<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by L'Arche Ireland</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001959</td>
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<td>Centre county:</td>
<td>Kilkenny</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>L'Arche Ireland</td>
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<tr>
<td>Provider Nominee:</td>
<td>Mairead Boland Brabazon</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Cronin</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Michelle O'Connor</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
<tr>
<td>Number of vacancies 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.
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 inform a registration decision. This monitoring inspection was unannounced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 26 November 2015 08:50
To: 26 November 2015 17:00

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection
This was the centre’s third inspection which was conducted as a follow up to the registration inspection that occurred over two days day in May 2015. On the registration inspection there were significant non compliance in relation to some fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core aspects of governance which included, risk management, staffing, staff training and monitoring quality and safety of care. In the meantime representatives of the registered provider had been requested to attend a meeting in the Authority’s head office to discuss these, matters.

The follow up inspection took place to inspect against the actions from the previous inspection. As part of the inspection the inspectors met with the provider, person in
charge, administration manager, community nurse and staff. The inspectors followed up on actions from the previous inspection and reviewed documentation such as care plans, finances, training records, rosters, policies and procedures.

Overall, since the last inspection progress had been made with regard to staffing and management of risk in the centre in order to provide improved outcomes for residents. From reviewing the day time staff duty rota, communication with house leader and staff inspectors found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents.

While some areas for improvement were identified, overall inspectors found that there was an adequate level of compliance, with the requirements of the Health Act 2007 Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.
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):*

The action(s) required from the previous inspection were satisfactorily implemented.

### Findings:

On the previous inspection there was no appropriate advocacy service available suitable to the needs of the residents. Inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint. There was no second nominated person to respond and maintain complaint records as required under regulation. On the previous inspection in relation to residents’ finances inspectors were informed that all expenditure is sanctioned by the managers there was no documentary evidence of such requests being made, how and by whom authorisation was given.

On this inspection the inspectors were informed that the person in charge had made telephone contact with the local advocacy services for people with disabilities. The advocate was due to meet with residents from the centre. However, there was no documentary evidence to support this. However, inspectors viewed minutes of the internal rights committee meetings and saw that the advocate had attended two of these meetings the last one held in May 2015. Another meeting was to take place the week following inspection. On the last inspection staff were unclear of the process in relation to residents being facilitated to vote. A policy had been developed on civic and inclusion which included the process to follow in relation to voting. However, the policy was not signed off by the management team, there was no review or implementation date on the policy. This is actioned under Outcome 18.

There was a complaints policy and procedure in place dated 23 February 2015. Inspectors saw that a second nominated person to respond and maintain complaint records as required under regulation was included in the policy. In relation to residents
finances inspectors observed that there were financial request forms in operation since September 2015. The person in charge signs off on any expense over £200 per month and family members are consulted if appropriate. The ledgers and receipts viewed by inspectors detailed all expenditure and all with drawls were co signed. The inspector saw that all receipts corresponded with the ledger

**Judgment:**
Compliant

**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection in one instance inspectors saw that the communication plan was not reviewed for a resident who required pictured picture enhanced communication. Staff told inspectors that this resident could display challenging behaviour if staff did not understand him. On this inspection inspectors observed that communication plans had been reviewed. Staff who spoke with the inspectors knew residents well, which assisted them in understanding their needs

**Judgment:**
Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection the admissions policy did not take into account of the need
to protect residents from abuse by their peers. The policy did not include transfers or temporary absence of residents. The statement of purpose did not outline the specific care and support needs that the centre is intended to meet. Details of charges for additional services were not covered in the contract.

On this inspection inspectors observed that the policy did take into account the need to protect residents from abuse by their peers. The policy included transfers and temporary absence of residents. An inspector reviewed a sample of contracts of care and found that additional services were covered in the contracts.

