

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Beeches
Centre ID:	OSV-0003322
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Limited
Provider Nominee:	John Hannigan
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

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: 16 May 2016 09:30 To: 16 May 2016 18:00

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

Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
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 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 was the third inspection of this designated centre. This inspection was to monitor ongoing compliance in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

How we gathered our evidence:

As part of the inspection the inspector visited the designated centre, met with three residents and three staff members. 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 and was home to four male residents. The provider had produced a document called the statement of purpose, as required by

regulation, this described the service provided. This document outlined the designated centre aimed to provide residential and day care services to male adults over the age of 18 with intellectual disabilities and complex medical issues. The designated centre was a detached bungalow located in the community.

Overall judgments of our findings:

Eleven outcomes were inspected against one outcome was found to be in full compliance. Four outcomes were found to be substantially compliant and six outcomes were found to be non-compliant moderately. Areas of improvement included the information contained within residents' files, medication management and in the area of risk management and emergency guidelines.

A staff member facilitated the inspection in the absence of the person in charge.

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.

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):

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.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

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

Residents were provided with access to therapy treatments within the designated centre, however, the written agreements did not include the fees for these services.

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:

Resident's social care needs were identified and they had the opportunity to participate in activities appropriate to their interests and preference. These included areas such as, hydrotherapy, holidays, equine therapy and community activities such as, attending sport events. However, the inspector found the wellbeing and welfare for residents required improvement in a number of areas within residents' plans including, the details contained, evidence of implementation and review of both personal and healthcare plans.

The system of personal social plans within the designated centre involved personal outcome measures encompassing 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 titled '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 five residents' plans and identified the following issues with these plans:

- One resident had an assessment completed in 2013. The inspector was unable to view this as staff did not have access to this within the IT system. Therefore, the inspector was unable to see evidence of review or progression in relation to this plan. A staff member informed the inspector a change of system occurred and staff had commenced a handwritten version of the assessment. This had commenced on 28 January 2016 and remained ongoing on the day of inspection. The inspector found this plan was not in accordance with the organization's policy for example, goals were identified and reviews were completed without an assessment.

- 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.

- Another plan viewed had an assessment dated 25 November 2014. The inspector asked to view the progression since the assessment was completed. The inspector was informed the goals set were ongoing since 2014. The inspector found this system was not reflective of practice, as some goals set had been achieved for example, going on holidays and community integration.

- Another resident had an assessment completed on the 26 October 2015 and an review on 15 April 2015. The inspector was informed the date of review was inaccurately recorded. The inspector found no evidence within the review of how goals set were progressing or who was responsible for assisting the resident to achieve these areas within a specified time frame. These included go on holidays, attend hydrotherapy and go to a musical.

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

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence for this maintained within the resident's files.

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):

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 the action remained outstanding.

The action related to the accessibility of the premises as previous identified in 2014. The driveway to the designated centre was very steep. The front gardens were not wheelchair accessible. The exterior of the property was largely inaccessible for residents. Risk assessments and control measures were in place in relation to the steep front driveway to the designated centre. The inspector found this aspect of the designated centre was not suitable or safe for wheelchair users and therefore, did not meet the needs of residents. Both residents and families highlighted their difficulties associated with the safety and suitability of the steep driveway and accessibility to the front gardens in their feedback to the inspector on a previous inspection.

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:

The inspector found the designated centre was suitable and safe for the number and needs of residents. Improvements were required in the area of risk management and emergency guidelines.

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 panel 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. The inspector found this system required review in relation to the regulation of water temperature on the day of inspection. The inspector also found the radiators were excessively hot. The inspector observed one resident self-mobilising in their wheelchair. However, the hallway was narrow and the resident's hands rubbed up against the radiator. The inspector brought this to staff members attention and maintenance rectified this on the day of inspection.

There were individual risk assessments for residents in place these included fire, epilepsy, aspiration and choking. The person in charge had reviewed and signed these off on the 30 January 2016 however, the senior service manager had not signed these off on the day of inspection for high risks as identified within the risks assessments.

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 that 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 and power failure. The plan identified the specific alternative accommodation to be provided in the event residents could not return to the designated centre. However, two documents were present one identified a day service and the other document identified a different location. The inspector found this system required review.

Fire drills had taken place and documents recorded the time taken to evacuate and any issues identified. The inspector viewed a fire drill completed in the 15 May 2016 involving two residents. Another drill was completed in January involving all four residents.

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

Judgment:
Substantially Compliant

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:
The inspector found appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans and the review of restrictive practice.

The inspector found residents positive behavioural support plans required improvement. Plans were being reviewed; however, the information contained within the plans was inconsistent. One behavioural support plan outlined residents did not require restrictive interventions. However, medication was prescribed and used for altering displays of behaviours.

