan to identify the instruction/protocols for the medication to be administered. The new prescribing sheet will identify the time intervals between doses and any specific monitoring or actions to be taken if the resident fails to respond to a medication will be documented in the Support Plan.

**Proposed Timescale:** 15/07/2015

**Theme:** Health and Development

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

The audit system in place at the time of inspection was not sufficiently comprehensive to ensure effective monitoring of all aspects of medication management practices within the centre.

**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:**

A new audit system has been developed by the Practice Development Project Manager. This audit system has been presented to the Management Team for approval on the 18th May 2015. A Medication Audit schedule has been set and will be complete by the end of August 2015.

**Proposed Timescale:** 30/08/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The information on the facilities provided had not been updated to reflect the recent installation of a pre fabricated portable wooden building at the back of the centre. The organisational chart included in the statement of purpose did not clearly identify the person in charge or the provider nominee. There was insufficient information provided within the statement of purpose regarding the arrangements made for consultation

with, and participation of, residents in the operation of the designated centre.

**Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Statement of Purpose has been reviewed to include all identified non compliances from the unannounced inspection.

**Proposed Timescale:** 07/05/2015

**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:**

There was limited evidence of the extent of consultation with residents and/or their representatives within the centre in the gap analysis conducted.

**Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

A Family feedback questionnaire was distributed to all families with a request to return it at the next Family and Friends of Gheel meeting on the 20th May. The data will be gathered and analysed to identify areas for improvement by the end of July.

**Proposed Timescale:** 30/07/2015

**Theme:** Leadership, Governance and Management

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

A copy of the review was not made available to residents.

**Action Required:**

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

The Quality and Safety Report that will be developed by the end of June will be made available to the residents in this designated centre.

**Proposed Timescale:** 30/06/2015

**Theme:** Leadership, Governance and Management

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

The report on the safety and quality of care and support provided in the centre, compiled following the unannounced visit by the provider nominee did not contain an effective plan to address the identified concerns.

**Action Required:**

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

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

A full review on the Quality and Safety of care and support will take place in June 2015. This review will include a plan to address all areas for improvement identified in the audit.

**Proposed Timescale:** 30/06/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The rosters viewed by the inspector did not indicate the full names of the staff as no surnames were included on the rosters. The roster did not detail the actual hours worked by the staff, and the hours worked by the person in charge were also not included on the rosters

**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 roster has been amended to include full names and dates.

**Proposed Timescale:** 07/05/2015