Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003015
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Clare Dempsey
Lead inspector:	Raymond Lynch
Support inspector(s):	Gary Kiernan
Type of inspection	Unannounced
Number of residents on the date of inspection:	20
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 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:	To:
25 May 2016 10:00	25 May 2016 18:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
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

Summary of findings from this inspection

Background to inspection

This was an unannounced triggered inspection following a number of serious notifications received by the Health Information and Quality Authority (HIQA) in May 2016 concerning this centre. The centre was last inspected in January 2016, where improvements across a number of outcomes were identified. However, this inspection found that the governance and management of the centre was not adequate to ensure improvements were sustained.

Since the inspection in January 2016 HIQA held a meeting with the provider regarding the unsuitability of the living environment and future plans for this centre. During this meeting the provider presented documented plans for a significant number of residents to move to suitable accommodation before the end of 2016. Inspectors found evidence that some consultation had taken place with residents and their representatives to facilitate this.

How we gathered evidence

The inspectors met with six residents, three staff members (two staff nurses and one health care assistant), the Clinical Nurse Manager I (CNM I) the Person in Charge, the Director of Care and Support and the Director of Services over the course of the

inspection. Most residents were non verbal and on arriving to the centre inspectors observed that some were waiting in a reception area to go to their various day services.

One resident did speak with inspectors. They were working on a table top activity with a staff member and appeared content in doing so. Another resident was happy to show the inspectors their bedroom. While it was noted that this was a very small room, it was decorated to the resident's individual style and preference.

Both inspectors spoke with the person in charge and CNM I extensively over the course of the inspection. A staff nurse and health care assistant were also spoken with by inspectors. A sample of policies and documentation were also inspected as part of the process including health and social care plans, complaints log, risk assessments, safety statement and audits.

Description of the service
The centre comprised of four houses on a campus based setting belonging to St. John of Gods in County Louth. Twenty residents were supported across the four houses that comprised the centre. There were a range of small villages and towns in close proximity to the centre however, due to its isolated location private transport was required to access these amenities. It was noted that the centre had transport to support the residents in accessing their surrounding facilities.

Overall judgment of our findings
While improvements were found in the last inspection in January 2016, this inspection found significant non compliance across a number of outcomes. Of the nine outcomes assessed workforce, notification of incidents and medication management were found to be compliant.

However, major non compliances were found in governance and management, social care needs, healthcare needs and premises. Moderate non-compliances were found in safeguarding and health, safety and risk management while medication management, notification of incidents and workforce were found to be compliant.

Inspectors found that while some progress had been made to support residents to move to more suitable accommodation, sufficient systems were not in place to implement the overall plan in accordance with the timeframes and undertakings given to HIQA.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
The last inspection in January 2016 found that comprehensive individual personal plans were being put in place for each resident living in the centre. However, this inspection found that those plans had not been progressed and from the sample viewed by inspectors, had not been completed, reviewed or updated. It was also noted that some residents assessed needs were not being provided for in the centre.

The inspectors viewed a sample of personal plans and found them to be incomplete and not reviewed or updated as required. For example, one resident's personal plan identified three goals that were important for them to achieve. These goals were identified in July 2015.

However, there were no actions plans drawn up to support the achievement of the goals, some of the documentation was left blank and there was no evidence available to inform the inspectors if the goals had been achieved. Staff working in the centre were also unsure as to whether the residents goals had been achieved. On the day of inspection the inspectors also observed that there was no evidence of multi disciplinary input into the assessment of social care goals.

There were a number of activities available to residents to partake in on a daily basis. For example, residents could attend a local activity centre to avail of activities such as exercise classes. However, a number of activities continued to be facilitated on campus. For example, from the sample of personal plans viewed the inspectors observed that walks around the campus, in house table top activities and relaxing at home made up for a lot of the everyday activities that formed part of the residents daily lives.

The assessed needs of some residents were not being met. The inspectors observed that in one house that comprised the centre there was an arrangement in place to support three residents. However, it was also observed that because of behavioural issues that one of the residents presented with, the other two residents could only access their home when this resident was in bed.