A restriction intervention was also identified as required in the form of locking the kitchen door at specified times when reduced numbers of staff were present. There was no evidence of this intervention being reviewed by the organisations rights restriction committee or being reviewed by a multi disciplinary team.

Two staff members required training in the area of prevention, detection and responding to abuse. The inspector was informed these staff member would complete training in a number of weeks. These staff members would not be working in a lone worker capacity. Staff members spoken with 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):

No actions were required from the previous inspection.

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.

The inspector identified the following within residents healthcare plans:

- Duplication of documentation was evident in files for example, support plans and care plans were developed for the same aspect of care delivery for example, epilepsy. Within one file three versions of interventions were present for the same assessed need, each

consisting of inconsistent information. The inspector found these documents did not guide staff effectively in the areas of care delivery

- Plans in relation to the management of seizures did not reflect current practice for when emergency medication was to be administered as the administration sheet contained different information
- Information contained within residents health development plans did not correspond with support plans developed for the same aspect of care. The inspector discussed this with staff members on the day of inspection and found several areas of inconsistent information. For example, oral hygiene was required every two days by two members of staff. The inspector was informed this information was inaccurate
- The inspector found the recording of resident's seizures were inconsistent. The inspector identified some seizures were not identified within the resident's daily notes. Staff identified seizures were usually documented within in daily notes
- Some support plans and care plans were not based an assessment for example, pressure sore care plan was in place dated 5 February 2016. One of the interventions identified was the completion of an assessment. The inspector viewed a blank assessment document within the file. Staff conformed no assessment had taken place in relation to this aspect of care.

Residents had access to allied healthcare professionals, the inspector viewed evidence of chiropodists, optician, psychiatrist and physiotherapist input. The inspector found some recommendations were implemented. However, some physiotherapy recommendations required improvement in relation to the use of mobility aids. Two staff were required to assist a resident in relation to area of care provision. This was not evident within the resident's health development plan nor within the resident's daily notes. From the records available the inspector found the last time this intervention was implemented with the resident was 4 March 2016. Staff also confirmed this on the day of inspection.

Residents requiring modification to the texture of their food was outlined in the residents file. The inspector found this to be inconsistent for example, one resident was assessed by a speech and language therapists on 7 March 2008. This resulted in a grade three consistency being prescribed. On the 20 November 2009 the resident was reassessed and a grade two consistency was prescribed. The inspector also viewed documentation from the residents' GP this identified the resident required 2-4 scoops of a thickening agent. The inspector found staff were not afforded with consistent documentation to guide their practice. Staff members confirmed a grade three consistency was provided to the resident. The inspector also viewed a health and development plan dated 24 February 2016 this identified no current problems with eating and drinking. However, the inspector found a support plan had been developed for eating and drinking for the same resident. The inspector found documents inconsistent and not reflective of current practice nor were plans effectively guiding evidence based practice.

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 for refreshments and snacks were available for the residents outside mealtimes within the designated centre.

Residents had access to a GP, four residents had received an annual review including phlebotomy tests as required for some residents due to their medication.

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:

The inspector found the medication management system within the designated centre required some improvement in relation to the management and administration medication.

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 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 and the 12 hours clock was specified in the other document.

The maximum dosage of p.r.n. medicines (a medicine only taken as the need arises) was not specified for all p.r.n. medication viewed.

No guidance was available in relation to the administration of some p.r.n. medication. The inspector found staff members were not guided effectively and consistently in the administration of medication for example, when a resident was anxious.

The designated centre had no guidance available for the process of second dispensing of medications and the organizations policy did reflect the practice within the designated centre.

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.

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

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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 area of annual reviews and staff meetings.

There was no annual review of the quality and care completed within the designated centre, staff identified this was due in May. The inspector requested to see the previous annual report however, this was unavailable.

The inspector requested to view minutes of staff meetings within the designated centre, however, these were very limited. Two sets of minutes was present for 2016 with the most recent dated 06 March 2016. The inspector found the frequency of staff meetings required improvement.

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 on 26 June 2015 and an action was developed to address the areas identified. Another visit was conducted on 14 and 15 January 2016 this also had an action plan developed.

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 found there was a clearly defined management structure this 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.

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 safeguarding training, prevention, detection and response to abuse.

The inspector viewed the proposed and actual staff rota's within the designated centre. 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.

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 for example, assessed needs of residents, safety issues and training were discussed. Revised supervision forms had commenced with a focus on three main functions including, executive, education and support.

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):

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

Findings:

The inspector reviewed this outcome in respect of the actions identified from the previous inspection and found the actions were achieved.

