**Health Information and Quality Authority Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Hall Lodge</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001709</td>
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<tr>
<td>Centre county:</td>
<td>Wicklow</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Sunbeam House Services Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>John Hannigan</td>
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<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<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>
<td>5</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 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: 13 May 2016 09:30
To: 13 May 2016 20:30

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

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Summary of findings from this inspection

Background to the inspection:
This was the third inspection of this designated centre. This inspection was to monitor ongoing compliance with the regulation and standards.

How we gathered our evidence:
As part of the inspection the inspector visited the designated centre, met with four residents, the person in charge and three staff members and one family member. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs, policies and procedures. Over the course of this inspection residents communicated in their own preferred manner with the inspector.

Description of the Service:
This designated centre is operated by Sunbeam House Services (SHS) Limited and is based in Arklow County Wicklow. There were two full-time residents living in the designated centre and two respite beds also available within the designated centre during this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The
designated centre aimed to provide residential and day care for both male and female adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose.

The designated centre was a bungalow type home located on a campus there was also administration offices and a day care service located within the same campus.

Overall Judgments of our findings:
Eleven outcomes were inspected against one outcome was found to be in full compliance. Five outcomes were found to be substantially compliant and five outcomes were found to be moderately non-compliant. Areas of improvement included the information contained within residents' files, medication management and details contained within residents written agreements.

The person in charge facilitated the inspection.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector reviewed this outcome in respect of the complaints procedure only. No other aspect of this outcome was inspected. Improvements were required in relation to the complaints procedure.

There was a complaints policy and procedure in place, it was unclear who was the nominated person independent of the person nominated to deal with complaints within the organization. This was to ensure all complaints were appropriately responded to and maintain records specified under paragraph 34(3) of the regulations. This remained outstanding from the previous inspection in 2014.

Judgment:
Substantially 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:
The inspector reviewed this outcome in respect of the action identified from the previous inspection and found the action was achieved.

However, the inspector found some residents were privately funding care hours. It was unclear to the inspector what was not provided by the provider and what was being provided privatively. The documentation viewed within files was also unclear. This was discussed with the person in charge on the day of inspection. For example, the document stated the resident was in receipt of 100 care hours per month from a personal assistant, when in fact this was 80 hours per month. No clear guidance was present in relation to what was to be completed during the time the personal assistant was present with the resident.

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:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found the wellbeing and welfare of residents were being met, issues in relation to the supporting documentation and monitoring of achievements for residents required improvement.

The system of personal social plans within the designated centre involved personal outcome measures including 23 quality of life indicators as an assessment completed once every three years. The information gained during the process contributed to the development of a personal plan. This plan was to be completed annually and reviewed every six months. The healthcare needs of residents were completed via a plan entitled 'my health development plan', from this a care plan and or support plan was developed.
The inspector found improvements were required in both the social and healthcare plans. The inspector viewed four residents' plans and identified the following issues:

One plan viewed was due for reassessment in August 2015. The assessment was sent to the internal personal outcome coordinator on 10 August 2015 and on 2 March 2016, confirmation was received that the document was reviewed. The inspector queried why this process was took six months however, this information was not available. The system required a member of the organizations quality team to sign off on the assessment before the document could be implemented. This system was found to be delaying the implementation of goals and related planning meetings for the resident due to delays in this sign-off process. However, the inspector asked to view the plan the resident had in place during the six months interim period and two versions of a plan was presented. One plan was a paper version with four goals and the second plan available within the IT system had nine goals.

The monitoring and implementation required to assess the effectiveness in residents' plans was not evident. In some plans if goals identified were not achieved no evidence of what was achieved or the level of progression was provided.

Healthcare assessments were in place however, the inspector found two plans in place for one resident and these were not linked to the healthcare interventions the resident had in place. The information was also different within the two plans.

Some aspects of residents healthcare needs were not evident within the residents assessments in the areas of gastro intestinal issues, yet interventions were in place for these issues.

Duplication of documentation was evident in residents files for example, health and development plans were present in two different templates and plans in relation to care interventions were also duplicated.