This arrangement was in place so as the residents, whom all lived together, did not have to spend time in each other's company. The inspectors informed the person in charge, the CNM I and the Director of Care and Support that this arrangement was not in any way meeting the assessed needs of any of the three residents residing in this part of the centre.

Judgment:
Non Compliant - Major

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

Findings:
As with all previous inspections of this centre, the physical layout and design of the centre continued to provide significant challenges to providing a quality based service to the residents. However, inspectors found that some improvements had been made and a plan to support residents to transition to a more individualised community based service was underway. This implementation of this plan is further discussed under outcome 14 (Governance and Management).

Parts of the centre were found to be clean, warm and kept in a good state of repair. Of the bedrooms viewed by inspectors, they were found to be personalised and decorated taking into account the residents individual taste and preference. However, the bedrooms were small (approximately five to seven square metres gross floor area) and the windows in each bedroom were not suitable as residents could not access them or view the outside from them due to their institutional design.

It was also observed that storage space for personal belongings was inadequate and the layout of the bathrooms continued to compromise the dignity and privacy of individual residents.

For example, and as found in the last inspection, some bathrooms comprised of communal facilities. It was also observed that they required cleaning, updating and repair. Some of the tiling remained cracked and broken and the shower was in a poor state of repair. The inspectors also observed that in one house that comprised the centre that communal rooms were large and furniture was sparse which impacted negatively on creating a homely environment.

Some of these issues were identified and actioned in previous inspections. However, in the previous inspection in January 2016 the Clinical Nurse Manager 1 (CNM 1) stated to inspectors that a de-congregational implementation committee had been initiated in May 2015. This committee was to commence transitional plans for each individual residing in the centre and would be informed by a support intensity scale assessment for each resident.

On this inspection the inspectors observed that the support intensity scale assessment for some residents had been completed and transitional plans for approximately ten residents had commenced and were in progress. Residents and family members were involved in the process and input from an external disability advisory agency also formed part of the process.

Inspectors viewed a sample of the transitional plans and found them to be informative and supportive in meeting residents needs during the proposed transitional period. Inspectors were told that residents would start to move to community based settings from November 2016.

Judgment:
Non Compliant - Major

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 previous inspection in January 2016 found issues with the safe evacuation of all residents from the centre in the event of a fire. This issue was still evident on this inspection. Issues were also found with the implementation of some individual risk assessments.

Fire drills were carried out routinely and records from one house of the centre informed that the last fire drill was conducted in February 2016. According to the fire register it took one minute and twenty five seconds to evacuate all residents from the house and no concerns were noted. The last inspection also found that individual personal emergency and evacuation plans were found to be in place for each resident.

Weekly checks continued to be facilitated for emergency lighting and fire extinguishers and on viewing records they were signed off and up to date. Annual maintenance records for all fire equipment such as fire extinguishers were viewed and it was found that they were up to date having been checked in May 2016.

However, and as stated above some bedrooms only had access to escape exits via a living space (as opposed to a circulation space such as a corridor), which inspectors found could present with a possible impediment to evacuating residents in a safe and timely manner.

Individual risk assessments were in place and were viewed by inspectors in residents' individual personal plans. Of the sample viewed, it was found that they provided a good overview of risks associated with each individual and how to mitigate each risk. Inspectors found that a recent risk identified in the centre related to one resident leaving unsupervised was assessed adequately and appropriate measures had since been put in place to mitigate the risk.

However, it was also noted that a risk assessment was not completed for another resident who presented with behavioural issues. There was a significant restrictive procedure in place for this resident in order to keep them safe. The restriction was passed by the 'Authorisation of Restrictive Practices' committee of the organisation and was reviewed on a regular basis.

Staff also kept daily notes on the use of this particular restriction. In the organisational policy on the use of restrictive practices however, it clearly states that an individual risk assessment must be carried out prior to the implementation of any restrictive practice. This had not been undertaken for the resident in question. This matter was discussed in detail with staff in the centre at the feedback meeting at the close of inspection.

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):
No actions were required from the previous inspection.