The inspector found the retrieval of schedule 3 documents difficult as some documents were present in duplicate versions. For example, support plans and care plans were developed for the same aspect of care delivery for example, epilepsy. Within one resident's file three versions of interventions were present for the same assessed need, each consisting of inconsistent information. The inspector found these documents did not guide staff effectively in the areas of care delivery

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	The Beeches
Centre ID:	OSV-0003322
Date of Inspection:	16 May 2016
Date of response:	10 October 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 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:

Some written agreements viewed did not contain information in relation to additional fee for services provided within the designated 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 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:

Service Level Agreements now include the fees charged by services such as massage that resident's access in their home.

Proposed Timescale: 30/06/2016

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:

Some personal plans viewed did not have an annual review completed.

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:

All resident's within the location will have an annual review completed.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

Some residents did not have a comprehensive assessments present within the designated centre.

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:

All assessments to be improved in content, evidence of implantation and review.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

Some personal plan reviews did not assess the effectiveness of the plan and take into account changes in circumstances and or new developments.

4. 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 Personal Planning process is currently under review. The reviewed personal plan will be more effective in taking into account changes in circumstances and new developments.

Proposed Timescale: 31/01/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Access to the designated centre was limited as non-ambulant residents could not leave the premises without the use of transport.

5. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

A proposal has been submitted to improve the garden and driveway.

Proposed Timescale: 30/09/2016

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:

The system in place in the designated centre for the assessment, management and ongoing review of risk required improvement in relation to both location and individual risks.

Two emergency evacuation plans were present both identified two different locations as an alternative accommodation.

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:

The emergency evacuation plans are to be amended to identify a clear plan when alternative accommodation is required.

Proposed Timescale: 30/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Reviews were not present in relation to an environmental restriction in the form of locking the kitchen door.

7. Action Required:

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.

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

The rights restriction was reviewed by the rights review committee and approved.

Proposed Timescale: 02/06/2016

Theme: Safe Services

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

The information contained within some behavioural support plans did not provide appropriate information for staff members to consistently manage behaviours. Some plans viewed were inconsistent for example, chemical restraint was not identified when prescribed.

Some sections of behavioural support plans were blank.

No guidance was contained within the behavioural support plans for staff when to administer medication to alter the resident's behaviour.

8. 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:

Positive Behaviour Support Plans were amended. Chemical restraint was discontinued on prescription when not required.

Proposed Timescale: 31/08/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Healthcare plans did not effectively guide practice for example, seizure management plans and oral hygiene plans.

Implementation of some recommendations such as, physiotherapy was not evident within the resident's health development plan nor within the residents daily notes.

Some support plans and care plans were not based an assessment for example, pressure sore care plan.

The recording of resident's seizures were inconsistent.

9. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

Healthcare plans are currently under review. The reviewed healthcare plans will include all the above.

Support plans to be reviewed and suitable assessments put in place.

Seizures to be recorded as per protocol within the location.

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:

Residents requiring modification to the texture of their food was inconsistently documented within plans.

10. 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:

Speech and Language confirmed the correct protocol of individuals.

Proposed Timescale: 30/06/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The administration recording sheet did not match the administration record.

The maximum dosage of p.r.n. medication was not specified for all p.r.n. medication viewed.

No guidance was available in relation to the administration of some p.r.n. medication.

11. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The administration records were amended to have the 24hour clock on them instead of the 12hour clock.

Maximum dosages for PRN medication reviewed and updated on medication kardex's.

Guidance now in place to guide staff in relation to the administration of the PRN medication.

Proposed Timescale: 30/06/2016

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.

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:

Policy to be amended to allow for non-nursing staff to second dispense medication for outings on a regular basis, to match with current practice.

Proposed Timescale: 31/12/2016

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:

An annual review was not present within the designated centre.

13. 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:

Annual review was completed on the 27th May 2016.

Proposed Timescale: 27/05/2016

Theme: Leadership, Governance and Management

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

Effective arrangements to support, develop all members of the team to exercise their professional responsibility for the quality and safety of the services within the designated service through team meetings was limited.

14. 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:

Staff are provided with quarterly 1 to 1 supervision. Staff team supervision meetings take place quarterly also.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The actual staff rota required a coding system.

15. 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 now in place.

Proposed Timescale: 16/07/2016

Theme: Responsive Workforce

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

Two staff members required training in the area of abuse prevention, detection and response.

16. 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:

Staff have been trained or are scheduled to attend training.

Proposed Timescale: 17/01/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Some of schedule 3 documents were present in duplicate versions containing different information.

17. 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:
A review of documentation is ongoing.

Proposed Timescale: 31/01/2017