Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by L'Arche Ireland
Centre ID:	OSV-0001959
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	L'Arche Ireland
Provider Nominee:	Mairead Boland Brabazon
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 May 2016 10:00	10 May 2016 20:00

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

Outcome
Outcome 02: Communication
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 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the Inspection

This inspection was undertaken as a follow up to two previous inspections which had taken place in the centre. The registration inspection took place in May 2015 and a follow up inspection took place in December 2015 as there had been two major and 11 moderate non compliances found at the inspection. There had been a significant improvement in compliances found at the time of the follow up inspection, However, given the nature of the initial findings it was deemed advisable to undertake a review of the core outcomes prior to making the final decision on the registration status.

As part of the current inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection and found that most of the actions had been resolved. This inspection was unannounced and took place over two days. Eight of the core outcomes required to demonstrate compliance with the legislation and regulations were inspected against with two further outcomes partially reviewed.

How we gathered the evidence

Inspectors met and spoke with the resident in the day service and in the centre. Residents who could communicate told of their activities and achievements and the

plans being made with them. They said they felt safe and liked the staff and managers. It was also apparent from observation that they were comfortable with the staff.

The inspector spoke with the person in charge, provider nominee, team leader, staff and the health and safety officer. The inspector observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, audits, policies, procedures and staff files.

Description of the service
The centre is designed to provide care for four adult residents with intellectual disability with some challenging behaviours and those on the autism spectrum.
It is a two story house with large gardens located in a rural location. It is near the local church and a small shop and there is transport available to ensure they have access to other amenities.

Overall judgement of the findings
The findings of this inspection are impacted upon by the governance arrangements and lack of access to suitable allied health services especially speech and language services.

This inspection found that
• residents had good access to activities and meaningful day services. (outcome 5)
• there was very good communication with families and regular consultation with the residents in regard to their wishes and preferences (Outcome 5)
• requirements to forward notifications to HIQA had been complied with (outcome 9)
However, lack of effective governance arrangements impacted on residents in the following ways;
• the person in charge was unable to carry out the duties effectively due to lack of adequate support arrangements (outcome 14)
• potential risks were identified in health and safety due to some deficits in the implementation of risk management strategies (outcome 7)
• safeguarding systems in relation to recognising the need for and implementing behaviour support plans required review
• lack of adequate access to allied health services including psychology and speech and language which impacted on residents overall well being and development (outcome 5, & 11)
• some deficits in staff knowledge of resident care needs which could pose a risk to the health and wellbeing .

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) 2013.

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 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):
No actions were required from the previous inspection.

Findings:
This outcome was not reviewed in its entirety. However, the inspector did not find that that the diverse communication needs of the residents were satisfactorily recognised or supported. While staff were very knowledgeable on the residents' means of expression only one resident had a communication passport or pictorial guide to help them communicate. This was a very detailed guide and the resident brought this on all activities. However, it was not provided for other residents who had communication support needs.

The personal plans and complaint procedure were synopsised in a suitable and user friendly pictorial format for the residents.

Judgment:
Non Compliant - Moderate

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

Findings:
The action from the previous inspection had been partially but not fully resolved.

There was evidence of improvement with annual reviews being held and some evidence of multidisciplinary involvement via the community disability services in these reviews.

The review reports prepared by the staff were comprehensive and took account of most aspects of the residents' lives. Additional reports were prepared by the workshops and day services. In this way there was an overview of the care provided and the life of the residents. Both the residents and their representatives attended the review.

However, there was insufficient evidence that residents care planning was driven, as required, by a comprehensive assessment as dictated by the residents presenting or changing needs and planned accordingly. This was especially evident where residents had ongoing mental health, psychological, or physiological issues.

From the documentation available and from speaking with staff there was no comprehensive knowledge and understanding in regard to residents' intellectual disability or medical conditions. For example, one resident periodically attended a mental health specialist. The information available as to why this occurred was scant and staff could not explain the reason or the outcome. The ability to prepare a comprehensive personal plan was not therefore possible.

Goals were set following reviews but as in previous inspections the documentation did not identify systems for implementation or those responsible.

There were very person centred pictorial plans undertaken with the residents which detailed their preferences for activities and personal supports. Staff also completed detailed daily plans for activities of daily living and the supports needed which were seen to be made available to the residents.

Overall the lack of assessment and key information did not provide a satisfactory basis for ensuring that the care provided took account of the residents health, personal and psychosocial needs as required by the regulations. Some but not all of these findings were significantly influenced by the deficits in accessing some allied services via the state agencies.