**Judgment:**
Compliant

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**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

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**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
On the previous inspection inspectors found that resident's needs were not sufficiently assessed and documented to ensure staff were providing safe and effective care in line with their assessed needs. Personal plans did not have a multi disciplinary or comprehensive focus and had not been implemented to meet the changing needs of some residents. The plans did not adequately address:

- education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support
- transport services
  the resident's wishes in relation to where he/she want to live and with whom
- the resident's wishes or aspirations around friendships, belonging and inclusion in the community

On the previous inspection inspectors saw that a resident had repeated falls. There was no evidence that falls assessments were maintained in relation to the areas of
vulnerability identified and therefore there were no individual safeguards put in place even though staff had identified that the resident was at risk. On this inspection inspectors saw that a falls chart was maintained. All falls/ incidents were discussed at the co-ordinating/management meetings to analyse and manage risk as observed by inspectors.

Regarding individualised assessment and personal planning, the inspectors found variance in the standard of personal plans, care plans and person centred support plans. For example not all goals set out for residents had been achieved, 'on going' was documented for some goals such as attending a football match. There was no evidence of training needs or education being addressed. The personal plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to realise their goals. As on the previous inspection there was limited evidence of multidisciplinary involvement in the annual reviews.

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
On the previous inspection there were a number of areas of risk in the centre particularly in relation to the outdoor areas which were identified on the previous inspection and had not been rectified which included:

•Unrestricted access to a main road from a garden area, particularly as one resident had been identified as at risk of wandering
•unrestricted access to a boiler room in the garden area
•pipe work for radiators not being covered and exposed chimney flues.

On this inspection inspectors saw that these risks had been mitigated. A barrier had been erected outside the house to prevent direct access onto the main road. The boiler room was restricted and the chimney flue was not in use since September 2014.

On the previous inspection staff whom inspectors spoke with were vague in relation to the relocation of residents in the event of an evacuation and find interim accommodation for residents. Some staff members did not demonstrate an appropriate awareness of identifying hazards and managing risk. In some instances there was little knowledge of the content of the risk assessment or any planning in relation to this such
as unlocked doors and access onto the main road. There was no evidence of the alarm being serviced since it had been installed in November 2014.

On this inspection inspectors saw that there were policies and procedures in place for risk management and emergency planning. Inspectors saw that risk assessments were implemented throughout the centre. The measures in place to control risk and the arrangements in place for identification, recording, investigation and learning from incidents were outlined in the policy. There was a reporting of accidents/incidents policy which included:

- critical incidents
- untoward incidents
- behavioural incidents
- missing persons

There were personal risk assessments for residents and a risk register also. There was a health and safety statement which outlined the centre’s response to fire and evacuation arrangements. It also dealt with other emergencies like loss of power, loss of lighting or flooding. Staff whom inspectors spoke with were familiar with the relocation of residents in the event of an evacuation and interim accommodation for residents.

There was evidence that the fire alarm system and emergency lighting was checked on a regular basis. Staff told the inspectors that regular fire drills were completed. Inspectors saw that each resident had a personal emergency evacuation plan which included procedures for evacuation.

**Judgment:**
Compliant

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**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
On the previous inspection there was limited evidence that residents were provided with
emotional, behavioural or therapeutic support that promotes a positive approach to
behaviour that challenges as outlined under Outcome 5.

There was a policy on restraint dated February 2015 which was not centre specific. It
was based on guidelines issued by the Authority. Inspectors saw that chemical restraint
was used. Staff were unclear as to what constituted chemical restraint. There was no
evidence of any other multidisciplinary input into the management of chemical restraint
apart from the general practitioner (GP).

On this inspection inspectors saw that there was revised restraint policy. However there
was no implementation or review date present nor was there any evidence of staff
reading and signing off their understanding of the policy. It was unclear whether or not
the policy was based on the national policy on restraint. Inspectors saw that some
residents had been reviewed by a behavioural therapist who is now onsite once per
month. The community nurse had completed training for staff on chemical restraint.

