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:	Camphill Community Kyle
Centre ID:	OSV-0003625
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	2

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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 August 2016 17:30	22 August 2016 20:30
23 August 2016 08:30	23 August 2016 13:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce

Summary of findings from this inspection

This was the third inspection of this centre.
This inspection was undertaken in response to a significant concern received by The Health Information and Quality Authority (HIQA) in relation to the care and welfare of residents in the centre. On reviewing the nature of the concern and taking into account the findings of the previous inspection it was decided to undertake an unannounced and out-of-hours inspection.

A monitoring event was undertaken in 2014 and the registration inspection was undertaken in April 2016. As a result of the findings of that inspection an immediate action plan was issued to the provider regarding training in fire safety and the management of choking incidents. It was decided that a further full follow up inspection would be required to ensure the centre practises were complaint with the regulations.

As a result of concerns regarding overall safeguarding systems and responses within the organisation as a whole the provider was requested to attend a meeting with HIQA in April 2016. Following this meeting a warning letter was issued and the provider was requested to submit a plan to improve safeguarding systems within the organisation.

How we gathered our evidence
The inspector met with seven residents, spoke with two residents and observed practices and residents' routines. The residents who could communicate with the inspector stated that they enjoyed their activities kept busy and one was very happy with the changes planned for the living accommodation. The inspector observed that residents appeared to be at ease with staff.

The inspector also met with the person deputising for the person in charge, volunteers/co-workers, the local designated safeguarding officer, senior co-workers and a house coordinator.

The inspector reviewed documentation including medicine records, staff supervision records, resident's records and personal plans, rosters, activities schedules and daily diaries.

The inspector focused on the six outcomes and aspects of the outcomes which pertained to the details of the concern.

Description of the service
The statement of purpose states that the service is designed to provide long-term residential services to people with moderate to severe intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviours.

It is located in a rural area on its own grounds. Transport is required to access the local town and amenities.

Overall judgement of our findings
The findings of this inspection are influenced by a number of factors including the fact the some residents and staff were on leave, changeover of a number of the volunteer staff had recently taken place and difficulties in accessing some documentation, incomplete documentation and lack of clarity available from staff as to actual procedures in some instances. This was not a consistent finding across all units visited however. The person deputising for the person in charge was also new to the post.

Overall, the inspector was not satisfied that the provider had put systems in place to ensure that the regulations were being met. This resulted in potential risk and the potential for poor quality of care for residents in some cases, the details of which are described in the report.

The inspector found that while the details of the concern were not fully substantiated there was enough evidence to suggest that some practices required review in order to ensure the safety and quality of resident lives.

The inspector found that the systems in place resulted in resulted in:
• poor emergency medication management systems which could expose residents to risks (outcome 8 and 12)
• lack of adequate oversight and decision making in regard to the use of restrictive practices which impacted on residents welfare (Outcome 8)

• inconsistent implementation of prescribed clinical interventions and care planning which could impact on residents' care and development (outcome 5)
• limited access for some residents to meaningful activities and poor skill mix and availability of experienced staff which impacted on the support available to residents and their quality of life (outcome18)

It was of some concern to HIQA that misleading information was provided in regard to the outcome of a matter of significance which had been raised at the previous inspection. This was discussed with the person in charge during and following the inspection.

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

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
While systems for needs assessment and personal planning were evident improvements were required to ensure the necessary interventions agreed following assessment were implemented.

There were a range of assessment tools used and number of the clinical assessments required by the previous inspection had been sourced. These included occupational and speech and language therapy. Some of the recommendations of these clinicians had not as yet been implemented such as communication passports but were in development. A number of staff were scheduled to receive training in sign language to support communication with the residents. Behavioural supports had been assessed for some residents although the reports were not available.