Residents' need for social interaction and meaningful day occupation were being well supported. They attended the workshops which included art, computers, weaving, making cards and music. They could participate in the horticulture projects. They went to social events, concerns and sporting events. Where one to one supports were required these were made available. They went swimming and attended a range of local events, had meals out and went on holidays. On the evening of the inspection residents had a take away meal of their choice and were attending a disco organised by the organisation. Resources were made available for them to meet these social needs.

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):
No actions were required from the previous inspection.

Findings:
While there were good structures and procedures in place for the management of risk, systems for recognition of and implementation of the control measures within the actual centre required some review.

This is demonstrated by the following:
A resident assessed as being at risk of wandering was accommodated on the ground floor. On occasion, no staff would be present overnight on this floor. The front door had a censor alarm fitted should any one enter or leave inadvertently. This alarm was not checked to ensure it was in working order. Additionally, the door was secured via a lock which could be easily opened by an uninvited visitor.

A resident at risk of falls had falls risk management plan in place. However, staff gave contradictory information as to the measures which they were taking in certain circumstances to support this resident. An alarm was used to alert staff to a fall in the vicinity of the centre which supported independence. There was no systems to ensure that the alarm was operational on a regular basis. Staff also had contradictory information as to how this mechanism worked.

The key to one of the fire exit doors was located in the lock. This was the only key and should it be inadvertently misplaced the door could not be exited. Inspectors acknowledge that this door will be replaced as part of the fire upgrading works underway at the time of inspection.

While fire drills were held they did not take account of the different sleeping accommodation for the residents and how one resident would be accessed if all staff were upstairs.

A satisfactory risk management policy was in place and the risk register was very detailed for both environmental and individual risks for the resident. Fire training had taken place for staff and there was evidence of new staff or volunteers having a detailed fire safety induction.

There was evidence that the fire alarms and detection systems and emergency lighting was serviced annually and quarterly as required. Additional works, at considerable cost were being undertaken at the time of the inspection, which included the installation of fire doors and a external fire escape had been installed.

There was an emergency plan and interim accommodation arrangements had been made.

The policy on infection control was detailed. Staff were observed taking appropriate precautions and using protective equipment including gloves as 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The policy on the protection of vulnerable adults was in accordance with the national revised policy. As required by previous inspections staff and the designated officers had undertaken the required training in this procedure.

Staff expressed their confidence in the actions of the person in charge should any abusive incident occur. Residents who could communicate with inspectors stated that they felt safe and would tell staff if they had any concerns. There were detailed personal and intimate care guidelines in each plan. An external advocate had been sourced and inspectors saw evidence of active involvement to support one vulnerable resident who did not have any external family members to do so.

Behaviour support plans had been developed for a resident based on a review by an external behaviour specialist and the person in charge who also has training in this matter. However, another resident presented with specific behaviours which had been deemed to potentially place others at risk. Also of concern to the inspector was the impact the behaviours may have had on the resident in terms of social situations and interpersonal interactions.

The staff demonstrated a high degree of tolerance and understanding in relation to this. However, this empathy was not supported by psychological or behavioural support for this resident to guide staff and develop consistent strategies which would be of benefit to the resident. Inspectors were informed that one resident on occasion removed himself to the bathroom as the level of noise being made was disturbing.

Inspectors found that no chemical restraints were being used and no restrictive practices were being used. Staff had up to date training in the management of behaviours that were challenging.

All residents had their own bank account and with staff support managed their finances. A review of a sample of the records pertaining to the management of resident's monies as fee payments and for other purposes indicated that the systems for recording this money and its usage were detailed and transparent. All monies given for resident's use were dated and the expenditure was recorded and receipted for the finance office. Records were available for review at any time.

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):
No actions were required from the previous inspection.

Findings:
A review of the accident and incident logs, resident's records and notifications forwarded to HIQA demonstrated that the person in charge was compliant with the obligation to forward the required notifications.

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

Findings:
Inspectors found that improvements were required in the systems to ensure that residents' healthcare needs were being identified and that they were supported and understood by staff.

A local general practitioner provided care to the residents. While there was evidence of general reviews, medication reviews and appointments there was no overall clarity on the residents' healthcare status or underlying conditions. This did not support continuity or consistency of care. This is actioned under outcome 18 records and documentation.

Inspectors found that referrals to appropriate allied services as required were not facilitated consistently. There was no access to speech and language therapy either for communication or where concerns with food were identified.

In addition, the inspector did not find that all staff were familiar with the healthcare needs and how to enable the residents achieve the optimum health. This is evidenced by the lack of clarity on issues identified in some personal plans or documents. For example, why a resident was wearing a specific support garment, whether or not a resident had cholesterol or blood pressure and a lack of satisfactory review of specific healthcare presentations which impacted on the resident's quality of life. An experienced suitably qualified nurse was employed part time by the centre and supported the non medical staff.