Residents social care needs were identified and residents had the opportunity to participate in meaningful activities appropriate to their interests and preference. These included areas such as, attending music events, art exhibitions, swimming and sporting events.

Resident's family members were consulted in relation to the personal plans in line with residents and family member's preferences. There was evidence of this maintained within the residents file.

**Judgment:**
Non Compliant - Moderate
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector reviewed this outcome in respect of the action identified from the previous inspection and found the actions had been achieved. No other component of this outcome was inspected.

Judgment:
Compliant

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:
The inspector found the designated centre was suitable and safe for the number and needs of residents. Improvements were required in the area of fire evacuation.

Fire drills had taken place and documents recorded the time taken to evacuate and any issues identified. The records provided to the inspector did not identify what residents participated in the drill. The inspector found no evidence available within the designated centre to ensure all residents has participated in a fire drill and were safely able to evacuate from this designated centre particularly as two respite beds were in use within the designated centre.

The inspector viewed a number of residents PEEP (personal emergency evacuation plans) and safety plans, these were found to be up-to-date.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company as required by regulations. An
annual service completed in December 2015 and the previous quarterly completed in March 2016. Staff also completed checks on the exits, alarm panels and equipment some gaps were evident and these were highlighted to the person on the day of inspection.

The designated centre had an organisational risk management policy in place this included the specific risks identified in regulation 26. The designated centre had a risk register this recorded a number of risks within the house and the controls in place to address these.

There were individual risk assessments for residents in place these included fire, unexplained absences, choking and aspiration the person in charge had reviewed and signed these off on 3 January 2016, however, the senior service manager signed them off on the day of inspection.

The designated centre had a health and safety statement this outlined the responsibilities of the various post-holders within the organization. The statement referenced a wide range of policies and procedures supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as, fire adverse weather conditions, flooding, power failure and possible gas leakage. The plan identified the specific alternative accommodation to be provided in the case residents could not return to the designated centre.

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

**Findings:**
The inspector found appropriate measures to protect residents from being harmed were not in place within the designated centre. The action identified in the previous inspection was addressed. However, the inspector found improvements were required in relation to behavioural support plans, reviewing of restrictive practice and staff members
knowledge of the reporting procedure should an allegation of abuse arise.

Overall the inspector found residents positive behavioural support plans required improvement, these were being reviewed however, there was no evidence of behavioural or psychiatrist input considering the inclusion of both physical and chemical restraint within the behavioural support plans.

The inspector viewed a behavioural support plan in place this identified that two members of staff were required to provide support due to a high risk of injury. Aspects of the plan were very clear and informative however, other aspects of the plan did not guide staff effectively. For example, the reactive strategies did not identify when p.r.n. (a medicine only taken as the need arises) medication was to be administered. In addition the document also identified three staff members were required in relation to supporting phlebotomy tests. The rational for this support was due to the risk of a needle stick injury. The inspector asked what the role of the three staff members were however, this was not available within the designated centre. The inspector asked to view evidence of this intervention being reviewed this was also not available.

A restriction intervention was also identified as required, however there was no evidence of this intervention being reviewed by the organisations rights restriction committee or being reviewed by a multi disciplinary team. Chemical restraint was also evident within the plan however, the inspector found this was not guiding practice for example, two to four milligrams of a specific medication was to be administered. No guidance was available when two milligrams should be administered and what indicators would warrant administrating more than two milligrams.

The inspector did view evidence of a restriction being reviewed in relation to the locking of the front door on 24 April 2015 and 25 May 2016.

Staff members had received training in the area of resident prevention, detection and response to abuse. Staff members spoken with by the inspector were knowledgeable in relation to the management of an allegation of abuse. However, some staff members were not fully clear of the procedures to be followed should such an allegation arise.

There was a policy in place on the prevention, detection and response to abuse.

There was a policy in place for providing intimate care and plans were in place for residents whom required support in this area.

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):**

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

**Findings:**

Each resident was supported to achieve the best possible health. However, improvements were required in the information contained in residents healthcare plans and the implementations of recommendations from allied health professionals.