Inspectors spoke with staff who were clear as to who assumed the role of the
designated safeguarding officer. However, training records were reviewed and not all
staff had received training in relation to safeguarding residents and the prevention,
detection and response to abuse.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where
required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
On the previous inspection the provider has not submitted any notifications to the Chief
Inspector since 30 December 2014. This action is complete and all required notifications
are submitted as per the Regulations.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible
**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
On the previous inspection inspectors saw limited evidence of referrals to specialist services and allied health care services such as physiotherapy, occupational therapy, speech and language therapy based referrals. In all personal plans reviewed inspectors saw that referrals to some allied services such as dietetics and speech and language therapy had only just commenced. However, there was no evidence of any multidisciplinary input into the resident’s care which would achieve the best possible outcome for this resident.

On this inspection inspectors observed that when residents required services of allied health professionals this had been facilitated. Inspectors saw that residents were encouraged to have appropriate health interventions in order to promote and achieve the best possible health. The person in charge told inspectors that if a resident refused treatment that the centre would involve an advocate where appropriate. However, as on the previous inspection there was no evidence of any multidisciplinary input into each resident’s annual review as required by the Regulations.

**Judgment:**
Non Compliant - Moderate

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**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection inspectors saw that there were four incidents of medication errors. In one instance there was no evidence of any follow up action or systems put in place to prevent incident reoccurring. There was no system in place for reviewing and monitoring safe medication practices.
The centre was a non nurse led service. Non nursing staff had undergone training on safe medication administration. The inspector saw evidence of this training in the staff files.

On this inspection inspectors saw that the pharmacy had completed a detailed audit on 13 November 2015. An improvement plan had been put in place following the audit. The medication policy had also been reviewed. Inspectors were informed that any errors or near misses are discussed at the weekly management meetings. Inspectors saw evidence of this in the minutes of these meetings.

Judgment:
Compliant

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
On the previous inspection the statement of purpose, the most recent of which was revised April 2014, for the most part complied with the Regulations. Some areas for improvement included an:

• accurate description of the organisational structure for the designated centre
• specific care and support needs that the designated centre is intended to meet.

This action is complete.

Judgment:
Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.
**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
A system of audits had been put in place within the organisation by members of the senior management team, and the inspector saw evidence of some audits carried out in relation to this designated centre. On the previous inspection an annual review to capture the quality and safety of this designated centre had been completed. However, this review did not present an overview on the quality and safety of care and support provided to residents as it included:

- Ethos of L’Arche
- House assistants coping with change
- Retreats and spirituality

There was a new house leader whom inspectors engaged with during the inspection. Staff told the inspectors that the person in charge would visit the house regularly and all residents attended day services where the person in charge was based. Inspectors observed that unannounced visits to the centre were taking place. The annual review remains the same and does not present an overview of the quality and safety of care and support provided to residents. Inspectors observed that there was a planned programme of support and supervision for staff members. Inspectors saw that the person in charge did receive supervision from the registered provider. There was evidence of regular meetings taking place between the provider and person in charge.

**Judgment:**
Substantially Compliant

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection there was no deputy person in charge in place. This action is complete and inspectors spoke with the deputy person in charge on this inspection.

**Judgment:**
Compliant

<table>
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<th><strong>Outcome 16: Use of Resources</strong></th>
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<tr>
<td><em>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</em></td>
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**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection the provider and person in charge said that the centre was not resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose. Inspectors saw that staffing levels were low in the house particularly at weekends which was inadequate to meet the needs of residents. On this inspection the provider assured inspectors that the centre was sufficiently resourced. From a review of staffing rosters inspectors saw that there were adequate staff on duty over a seven day period. Staff who spoke with the inspectors during this inspection said that there was adequate staff on duty at all times to meet the needs of residents.