Findings:
There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided clear guidance to staff. The CNM 1 also informed inspectors there was a designated person to deal with any allegations of abuse. Personal and intimate care plans were also in place and provided guidance to staff ensuring, consistency, privacy and dignity in the personal care provided to residents. However, and as identified in the previous inspection, some staff required training in positive behavioural support.

After speaking with two staff members the inspectors were assured that they understood what abuse was, were familiar with the reporting procedures on abuse and were able to make reference to the policy and procedures in place on safeguarding vulnerable adults.

Of a sample of individual personal plans viewed, positive behavioural support plans were also in place. Positive behavioural support plans clearly identified possible triggers and antecedents to challenging behaviour and provided staff with guidelines on how to manage it proactively. Reactive strategies were also included in the plans.

All residents where required, had a positive behavioural support plan in place. Of the staff spoken with by inspectors, they were able to verbalise their knowledge of each individuals behavioural support needs, making reference to the behavioural support plans in place.

However, gaps were identified with regard to training for the Therapeutic Management of Aggression and Violence and some staff had not received training in positive behavioural support. Training for all staff in positive behavioural support was due for completion in October 2015 as detailed and required in a previous action plan.

The CNM 1 at that time informed inspectors that this training would take place in February 2016. On this inspection, gaps were still to be found and some staff had still yet to undergo this training. This gap in training was of considerable concern to the inspectors as some of the residents living in the centre presented with behaviours of concern on a regular basis.

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:
This was a triggered inspection after HIQA received a number of notifications regarding the health, safety and welfare of some residents living in the centre. It was observed that some of those notifications were not submitted to HIQA in line with the required timeframes and regulations.

However, by the time of this inspection, inspectors found that a record of all incidents occurring in the designated centre were maintained and where required, notified in a timely manner to the Chief Inspector.

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

Findings:
The healthcare needs of residents were being adequately provided for however, a serious incident where a resident had been identified as being at risk of concussion was not managed in an appropriate or timely manner.

For the most part inspectors were satisfied that the monitoring of residents' healthcare needs was being routinely managed and provided for. Care plans resulting from the medical assessments were reviewed at three monthly intervals or as required. Required frequent recordings such as monthly weights were documented while any issue identified during such monitoring was responded to.

From a sample of files viewed, residents had a good quality assessment in place of their current health care needs and there was regular access to GP services as and when required. Access to other allied health care professionals was also provided for where and when required. For example, where required residents were facilitated to see a dietician, speech and language therapist (SALT), physiotherapist and dentist.

Where required residents had access to mental health supports and there was evidence of good care plans to manage conditions such as anxiety which the inspectors viewed on the day of inspection. There were also informative care plans for other conditions such as dermatitis.

However, appropriate health care was not facilitated in relation to an incident reviewed on inspection. On the day of inspection a resident was in hospital further to a recent multi-disciplinary assessment. The resident in question was prone to falling. Inspectors noted that this resident had been the subject of notifications to HIQA about injuries and requested records of the care provided to them. On the 22 April 2016 it was recorded that the resident had swelling and bruising around their eyes. Daily reports informed that the resident had engaged in behaviour which resulted in impact to the head and face during the night.

The resident was viewed by the on-call CNM 3 at 08.00 am who recommended that the resident be brought to hospital as there was a risk of concussion. However, the resident was not transferred to hospital in accordance with this assessment. The resident was eventually seen by a GP at approximately 14.00 pm on 22 April. Inspectors asked to see the records of the clinical observations used to support the decision not to transfer the resident to hospital. However, prior to the GP visit, there was insufficient documentary evidence available to show that an evidence based approach to managing a resident at risk of concussion had been implemented. For example, records of neurological observations were not available to track any deterioration in the resident's condition. Inspectors read where these observations had eventually been recorded at regular 30 minute intervals later on in the evening of 22 April.

Judgment:
Non Compliant - Major

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:
This inspection found that there continued to be systems in place to ensure that residents' medicines were managed appropriately.

Overall, inspectors found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by appropriately qualified and trained staff members. Documentation with regard to the administration and prescription sheets contained the required information to support the safe administration of medicines.