Residents had access to allied healthcare professionals, the inspector viewed evidence of this including chiropodists, optician, and physiotherapist. However, some reviews were not evident in relation to these professionals, for example, the physiotherapy plan was not reviewed since 2014. The inspector requested to see evidence of mental health reviews, however, this was not available. The inspector was informed reviews with the psychiatrist were not always documented. The inspector found a series of notes and instructions handwritten for 'the attention of HIQA' for example, "If HIQA reads this note it is important they look into all the residents old files". The person in charge identified these had been brought to the attention of the senior service manager and the chief executive officer and they were investigating this issue. Currently the resident did not have a psychiatrist as the position was vacant. However, a clinical nurse specialist was available should the need arise.

Residents had access to a GP (general practitioner), all residents had received an annual review including phlebotomy tests as required for some residents due to their medication.

Regarding food and nutrition the inspector found residents received food at mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices.

The inspector viewed user-friendly menu selection refreshments and snacks were available for the residents outside mealtimes within the designated centre.

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

Findings:
The inspector found the medication management system within the designated centre required some improvement. Some of the areas identified in the previous inspection had been addressed, the inspector found improvements were still required in relation to safe medication practices. The stock control system for p.r.n. (a medicine only taken as the need arises) medication was inaccurate, administration practices were not corresponding with the organizations policy and administration recording sheets were not corresponding with administration records.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received and a stock check was carried out once a week. The system was unclear for p.r.n. medication. The inspector was informed once p.r.n. medication was brought into the designated centre the medication was checked. On the day of inspection inaccurate stock balances were found for one batch of medications despite a recording sheet in place. The inspector viewed the stock balance sheets and found gaps within these for example, 27 December 2015 no balance was specified. The inspector found this system to be ineffective in relation to stock control.

The inspector also viewed evidence of staff nurses engaging in the process of second dispensing regularly within this designated centre. However, the organizations policy did not correspond with this practice. The policy stated "In the case of nurse-led locations, the keys to the medication storage unit should be held on the nurse’s person at all times as per An Board Altranais guidelines". "When clients are leaving a location second dispensing should only be undertaken by staff in exceptional circumstances". The inspector queried if the incidences the inspector viewed were exceptional circumstances however, staff confirmed these were not.

Administration recording documents were in place for each resident and a number of these were viewed by the inspector. These were found to be up-to-date and showed that staff administered and signed for medication. However, administration recording sheets did not match the administration records for example, the 24 hours clock was identified in one document while the 12 hours clock was specified in the other document.
There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the designated centre and found preventative measure were put in place to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the designated centre was completed.

The inspector observed that all medication was stored in a secure, locked cabinet in a locked area and the keys to access the medication cabinet were held securely by staff.

Residents had p.r.n. protocols in place, the inspector found these provided clear and accurate information to assist with the safe administration of p.r.n. medication.

**Judgment:**
Non Compliant - Moderate

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**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):**
No actions were required from the previous inspection.

**Findings:**
The inspector found the quality of care and experience for residents' was monitored and developed on an ongoing basis. Improvements were required in the areas of unannounced visits and actions resulting from audits.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. The inspector viewed one completed in March 2016 and an action was developed to address the areas identified. However, no unannounced visit was available for 2015, and staff confirmed this.

Follow up from some audits was not evident for example, medication management no action plan was available for the areas identified.

There was an annual review of the quality and care completed within the designated centre dated 15 June 2015.
The inspector viewed minutes of the person in charge attending the senior management team meeting on 22 March 2016 and 26 April 2016. Areas discussed related to the whole organization including leadership, staff forum transfers and policies such as, the safe guarding policy.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meeting) on 19 August 2015 and 25 February 2016. Issues in relation to safeguarding, finances, budgets and complaints were discussed.