**Judgment:**
Compliant

<table>
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<th><strong>Outcome 17: Workforce</strong></th>
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<tr>
<td><em>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.</em></td>
</tr>
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**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
On the previous inspection inspectors were not satisfied that the skill mix of staff available during the inspection was appropriate to meet residents’ needs. Some staff members who were predominantly known as volunteers by the community had very little experience of working with people with disabilities. On this inspection inspectors were satisfied that the skill mix of staff was appropriate to meet residents’ needs. There was a new house leader who had many years experience in the disability sector. Inspectors spoke with the volunteers currently working in the centre. There was a programme of induction in place as observed by inspectors and new staff confirmed this to inspectors.

On the previous inspection, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night. On this inspection improvements were noted in the rosters. It was clear and reflective of staff of duty, designated team leader and shift times.

Inspectors reviewed staff files and noted for the most part were compliant Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, in one instance inspectors noted that a written reference from a staff member’s most recent employer was not present. This has been a repeat finding on all inspections to date.

**Judgment:**
Substantially Compliant

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**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
On the previous inspection improvements were identified in relation to the policies in place. A small number of written operational policies as required by Schedule 5 of the
Regulations were not in place. These included staff education and training and creation of, access to maintenance of and destruction of records. These policies were now complete. However, inspectors observed many of the policies did not have an implementation or review date and had not been signed off by the management team.

It was unclear if the policies and procedures had been reviewed at intervals not exceeding three years and where necessary reviewed and updated in accordance with best practice. There was no evidence base to many of the policies reviewed by the inspector. There was no evidence of staff reading and signing off their understanding of the policies.

**Judgment:**
Substantially Compliant

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**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:**

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

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<td>Date of Inspection:</td>
<td>26 November 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 December 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:

Personal plans did not have a comprehensive focus and had not been implemented to meet the changing needs of some residents. The plans did not adequately address:

- education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
• transport services the resident's wishes in relation to where he/she want to live and with whom
• the resident’s wishes or aspirations around friendships, belonging and inclusion in the community

1. **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 PCP plans will include education, network of support, wishes with regard to where and with whom he/she wants to live and belonging in the community. All this will be part of the annual reviews in January and a new template will be in place to address all these.

**Proposed Timescale:** 29/02/2016

**Theme:** Effective Services

The **Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was limited evidence of multidisciplinary involvement in the annual reviews.

2. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
The person in charge and the provider will continue to source additional MDT involvement for the annual reviews which are now scheduled for January 2016. If attendance by a particular health professional is not possible the person in charge will ensure that an up to date written report is provided for the review meeting.

**Proposed Timescale:** 31/03/2016

**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:**
Training records were reviewed and not all staff had received training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
The staff in question has had one-on-one training with the safeguarding officer on 1 December 2015. A further safeguarding training day (POVA) is scheduled for 14 January 2016 for any staff who have not received this and for any staff requiring updated training.

Proposed Timescale: 31/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As on the previous inspection there was no evidence of any multidisciplinary input into each resident’s annual review as required by the Regulations.

4. 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 the provider will continue to source additional MDT involvement for the annual reviews which are now scheduled for January 2016. If attendance by a particular health professional is not possible the PIC will ensure that an up to date written report is provided for the review meeting.

Proposed Timescale: 31/03/2016

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 annual review remains the same and does not present an overview of the quality and safety of care and support provided to residents.

5. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
The 2016 annual review will review the quality and safety of care and support in the
designated centre, and that these are in line with the standards. The review will use bespoke auditing tools.

**Proposed Timescale:** 29/02/2016

### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

In one instance inspectors noted that a written reference from a staff member's most recent employer was not present.

**6. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

The written reference is now present.

**Proposed Timescale:** 22/12/2015

### Outcome 18: Records and documentation

**Theme:** Use of Information

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

It was unclear if the policies and procedures had been reviewed at intervals not exceeding three years and where necessary reviewed and updated in accordance with best practice.

**7. Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

All policies will have a date of issue and review and will be reviewed according to best practice.

**Proposed Timescale:** 31/01/2016