A psychological assessment required since 2015 had not been sourced for a resident with significant needs. In addition, the interventions agreed by therapists were not consistently implemented. For example, a sensory assessment carried out in 2015 provided a detailed programme to be implemented for the resident. This was to be followed and documented so that its effectiveness and suitability could be assessed. The records available showed that this had been carried out intermittently from January to April in 2016 and one in August 2016.The resident had complex needs and this work was considered crucial to stabilising behaviours and as a result improving the quality o the resident life.

A number of residents' records cited the potential for weight loss or gain and refusal to eat. The monitoring records were not completed consistently and the inspector was informed that there was no set protocol for how this would be monitored. There was no corresponding care plan to guide staff practice as to how to support residents who were dependent on staff to assist with eating. This lack of direction could have potential consequences for the resident's safety and dignity.

A number of residents had varied and meaningful social activities and a significant improvement was noted in one resident's access to activities and community life. However, in one instance the resident's daily routines as outlined were extremely limited with swimming once per week and outdoor activity and pottery one per week. Staff explained that the resident did not have the capacity to participate in the latter activity. A bath was listed as the activity on two days of the week. While it is understood that this procedure took time, significant staff support and was enjoyable for the resident it could not be ascertained if bathing was limited to twice per week. The staff on duty stated that it was.

Daily records seen indicated that a number of residents went to bed regularly at circa 8 or 8 30 pm although this was not the case across all units. Getting up times varied from early on weekdays to 9:30 10 am on the weekends. This was not the case across all units. Staff could not articulate the measures in place to ensure residents could access food or drink after supper time which was 6pm.

Some, but not all of these issues can be explained by the need to increase core staff to support the volunteer system which may result in a lack of follow through and oversight of personal plans made and capacity to provide adequate care for the residents.. This is actioned under outcome 17 workforce.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
This outcome was not reviewed in its entirety. However, inspectors noted that some risk areas were not consistently identified or assessed and did not have adequate control measures in place as an ongoing process.

These findings are demonstrated by the following:
• lack of clarity regarding the prescribed use of emergency medication
• lack of monitoring of seizure activity
• risk to residents of access by unauthorised person due to the exit doors being left open at all times day and night.

The protocol for and the administration records relating to the use of emergency medication was unclear and in one document it was incorrect .The records of administration written by staff differed in the timing of the administration of the medication. From the records available the inspector could not actually ascertain if the medication had been administered according to the correct protocol on a number of occasions. This was discussed with the person in charge who concurred with the finding and discrepancy.

While seizure activity was recorded and monitored during the day, night checks on the resident indicated no evidence of such incidents. As no alerting mechanism was used and the record showed staff monitored the resident only hourly the validity of this record cannot be determined.

The exit doors in all units were not secured at night. The reason given for this were that an integral part of the community ethos was the free movement for the co-workers between the units. The security of the residents who could not protect themselves from unwanted intruders was not considered.

The providers action plan indicated that emergency lighting had been installed where required and the provider had forwarded an updated action plan on 29 June 2016 which also indicated that staff had undergone the required training in the management of episodes of choking first aid , the use of the evacuation sheets where required and fire management. A newly recruited volunteer informed the inspector that she had been given medication management training and fire training was seen to be scheduled at the time of the inspection. The acting person in charge confirmed these findings.

The inspector saw that a manual handling plan and a plan for the safe use of the hoist had as required being implemented.

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

Findings:
There was a suitable policy on the protection of vulnerable adults and training had had taken place as required. Staff spoken with were able to describe the situations which would constitute abusive behaviours and were clear on who they should report to. The inspector was informed that there were no concerns or allegations of this nature being managed at the time of the inspection.

The local designated officer had been found to be very clear on her role at the previous inspection in April 2016.

The inspector remained concerned at the management of and consideration given to restrictive practices despite improvements which had been made. There was a detailed policy which was in accordance with national guidelines but this was not adhered to. There was again evidence of inconsistent risk assessment, lack of oversight, satisfactory rationale and understanding as to the impact and the risks of the use of some practices.