There was evidence that meals were nutritious and that residents had access to a healthy diet. Chiropody, dentistry and opthalmatic reviews were evident and a resident had access to physiotherapy as necessary. Regular blood tests, vaccinations and medication reviews were evident.

Inspectors were informed that if a resident was admitted to acute services staff had been made available to remain with them to ensure their needs were understood. There was a revised policy on end of life care in drafted which outlined supports with advanced planning arrangements. A pain identification and management chart was also being drafted to support this policy. There was no resident who required this care at the time of this inspection although the organisation had in the recent past support a resident at end of life care very well in another centre. There was access to community nursing and palliative care should this be required.

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):
No actions were required from the previous inspection.

Findings:
No actions were required from the previous inspection.

The policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for all medication including controlled medication were satisfactory although none were being used at the time of this inspection. There were appropriate documented procedures for the handling, disposal of and return of medication. Medication was dispensed in systems which assisted the non nursing staff to do so safely. The community nurse employed by the provider undertook medication management training with staff. This included a competency assessment.
Inspectors saw evidence that medication was reviewed regularly by both the residents GP and the prescribing psychiatric service. Audits of medication administration and usage were undertaken the nurse and the pharmacist.

No emergency medication was required at the time of the inspection. A number of medication errors were noted, and the actions taken to prevent reoccurrences were seen to be prompt and decisive.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that while there were suitable and committed governance arrangements in place these were not in this instance sufficiently effective. This is evidenced by the findings in Outcome 5 & 11. These findings can be linked to a lack of defined accountability in roles currently evident.

The person appointed to the position of person in charge of this centre had been in the organisation for a significant period of time and had training in intellectual disability, management and behaviour support. She was the person in charge of two other centres. As this was deemed at previous inspections not to be a suitable arrangement, house leaders were appointed to each centre. In this instance however, the duties and responsibilities for each role did not appear to be clearly defined. There were structured and formal reporting systems evident.

As part of the registration process the person in charge and the provider nominee demonstrated their knowledge of the regulatory responsibilities but the current arrangements did not allow for the effective adherence to the regulations and safe delivery of care.

The provider and the person in charge were however aware of this deficit and in discussion with the inspector indicated their intention to make suitable changes. There was an appropriate day and night time on-call system in place.

The gaps identified in staff knowledge, for example in health care, and ability to take responsibility for the quality of the service they are delivering also impacts on the findings for governance.

The provider nominee who was the service leader for the region had responsibility for all designated centres operated by the provider. She was found to be very familiar with the care and social support needs of the residents.

Other changes to the governance systems had been made since the organisations initial application for registration. These included the creation of a community director post with responsibility for financial management and overall service provision. However, this post was vacant at the time of this inspection.

Two six monthly audits /unannounced visits had been undertaken in 2015 and one in 2016.These were found to be detailed with the emphasis on rights personal planning and outcomes for the residents. Issues identified included improvements needed in care planning, behaviour support plans, development of communication support plans for the residents and rostering arrangements. It was apparent therefore that the governance systems could identify deficits.

An annual report inclusive of such issues had been compiled. Further improvements were outlined by the provider such as the inclusion of accident and incidents and complaint management to enhance the quality of the report. The inspector saw that surveys had been sent to residents and to family members and these helped to inform the report. Further unannounced visits were already scheduled.

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

Findings:
The number of staff was satisfactory. Full-time nursing care was not required for the residents.

The centre was staffed by a mixture of volunteers and some fulltime employed staff. The addition of two fulltime employed staff was undertaken to augment the volunteers and provide on the ground oversight and direction of care and continuity of care. However, the staff did not have a comprehensive awareness and knowledge of resident's critical care and support needs, for example in health, behaviour support and the implementation of risk management strategies.

The inspector saw and staff confirmed that they had a detailed induction programme which was designed to lessen the impact of change on the residents when the volunteers were finished completed the term of duty.

The staff roster was available and outlined the daily responsibilities for staff which was linked to the daily scheduling sheet for each resident. This ensured that the residents activities and primary care needs were continently provided. There were two staff on at all times with a minimum of two sleep over staff at night.

A review of the training records showed that training was available to staff which was recorded in individual files and all mandatory training was up to date.

Staff files were reviewed during this inspection and were for the most part compliant with 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 the inspector noted the absence of a clearly identifiable written reference from a staff member's former employee and an unidentified gap in another staff's employment record. The volunteer files had evidence of Garda vetting and clearance from police in their country of origin. The volunteer programme is co-ordinated by a designated staff member.

Weekly meetings took place attended by the community director, person in charge and house leaders. From a review of the documentation the inspector found that the focused on residents care and reporting of changes and any incidents.