There was a medication administration and management policy in place for the centre. These included processes to ensure appropriate procedures were in place for the handling and disposal of unused and/or out-of-date medicines.

As found in the previous inspection all medications continued to be locked securely in a press in each house that comprised the centre, and of a sample of medications viewed, inspectors found they were correctly labelled and in date.

There was also a system in place for reviewing and monitoring safe medication practices. For example, if a drug error occurred it was recorded and reported appropriately. The nurse administering the medication on the day of inspection reported that there had been no recent drug errors reported in the centre. He also informed inspectors that there were no barriers to reporting a drug error and there were systems in place to do so.

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:
There was significant concern regarding the provider's systems to oversee the safety and quality of the service.

Since the last inspection a deputising person in charge and deputising clinical nurse manager were responsible for the day to day management of the centre. Both were found to be knowledgeable of their responsibility and remit to the Health Act (2007) and Regulations. The person who was deputising for the person in charge was a very experienced, qualified nurse who also held qualifications in management. The CNM I was also an experienced and qualified nurse. Both demonstrated a full understanding of their roles and responsibilities under the Regulations.

There was also an on-call system in place where any staff member could contact a CNM III for support and advice at any time.

The inspectors reviewed the results of an unannounced audit by the provider of the quality and safety of care at the last inspection in January 2016. This audit was facilitated in November 2015 and was an in-depth analysis of how the centre was progressing in meeting the requirements of regulation. The audit described the actions required to address any gaps identified.

For example, it was identified in the audit that the person in charge was required to commence the process of supervision with the staff in the centre. The inspectors requested to see a copy of the supervision and were satisfied that the person in charge had commenced the process of supervision with his staff.

However, the provider did not have adequate systems in place to support, develop and performance manage all staff who worked in the centre on an on-going basis. For example, the provider did not have adequate systems in place to provide on-going support, supervision and performance management to the person in charge.

It was observed that other recommendations from the internal audit had not been implemented. For example, there was a requirement for the provider (or the person nominated on their behalf) to undertake an annual review of the quality and safety of care in the centre. This requirement was identified in November 2015 but to date no annual review had been undertaken in the centre. The audit also identified serious issues in the way in which complaints were being managed in the centre. Seven months after the audit these issues still remain unaddressed. This in turn meant the service was not being monitored effectively by senior management.

It was also observed that the person in charge had brought issues of concern regarding staff training to senior management of the centre however, his concerns had not been addressed and gaps were identified in training on this inspection.

Adequate management systems were not in place to support residents to move to more suitable accommodation. Inspectors reviewed the arrangements which were in place for residents to move out of the centre in accordance with undertakings given by the provider further to a meeting with HIQA in April 2016. While a number of actions had been implemented, for example consultation with residents, inspectors had concerns that there was a lack of a detailed strategy to support the delivery of this plan in a timely way. It was stated that 10 residents would move out of the centre by the end of 2016, however, suitable accommodation had not yet been secured and the detail of how this would be achieved for residents on time was not demonstrated.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors were satisfied that there were sufficient staff with the right skill mix, qualifications and experience working in the centre and the action identified in the last inspection had been adequately addressed.

Since the previous inspection in January 2016 a deputising Person in Charge and a deputising Clinical Nurse Manager had been put in place. Inspectors spoke to both at length throughout the inspection process and both were found to be knowledgeable of their remit to the Health Act (2007) and regulations.

A sample of staff supervision notes were viewed as part of the inspection and the inspectors found them to be informative on how best to supervise and support individual staff members.

Inspectors also spoke with two staff members (a staff nurse and a health care assistant) and found them to be knowledgeable and aware of the HIQA Regulations and standards as required.

Training records of all staff members were reviewed. As mentioned earlier in this report and in the last inspection not all staff had undergone required training in positive behavioural support. However, this was further discussed and actioned under outcome 8.

Inspectors reviewed a sample of staff files and found that all of the required documentation such as proof of identity and Garda vetting was maintained and available on the day of inspection.