All restrictions had been reviewed at some level since the previous inspection by occupational therapist, behavioural specialist or internally by the management team.

A number of internal locked doors remained in place. These were located in some resident's sleeping quarters to prevent access to other areas of the units although the resident had access within them to corridors and toilets. However, the risk assessment and rationale for the use of these locked doors was contradictory in the documentation reviewed and in the rationale as outlined to the inspector. In some instances no clear rationale was available. In others the risk of absconding was identified or the risk of accessing food in the kitchen was noted. In some instances a sleeping or a waking night staff was allocated to attend to the resident in these areas if they got up.

The re-evaluation of the internal locked doors was not robust and accounted only for the night time procedures. It did not consider whether these doors were locked due to the failure to secure the exit doors at night. A rest period was taken after lunch each day. During this time a number of residents went to their bedrooms and the doors leading to the reminder of the unit was locked. There were different reasons given for this but the staff understood it to be a means of them getting a rest period. If, for example, a resident continued to be active or walk around incessantly in the main body or outside of the unit this meant the staff did not get a necessary rest period.

There was no register of restrictive procedures and no records available of the number of times these procedures were used. There was no evidence that they were the least restrictive, had clear and reasonable grounds for implementation, that they were measures of last resort, used for the shortest time possible or that obvious alternatives

had been trialled.

This is of concern given the findings in outcome 5 social care where interventions which may help to mediate resident's incessant behaviours were not implemented.

While there were some behaviour management plans in place staff informed the inspector that they had not been advised as to how to manage one resident's behaviours other than to physically block the resident as they had observed others doing.

It is fully acknowledged that unsuitable audio monitors had been removed and more suitable replacements such as sensor alarms were in the process of being sourced. Waking night staff had been employed to support one resident without recourse to unusual restrictions and this was seen to have had very positive impact on the residents' quality of life, safety and behaviour.

The purpose built fully secluded (contained on all sides) system used to provide sleeping accommodation for one resident identified as unsuitable at the previous inspection was still present. When closed it required the removal of two bolts to gain access to, or visual sight of the resident due to its height. Inspectors had been informed via the provider's action plan that this was being reviewed for a more suitable system and also on 27 July that this sleeping system was no longer in use. The inspector found that this information was not accurate.

The only change made to the suitability or safety of this system was the provision of a portable two step ladder to allow staff visual access of the resident. No provision had been made for the substantive risk which was the need to alert staff to seizure activity or the impact of the system on the resident. This is actioned under outcome 7 Health and Safety.

The management of residents finances was not reviewed on this inspection.

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:
The provider was compliant with this regulation in terms of residents' overall healthcare needs and residents had access to appropriate general medical and allied healthcare services.

Residents healthcare needs were reviewed at a minimum annually and as required. There was good access to GP services and regular monitoring of, for example, bloods where this was indicated. Reviews of resident's health were undertaken. However, the GP does not record the outcome of the visit. This was done by the staff and in one significant area the record was not accurate.

In line with their needs the inspector was satisfied that residents had ongoing access to allied healthcare professionals including dentists and chiropodists or neurology where required. Records of referrals and reports of these interventions were maintained in residents' files.

There was evidence on documentation that residents and their representatives were consulted about their health and medical needs.

As observed by inspectors and confirmed by the residents the food was nutritious, fresh and choices were accommodate. Residents helped to prepare the food with staff assistance where this was necessary although some access to the kitchens was restricted. Where specific dietary needs were identified by dieticians these were seen to be adhered to. Issues identified in weight monitoring and personal planning are actioned under outcome 5 social care.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
This outcome was not reviewed in its entirety but the inspector found that there were systems in place for the safe receipt of storage administration and return of medication. However, the protocol for use of and administration of emergency medication was not clear or robust enough to guide practice and ensure the safe delivery of care to the residents. The protocol for and the administration records relating to the use of emergency medication was unclear and in one document it was incorrect. The records of

administration written by staff differed from the protocols in the timing of the administration of the medication. From the records available the inspector could not actually ascertain if the medication had been administered according to the correct protocol on a number of occasions. This was discussed with the person in charge who concurred with the finding and discrepancy.