The inspector also viewed minutes of staff meetings within the designated centre. Areas discussed included one policy from the organization at each meeting for example, finance policy. The person in charge outlined what the responsibilities of staff were in relation to the policy. During another staff meeting viewed dated 12 March 2016 the following was recorded "never take a staff off resident x as two staff are allocated to this resident in their plan. If however, the staff member feels ok to work alone with resident x and they come to you that is a decision that is made by the staff member". The inspector was informed by a number of staff members that residents x required two staff. The inspector viewed evidence of this within the resident's file. The inspector found the information contained within the staff meeting minutes did not correspond with the documentation in the resident's file.

The inspector found there was a clearly defined management structure identified the lines of authority and accountability. The designated centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service.

The person in charge was knowledgeable about the requirements of the regulations and standards. This staff member is the person in charge for two other designated centres.

This designated centre had under gone significant changes in relation to service provision as the numbers of residents had reduced to four residents from nine residents as identified within the registration certification.

**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):
No actions were required from the previous inspection.

Findings:
The inspector found there was appropriate staff numbers to meet the assessed needs of residents within the designated centre. Improvements were required in relation to staff training in the area of medication administration.

The inspector viewed staff rota's planned and actual and found when gaps where present these were filled by relief staff members. There was a coding system used within the rota the person in charge had developed. However, no grid was present to ensure all staff members were aware of what these were for example, X referred to when a staff member was in a different location while L referred to late shift.

The inspector viewed staff training records and some staff did not have up-to-date medication management training.

Staff files were not reviewed as part of this inspection as these are held within the organizations head office off site these were reviewed as part of the previous inspection.

The inspector viewed supervision conducted by the person in charge with staff members. Clear evidence of items discussed impacting on the quality of care provided to residents. Areas included in relation to the internal IT system and time become familiar with the organization's policies. The inspector was also viewed supervision notes between the person in charge and the senior service manager. These contained an executive, education and support function. Areas discussed included residents needs, budgets and staffing needs.

These were no volunteers within the designated centre.

Judgment:
Substantially Compliant

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

Findings:
The inspector reviewed this outcome in respect of the action identified from the previous inspection and found one of the actions was achieved while the other remained outstanding.

Over the course of the inspection the inspector found the retrieval of schedule 3 documents difficult as some documents were present in duplicate versions for example, health assessments and care intervention plans.

Schedule 5 documents were available within the designated centre.

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:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001709</td>
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<tr>
<td>Date of Inspection:</td>
<td>13 May 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>05 September 2016</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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure was unclear in relation to who the nominate person, other than the person nominated in Regulation 34(2)(a), was within in the organization who was also available to residents. To ensure that all complaints are appropriately responded to and a record of all complaints were maintained.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Outcome 04: Admissions and Contract for the Provision of Services
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fees charged and the provision of services provided to some residents were unclear within the documentation present in the designated centre.

2. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The contract of care was amended to include all the detailed information regarding what was not provided by the provider, and what the service user paid for privately.

Proposed Timescale: 01/06/2016

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:
Comprehensive assessments for some residents were not evident to reflect changes in need and circumstances at a minimum on an annual basis.

3. 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:**
Documentation relating to clients will be reviewed and up-dated.

**Proposed Timescale:** 30/09/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some healthcare interventions were not identified within the assessed needs for the residents.

4. **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:**
Ensure that all healthcare needs are identified, and that there is a comprehensive care plan in place to address this need.

**Proposed Timescale:** 15/05/2016

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some reviews did not identify what was achieved or the level of progression of goals.

5. **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:**
All documentation relating to client goals will be reviewed and up-dated. The provider is currently up-dating the system used to collate and evaluate the information relating to client goals.

**Proposed Timescale:** 31/01/2017
### 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:**
Adequate arrangements for evacuating all residents from the designated centre was not evident. No record was in place to identify the residents whom had participated in the fire drills.

6. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
The full names of all the service users involved in future fire drills/evacuations will be entered onto the documentation

**Proposed Timescale:** 15/09/2016

### 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:**
Some of the positive behaviour support plans did not guide staff effectively to support residents to manage their behaviours.

7. **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:**
The positive behavioural support plan was amended to assist and guide staff more comprehensively.