Judgment:
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:

Raymond Lynch
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 St John of God Community Services Limited
Centre ID:	OSV-0003015
Date of Inspection:	25 May 2016
Date of response:	19 July 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 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to meet the assessed needs of some residents living in the centre.

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

Please state the actions you have taken or are planning to take:
1. The Staff Team will receive centre based training on social goal setting.
2. Each resident's social assessment will be reviewed & updated as required by each resident's key worker.
3. Each resident's social goals will be reviewed and updated by their keyworker.
4. The PIC will ensure that a revised schedule regarding meaningful day activities will be in place for all residents which will include social based activities in the community.

Proposed Timescale: 29/07/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents personal plans were not being reviewed appropriately to ensure they were effective.

2. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
1. Residents 'Critical Information' document will be reviewed and updated as required by keyworkers ensuring all changes in need and circumstance are documented comprehensively.
2. The PIC will introduce a personal plan tracking sheet to key workers so all personal plans are reviewed annually or more frequently as required.

Proposed Timescale: 09/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not sufficient evidence of multi-disciplinary support with regard to the personal planning process.

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

Please state the actions you have taken or are planning to take:
1. The PIC will complete a schedule of Multi-Disciplinary review meetings with residents, their circles of support and keyworkers to ensure all personal plans are supported by applicable members of the multi-disciplinary team.
2. Once the schedule is complete the meetings will be facilitated & recorded in personal plans using a Multi- Disciplinary Team review template.

Proposed Timescale: 10/12/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises were unsuitable for meeting the assessed needs of the residents living there and did not meet the requirements of schedule 6 of the regulations.

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

Please state the actions you have taken or are planning to take:
1. A De congregation plan has been completed through the Transforming Lives Project: This occurred on the 31.03.16.
2. Ten residents have been prioritised to transition to live in the community as part of Phase 1 – Transforming Lives Project (TLP). This was agreed on the 31.03.16 Once complete this will facilitate more suitable living arrangements for the other residents remaining in the centre in line with schedule 6 until full de congregation of this Designated Centre is completed.
3. The Registered Provider has completed a detailed Transforming Lives Action Plan specific to this Designated Centre and is submitting to the Authority on the 8/07/2016.
4. Transitional Plans have commenced for each resident in April 2016 and on-going Communication has commenced with all families of residents prioritised to transition to live in the community in Phase 1 of Transforming Lives Project.
5. Four suitable houses will be secured for purchase by the Statutory Body responsible for funding the Service to provide appropriate living arrangements for the ten residents prioritised to transition in phase 1 of the Transforming Lives Project.
6. Three of these houses have been identified as suitable and have been referred to the statutory body with responsibility for purchasing these houses. The statutory body has confirmed in writing on 30/06/2016 that they are progressing three houses for purchase/ renovation. Once the houses are purchased an application for registration will commence.
7. A Transforming Lives Implementation Committee has been established to progress the work of Transforming Lives Project Phase 1. This commenced 16/2/16.
8. The Clinical Nurse Manager (PIC) has commenced training in Social Role Valorisation in order to support residents towards the Supported Self Directed Living Model of Service & the Discovery Process. This commenced on the 27/6/16.

9. The Clinical Nurse Manager (PIC) will initially prioritise 1 resident to complete the Discovery Process.
10. The Clinical Nurse Manger (PIC) will share the learning from the Social Role Valorisation course through scheduled information sessions with the staff team from the centre. 25/07/2016 to 30/09/2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathroom facilities required cleaning.

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

Please state the actions you have taken or are planning to take:
1. The registered provider nominee will ensure that general repair works regarding tiling in the toilet area & replacement of a shower bracket will be completed to ensure the area is suitably decorated.
2. A revised cleaning schedule has been developed by the Person In Charge to ensure the bathroom areas are at times cleaned and well maintained.

Proposed Timescale: 31/07/2016

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 were not in place to ensure that all risks were being monitored and managed effectively. One resident was subject to a significant restrictive practice which had not been risk assessed as required by the organisations own protocols on the use of restrictive practices.

