<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Vale Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004458</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Wicklow</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Sunbeam House Services Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>John Hannigan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
</tr>
</tbody>
</table>
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.
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: 24 August 2016 10:00
To: 24 August 2016 20:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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</thead>
<tbody>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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</tbody>
</table>

Summary of findings from this inspection
Background to the inspection:
This was the second inspection of this designated centre. This inspection was to monitor ongoing compliance with the regulation and standards. No residents resided in the designated centre during the previous inspection. The house was opened as a result of the provider reducing numbers in another setting and sourcing accommodation for five residents in the community.

How we gathered our evidence:
The inspector visited the designated centre, met with four residents and five staff members. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs and 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 was operated by Sunbeam House Services (SHS) Limited and was based in Arklow, County Wicklow. There were five residents living in the designated centre. On the day of inspection one resident was receiving treatment in an acute setting. The provider had produced a document titled the statement of purpose, as required by regulation, this described the service provided. The
designated centre aimed to provide residential care for both male and female adults over the age of 18 with intellectual disabilities. Residents with complex medical issues and physical disabilities with high level of dependency were accommodated within the designated centre as outlined in the statement of purpose. Staff members identified significant improvements had occurred for residents since moving to this designated centre. This was evident through the reduction of self injurious behaviours and displays of other behaviours. Another staff member identified residents now get the opportunity to go out into the community more frequently. Staff reported residents seemed happier now as they communicate more with staff in their own preferred manner.

The designated centre was a split level bungalow located in the community.

Overall Judgments of our findings:
Nine outcomes were inspected against and four outcomes were found to be substantially compliant. Five outcomes were found to of moderate non-compliance. Areas of improvement included the information contained within residents' files, medication management and the assessment of social care needs. Staff members facilitated the inspection as the person in charge was on leave.

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 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 residents had the opportunity to participate in activities appropriate to their interests and preference. These included areas such as, holidays and equine therapy and community activities such as, shopping. However, the inspector found the wellbeing and welfare for residents required significant improvement in a number of areas within residents' plans. This included, 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:

Three residents did not have an assessment completed every three years as identified within the organizations policy. One assessment viewed was dated 19 March 2012, the second assessment was dated 27 March 2015 and the third assessment was dated the 14 October 2012. These assessments related to when residents lived in another location.
The fourth plan had an assessment dated 22 October 2015, this assessment had yet to be finalised and the fifth plan was a hand written version, as the computerized version of the assessment had been deleted. Staff had re completed the assessment process, this was dated 20 March 2016. No other assessment was available since the resident moved into the designated centre in September 2015. In addition to the completion of an assessment a member of the organizations quality team was also required 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 residents due to delays in this sign-off process.

The review process of plans was unclear as some plans present had no annual reviews present, staff also confirmed this on the day of inspection.

Some goals set were no longer current to resident's circumstance for example, choose where I want to live. The inspector found this was achieved for residents as they had relocated to the current house in September 2015.

Duplication of documentation was evident in resident's files for example, support plans and care plans were developed for the same aspect of care delivery for example, weight monitoring. 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.

Information contained within resident's 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 inconsistencies within the information.

The monitoring and implementation required to assess the effectiveness in treatment or deterioration 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. For example, a sleep hygiene plan was in place without any assessment present. Daily notes viewed by the inspector identified the resident "slept well". Staff members were unable to provide evidence as to why this intervention was in place.

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

**Findings:**
The inspector reviewed this outcome in respect of the actions identified from the previous inspection and found all of the actions had been addressed.

The inspector found one leather chair in need of repair or replacement, one resident was using this chair on the day of inspection. The seat of the chair was ripped with padding, metal and timber exposed along with food items embedded on the seat. Staff identified this chair would not be used by residents until it was repaired or replaced.

The inspector requested evidence for the service or maintenance of pressure relieving mattress. Evidence was present for the service of beds however, no evidence or confirmation was present if this service included the pressure relieving mattress. Staff members were also unable to confirm if these products were serviced.

One resident was unable to leave the designated centre without the use of a vehicle. This was due to the inaccessibility of the footpath opposite the entrance of the designated centre. The inspector viewed minutes of meetings where staff members had identified this as issue. The person in charge had made attempts to rectify this issue with the local authority however, this remained outstanding since the designated centre opened.

**Judgment:**
Substantially Compliant

## Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
The inspector found the designated centre was not suitable and safe for the number and needs of residents. Improvements were required in the area of fire evacuation and risk and sharp management.

The inspector asked to view fire drills, these were not present within the designated centre and staff subsequently provided these to the inspector following inspection. The inspector viewed a drill had taken place on 1 June 2016 at 3:50 am and all residents evacuated the designated centre. The duration of time to evacuate the designated centre was 14 minutes. The inspector found this time frame to be unsafe. However, the inspector did view areas identified within in the drill were addressed for example, no lighting was available in the assembly point, this was addressed following the drill.

The inspector found fire contentment due to the layout of the house required significant improvement. Within the house some residents resided at a lower level and a staff sleepover room was located at an upper level. Improvements to ensure appropriate fire containment measures were in place to protect the means of escape for residents within the designated centre was required. Both lower and upper levels rooms had no means of escape except via the escape routes at the entrance level of the building. The staff member in the sleepover room could escape out via the window and wait for assistance to assist them to ground level. However, this would leave only one staff member available to evacuate all five residents, some of whom had significant mobility issues.