Staff had received training in medicines management. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Since the previous inspection a staff member had been given responsibility for auditing the administration practices for medication and the staff transcribing practices had ceased. A number of medicine errors were noted and actions taken to address the reason they occurred. In two of these instances residents had accessed staff medication from co-workers rooms, one of which was significant and had taken the medication. Medical advice was sought with no ill effect. The actions taken to prevent this reoccurring were satisfactory.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The provider was aware of the requirement to notify HIQA of any absences of the person in charge. This was complied with. The person in charge was seconded to another post within the organisation and a team leader had been appointed to deputise for the person in charge in the interim. The documentation was forwarded to HIQA. The arrangement as outlined was satisfactory. As he is the coordinator of one unit arrangements were being made to allocate an addition qualified social care staff to this unit to ensure consistency of care.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The inspector found that deficits remained in the skill mix of staff and the availability of more experienced staff to support the residents. On the evening of the inspection in one unit there was a very new volunteer present with two residents. She was unable to tell the inspector how she would access help or support should this be necessary. There was no roster available which could be seen by the inspector and therefore a lack of clarity as to who was available for the following days.

Matters identified in outcome 5 Social Care such as the implementation of prescribed interventions and in outcome 8 Safeguarding and Safety indicate that a more structured approach to staffing and deployment and to core staff to support the volunteers is necessary. This had been agreed by the provider following the previous inspection.

An additional waking night staff had been had been employed to support one resident at night to very good effect.

General training records and a full review of supervision records were not reviewed on this inspection.

Judgment:
Non Compliant - Moderate

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:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003625
Date of Inspection:	22 August 2016
Date of response:	14 September 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:
Resident's daily routines and supports were not consistently directed by their assessments, clinical guidance and care needs.

1. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:
• With reference to the resident in question, we have arranged for a psychological assessment privately (as this resident cannot access the public services due to long waiting lists). Because resident, has limited capacity to participate in many of the social activities, we acknowledge that the staff informed the inspector that the resident only receives two baths a week, these hydro-baths are part of the weekly activity - they are sensory, therapeutic and relaxing, however, this resident's personal care is adhered to on a daily basis. Again we have put in place additional sensory sessions which are now formalised in our therapy building and detailed records will be kept of each session. These commence week of 12th September 2016.
• All residents will be weighed on a monthly basis (four each week) by our RGN commencing Monday, 12th September 2016, the weight charts will be monitored on a monthly basis by the Person in Charge.
• All residents are engaged with Speech and Language Therapists (as a follow up action from our last inspection in April this year) Some residents, where relevant, have had swallow assessments and have detailed "swallow plans" to which we are adhering.
• We are in the process of introducing waking night staff for the house in question. We will have waking staff cover in this house by end October 2016. In the meantime we have begun a process whereby all residents are offered a light snack prior to them going to bed. This is monitored by the House Coordinator.
The residents have the ability to communicate to staff when they wish to retire which generally occurs around 20.00pm/20.30pm. The third resident in this house retires most nights after 22.30pm at his own accord. All residents are supported with their night time routines which includes washing of face and hands and dental routine.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to required psychological assessments.

2. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
With reference to the resident in question, we have arranged for a psychological assessment privately (as this resident cannot access the public services due to long waiting lists) and we are currently awaiting an appointment date.

Proposed Timescale: 14/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no satisfactory support plans to monitor residents nutritional needs and to assist residents with eating.

3. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
• All residents are engaged with Speech and Language Therapists (as a follow up action from our last inspection in April this year) Some residents, where relevant, have had swallow assessments and have detailed "swallow plans" to which we are adhering.
• All residents in have regular GP check-ups. Should issues arise regarding their nutritional and dietary needs, residents are referred to the appropriate professional which is already the case with some of our residents.