6. 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:
1. The Person In Charge & staff team have conducted a risk assessment for one resident who had a restrictive practice in place which was authorised by the Governance of Restrictive Intervention Committee.

2. The Person In Charge has commenced the updating of the risk register to ensure adequate oversight and safety in the Designated Centre.
3. The Risk Management Policy is currently been reviewed and updated by the Person In Charge this includes the emergency plan for the designated centre.

Proposed Timescale: 31/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were bedrooms which were inner rooms and therefore could impede the safe evacuation of the occupants.

7. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1. A fire evacuation plan is in place for the designated centre & being approved by a Fire Consultant.
2. Fire Drills have been carried out to ensure that residents can safely evacuate from their bedrooms and confirmed safe evacuation of all residents within appropriate timeframes. These were facilitated on the following dates since the inspection: 01/07/2016, 30/06/2016,
An additional schedule of fire drills is planned.
3. Each resident has a Personal Evacuation Plan in place and it has been updated to reflect the outcome of each fire drill.
4. All staff members have received mandatory fire safety training. Additional refresher training is scheduled for the staff team on the 6th & 12th of July 2016.

Proposed Timescale: 12/07/2016

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:
There were gaps identified in staff training for the management of challenging behaviour.

8. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
1. The Person In Charge will ensure that all staff members will receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.
2. Five staff members received training in positive behaviour support on the 28/6/16.
3. The remaining staff members are scheduled to attend on the following dates:
• 12/7/16
• 13/7/16
• 20/7/16
• 27/7/16
4. Eight staff members have received training in Therapeutic Management of Aggression & Violence on the 30/06/2016.
5. Eleven staff members are scheduled for Therapeutic Management of Aggression & Violence training on the 12th July 2016.
6. A schedule to ensure all remaining staff members receive this training and has it completed by 22/08/2016.

Proposed Timescale: 22/08/2016

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:
There was a delay in facilitating medical treatment which was recommended for a resident by an on-call CNM 3 on 22 April 2016.

9. Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
1. The Person In Charge and Clinical Nurse Manager 1 have meet the staff team at morning/evening handovers to emphasise the importance that all medical treatment recommended for residents is facilitated promptly.
2. Clinical Nurse Specialist in Health Promotion visits the designated centre Monday to Friday to ensure that resident's medical and nursing care is being met. This has continued since the inspection up to the 8th of July 2016.
3. A local head injury protocol has been devised and circulated to all staff members detailing actions to be taken for a resident who presents with a head injury. This was completed on the 25/5/16.
4. A protocol has been devised and circulated to all staff members in relation to recording vital observations. This was completed on the 29/6/16.

Proposed Timescale: 29/06/2016

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:** Adequate management systems were not in place to support residents to move out of the centre as planned. Management systems were not in place to ensure that the service was being monitored effectively. Actions from internal audits were not being addressed or implemented. **10. 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:** 1. The Person In Charge will review the Quality Enhancement Plan to ensure all actions from internal audits are prioritised & implemented within agreed timeframes. 2. See also actions & timeframes documented under outcomes 6, 7, 8.
Proposed Timescale: 02/09/2016
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** No annual review of the safety and quality of care had been facilitated in the centre, despite this being a requirement and action from an internal audit that had occurred in the centre in November 2015. **11. Action Required:** Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards. **Please state the actions you have taken or are planning to take:** 1. The registered provider nominee in conjunction with the PIC will complete an annual review of the quality and safety of care and support in the designated centre (2015). 2. All areas requiring further actions identified in the annual review will be prioritised for implementation through the Quality Enhancement Plan.
Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective arrangements were not in place for providing performance management and supervision for all members of the workforce.

12. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
1. The Performance Development Reviews (PDRs) are complete for all staff in this Designated Centre.
2. The Person In Charge is completing a revised schedule for all staff for Performance Development and Review
3. A revised supervision agreement procedure will be introduced to all frontline managers & Persons in Charge to enhance performance management.
4. The Director of Care and Support will commence bi weekly meetings with Persons in Charge, these meetings will be recorded on a supervision template to enhance performance management.

Proposed Timescale: 15/08/2016