**Proposed Timescale:** 15/05/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some restrictive practices contained within residents files were not reviewed by the rights committee or members of the multi disciplinary team.
<table>
<thead>
<tr>
<th>8. Action Required:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>Ensure all future restrictive practices are reviewed by the organisations rights restriction committee, and where appropriate to be reviewed by a multi disciplinary team. The rights restriction committee were informed of the restrictive practice and also a multi-disciplinary review was also carried out.</td>
</tr>
<tr>
<td>Proposed Timescale:</td>
<td>19/05/2016</td>
</tr>
<tr>
<td>Theme:</td>
<td>Safe Services</td>
</tr>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
<td>Some chemical restrictive practices in place were not reviewed by the rights committee.</td>
</tr>
<tr>
<td>9. Action Required:</td>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>All rights restrictions are sent to and are reviewed by the rights review committee.</td>
</tr>
<tr>
<td>Proposed Timescale:</td>
<td>15/09/2016</td>
</tr>
<tr>
<td>Theme:</td>
<td>Safe Services</td>
</tr>
<tr>
<td>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</td>
<td>Some staff members were unclear in relation to the procedure to follow should an allegation of abuse arise within the designated centre.</td>
</tr>
<tr>
<td>10. Action Required:</td>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>Safeguarding and protection is mandatory for all staff. Safe guarding and protection is discussed as a topic at staff meetings. Safeguarding and protection is also covered in a local audit around staff knowledge.</td>
</tr>
<tr>
<td>Proposed Timescale:</td>
<td>15/09/2016</td>
</tr>
</tbody>
</table>
### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Evidence of mental health reviews and physiotherapy reviews were not present for some residents.

**11. Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
Ensure that all reviews are recorded electronically, or in date order on the service users file. The psychiatrist position has now been filled.

**Proposed Timescale:** 30/09/2016

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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:**
Inaccurate stock balance was found in relation to p.r.n. medication.

**12. Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
A stock sheet was devised to accurately reflect the balance of the PRN medication on the location.

**Proposed Timescale:** 15/05/2016

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**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Dispensing of medications was not in line with the organizations policy on medication management.
13. **Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
Second dispensing of medication is required in the location for various reasons (Organised service user trips or outings, staff shortages, sick leave) The organisational medication management policy will be reviewed.

**Proposed Timescale:** 31/01/2017  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The administration recording sheet did not match the administration record.

14. **Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
A 24 hour recording chart was commenced to ensure that the administration recording sheet matched the drug administration record.

**Proposed Timescale:** 20/05/2016

**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:**
Evidence of an unannounced visits to the designated centre at least once every six months was not evident within the designated centre.

15. **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: |
| Ensure that 6 monthly unannounced visits are conducted by the provider. |
| Proposed Timescale: 31/10/2016 |
| Theme: Leadership, Governance and Management |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Implementation of corrective measures from audits conducted was not evident for all audits completed.

16. **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:**
Ensure that all audits conducted have identified action plans to address any issues that may come up. These action plans need to be reviewed on an on-going basis.

| Proposed Timescale: 31/10/2016 |
| Theme: Leadership, Governance and Management |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems in place in the designated centre to ensure the service provided was safe for some residents was not evident in relation to staff support as outlined in the main body of this outcome.

17. **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:**
Ensure that care plans are followed at all times by staff supporting the service users.

| Proposed Timescale: 15/09/2016 |
### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a planned and actual staff rota in place within the designated centre however, the coding system was unclear.

**18. 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:
Coding system put in place to make the rota clearer.

**Proposed Timescale:** 15/05/2016

### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff required medication administration training.

**19. 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:
All staff have either completed or are booked in to complete the medication administration training.

**Proposed Timescale:** 31/12/2016

### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector found the retrieval of schedule 3 documents difficult as some documents were present in duplicate versions for example, health assessments and care intervention plans.

**20. Action Required:**
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons
(Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

Please state the actions you have taken or are planning to take:
Ensure that all service user documentation is reviewed, and any duplicate versions to be archived. The provider is currently reviewing all standard documentation.

Proposed Timescale: 01/05/2017