Proposed Timescale: 14/09/2016

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:
Systems for the identification and management of risk were not satisfactory in relation to:
• lack of monitoring of seizure activity
• risk to residents of access by unauthorised person due to the exit doors being left open at all times but especially at night.

4. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
•The resident did return to Kyle for two nights in August to facilitate them to have a holiday. They were supervised on a half hourly basis by a waking night staff. We are presently supporting this resident with their transition to the other community whilst in their family home. In relation to one other resident such measures outlined i.e. mattress sensors have been implemented since our registration inspection.
• All of the residential unit doors are now locked from 10:30 until the following morning.

Proposed Timescale: 14/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of restrictive procedures were used which were not decided upon and implemented in accordance with national guidelines and best practice:
• the rational for the use of some restrictive practices was not clearly developed
• the procedures were not risk assessed
• alternative had not been tried or sourced
• the procedures were not adequately reviewed for suitability or effectiveness
• they were not assessed as being the least restrictive or for the shortest duration.

5. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
With the introduction of night staff in the coming months a number of these restrictive practices will no longer be in use. Specifically the switch released doors will be removed with the introduction of waking night staff as adequate supervision will be in place to support the residents at night. 31/10/16
Whilst rest hour is taking place a member of staff will be assigned to support the resident if they do not wish to have a rest hour. Immediate effect
Any restrictive practices thereafter will be reviewed by a MDT in relation to the restrictive practice itself and the MDT's respective areas of expertise.

A register of restrictive practices will be put in place by the end of October and all restrictive practice notified accordingly.

The unsuitable bed h\s been dismantled and is no longer in use. The bed had not been in use since April – regrettably the bed was used on one occasion in August.
This one occasion will be reported to the Authority in the Quarterly Report on 31st October 2016.

Proposed Timescale: 31/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems to guide staff to support residents with behaviours that challenge and the use of restrictive practices were not sufficient.

6. 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:
All residents have a behaviour support plan in place, we will ensure that all staff have read and understood these as part of their induction process. Also behavioural specialist will be holding behaviour support clinics every three to four months in Kyle in order to have greater multi-disciplinary input into the challenging behaviour of residents.

With the introduction of night staff in the coming months a number of these restrictive practices will no longer be in use. Specifically the switch released doors will be removed with the introduction of waking night staff as adequate supervision will be in place to support the residents in question at night.-31/10/16.
Any restrictive practices thereafter will be reviewed by a MDT in relation to the restrictive practice itself and the MDT's respective areas of expertise.

Proposed Timescale: 31/10/2016

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:
Systems for the administration of emergency medication did not protect residents. There was no clear guidance on the prescribed use of this medication.

7. 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:
All protocol on the administration of emergency medication in particular midazolam and stesolid will be reviewed by the house co-ordinators, PIC and GP to ensure that they correspond with best practice. These procedures will be explained clearly to the relevant staff. Also as part of our training for staff they take part in a course on the administration of midazolam and stesolid and also in the administration of medication. No staff will administer medication of any sort unless trained to do so.

Proposed Timescale: 30/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an over reliance on volunteers and poor deployment of staff to ensure residents care needs were being met and not impacted upon by staffing.

8. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Waking night staff will be employed in our 3 large residential units where the need is required for night staff. Also we are in the process of employing deputy house co-ordinators (social care workers) to support the co-workers and house co-ordinators on foot of our most recent inspection. This in turn will provide a more comprehensive service for the residents.

Our RGN's have also taken on more clinical responsibility in the community and have added to their existing duties for example medication audits, weighing of the residents and general nursing observations.

A behavioural specialist will be holding behaviour support clinics every three to four months in order to have greater multi-disciplinary input into the challenging behaviour of residents.

Some of our residents also have access to some public services for example G.P., Psychiatry, Dietician, Occupational Therapy, and Physiotherapy.

Proposed Timescale: 31/10/2016