The staff were observed to be respectful and very supportive of the residents at all times during the process.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
While this outcome was not reviewed in its entirety it was found that the records required by regulation in relation to residents, including assessment of need and ongoing medical assessment were not available. This could impact on continuity of care and delivery of appropriate care.

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:

Noelene Dowling
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[1]

Centre name:	A designated centre for people with disabilities operated by L'Arche Ireland
Centre ID:	OSV-0001959
Date of Inspection:	10 May 2016
Date of response:	03 June 2016

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 02: Communication
Theme: Individualised Supports and Care **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Systems to support residents to communicate were not available to all residents who required this.

[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 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
Residents who require, it will be to be referred to Speech and language therapist and their needs assessed.

The assessments and the needs and wishes of the residents will guide care plans in the future.

Proposed Timescale: 26/08/2016

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:
Residents care needs were not planned following a comprehensive assessment as dictated by the residents presenting or changing needs.

2. 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 residents will have comprehensive MDT assessments completed. Care plans will be altered to reflect the assessments as required.

Proposed Timescale: 26/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The reviews did not consistently show evidence of the outcome and effectiveness of the personal plans.

3. 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 Care plans/ PCP's will be reviewed at team meetings on a quarterly basis to ensure that Care plans/ personal plans are effective.

Proposed Timescale: 10/07/2016

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:
Systems for recognition of potential risks and adequate implementation of risk control measures required review.

4. 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:
We will review the system for recognition of potential risks. The Provider and PIC, through support and supervision, mentoring and team meetings, will develop the ability to recognise and implement risk control measures.

Proposed Timescale: 26/08/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements to ensure the safe evacuation of the residents required review with reference to:
• ease of egress from exit doors
• access to residents who require support where staff are not available in the immediate vicinity.

5. 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:
New key has been cut and is now in place.

A fire plan to address this has been completed and discussed at the team meeting. All staff have been informed.

Proposed Timescale: 03/06/2016

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:** Appropriate allied health support was not available to guide staff and support a resident to manage behaviours. **6. Action Required:** Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used. **Please state the actions you have taken or are planning to take:** Referrals have been made to a behaviour support specialist to review and plan the support the resident requires. This will guide staff and support residents to manage behaviours. First meeting with the behaviour support specialist will be on the 17-6
Proposed Timescale: 10/07/2016

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:** Residents did not have access to allied services including speech and language where this was recognised as being required. **7. 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:** The residents have been referred to a speech and language therapist and to a psychologist in order to have comprehensive assessments completed. Care plans will be altered to reflect the assessments as required.
Proposed Timescale: 26/08/2016

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 current arrangements to allow the person in charge to manage three centres do not provide effective operational management.

8. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
1. Weekly supervision with staff will focus on familiarisation on the health and support needs of residents and taking responsibility for the quality of the service being delivered
2. Auditing has taken place which focused on areas of non-compliance in this report.
3. The Provider will meet with the PIC every two weeks to review the operational management of the centre, identify deficits and take appropriate action through the organisation's internal policies and procedures.

Proposed Timescale: 26/08/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The current management structure did not provide sufficient oversight of the delivery of care via clearly defined roles and responsibilities.

9. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
1. Roles will be clarified through review of current role descriptions and amendments made to ensure that roles reflect responsibilities, lines of authority and accountability and that all roles include a specific remit for quality management
2. The Provider will ensure that supervision is taking place weekly with all staff and will be focused on role specifics for a period of one month
3. The Person in Charge will attend the centre's team meetings every two weeks to review the operational management of the centre, identify deficits and take appropriate action through the organisation's internal policies and procedures

Proposed Timescale: 26/08/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Staff did not demonstrate sufficient knowledge of the residents' needs in areas including health, mental health and behaviour supports. **10. Action Required:** Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. **Please state the actions you have taken or are planning to take:** 1. Information sessions by the provider and the person in charge will be arranged that will ensure staff have a comprehensive knowledge of resident's needs in areas including health, mental health and behaviour supports. 2. The nurse will attend the team meetings every two week for 2 months and as directed thereafter in response to issues arising. 3. Staff knowledge will be reinforced through supervision and the person in charge will attend team meetings every two weeks
Proposed Timescale: 26/08/2016
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Some staff files did not contain the required documentation to support safe recruitment. **11. 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 staff files will be completed.
Proposed Timescale: 10/07/2016

Outcome 18: Records and documentation
Theme: Use of Information **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Satisfactory records of assessment and on-going medical or psychological needs were not available.

12. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
The records of assessment and on-going medical or psychological needs will be in the residents' files.

Proposed Timescale: 26/08/2016