The inspector viewed five residents PEEPs (personal emergency evacuation plans) and found some of these required review in order for all staff to be guided effectively.

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. However, the inspector found this system required review, as additional risks were also identified during inspection for example, sharp injury and fires.

Sharps were used within the designated centre and the inspector requested to see documentation in relation to the management and disposable of sharps. These were not available, staff also confirmed this on the day of inspection. The sharps box was unidentifiable as no label or tagging system was evident.

There were individual risk assessments for residents in place these included, self harm and choking and aspiration the person in charge had reviewed and signed these off.

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. Annual service was completed in January 2016 and the previous quarterly completed in June 2016. Staff also completed checks on the exits, alarm panels and equipment some gaps were evident and these were highlighted to the person on the day of inspection.

The designated centre had 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, power failure and possible gas leakage. The plan identified the specific alternative accommodation to be provided in the case that residents could not return to the designated centre.

**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:**
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 restrictive practice. The action identified from the previous inspection in relation to staff receiving training in safeguarding and protection was achieved.

All of the residents had positive behaviour support plans in place. However, information within them was unclear and therefore was not effectively guiding practice. Issues identified included:

- Information contained within one plan was no longer current for example, attending art classes in a day centre.
- Interventions within another plan did not guide staff effectively or consistently despite this plan being signed by the person in charge and a keyworker on 25 February 2016. The plan identified the resident would be asked to stop engaging in the behaviour and informed they would have to leave the room. A hand written note stuck onto the typed document contained the following information "where will the resident go? and for how long? Please amend". Staff members were unable to provide clarity to the inspector in relation to this. The inspector found this plan ineffective in guiding staff members in a consistent approach to displays of behaviours.
- CPI (crisis prevention intervention) interventions were identified within another plan with no identification of the type required for the resident. Another plan viewed identified no CPI was used however, other information within the plan identified it was required.

Protocol to manage engagement in behaviours was not consistent within positive behaviour plans. Documents were unclear in relation to the administration of chemical restraint.

Restrictions in relation to removing residents to other locations were also evident within plans with no evidence of multidisciplinary review or rights review.

Intimate care plans were in place however, some of the plans were not reflective for current practice, in relation to the gender of staff to provided intimate care to residents. This was also confirmed by staff on the day of inspection.

There was a policy in place on the prevention, detection and response to abuse. Staff members spoken with by the inspector were knowledgeable in relation to the management of an allegation of abuse. Staff members could outline the procedures to be followed should such an allegation arise.

**Judgment:**
Non Compliant - Moderate

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**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 best possible health. However, improvements were required in the information contained in resident's healthcare plans and the implementation of recommendations from allied health professionals.

The inspector viewed plans in relation to the management of seizures. The inspector found theses plans did not contain information on the current practice of using oxygen therapy as prescribed.

The inspector viewed two pressure relieving products in operation for two residents, the inspector requested information in relation to the use of these products however, staff members were unable to provide this to the inspector. The inspector viewed the settings
of these devises and established these were not used correctly for example, one resident had their devise set at 80kgs. On viewing the resident’s file the resident’s weight was 41.5kg as recorded on 11 June 2016. No information or guidance was available within the designated centre for staff to follow in relation to this intervention. Nor was there any review of how effective these devices was for residents.

Residents had access to allied healthcare professionals, the inspector viewed evidence of this including, dentists, optician, psychiatrist and physiotherapist. The inspector found some recommendations were adhered to. Others required improvement such as, physiotherapy in relation to daily orthotic usage records were blank for seven consecutive days from 9 to 15 of the Month.

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

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

Residents requiring modification to the texture of their food was clearly outlined in the residents file. Staff members were knowledgeable in relation to the implementation of resident's food requirements. The inspector viewed feeding, eating, drinking and swallowing (F.E.D.S) assessments in place for some residents.

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

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 12. Medication Management</th>
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</thead>
<tbody>
<tr>
<td>Each resident is protected by the designated centres policies and procedures for medication management.</td>
</tr>
</tbody>
</table>

| Theme: |
| Health and Development |

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

| Findings: |
| The inspector found oversight of the medication management system within the designated centre required improvement. However, the issue identified in the previous inspection had been addressed. |
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.

Non-compliance identified with regulations included:

Maximum dosage for p.r.n. (a medicine only taken as required) medication was not identified for all p.r.n. medication.

Accurate stock balances were not maintained for some medications for example, antidepressants. This was discussed with staff members and administration sheets were viewed. The number of medications administered in one instance did not correlate with the amount of medication remaining in stock. Staff members informed the inspector a medication error form would be completed. The inspector was also informed the G.P. was also contacted about the drug error.

Medication was present without any label identifying the name and the expiry date.

Stock balance sheets did not contain accurate information for example, incorrect medication was identified; 400mg tablets were specified in the stock records however, 200mgs was the dosage of medication present in the designated centre.

Some prescriptions did not match information provided to staff for example, oxygen therapy was prescribed at 2ml however, during a team meeting it was documented to administer up to 15 mls.

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

Administration sheets 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.

There was a system in place for recording, reporting errors and reviewing medication and the inspector viewed examples of this.

**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 relation to the follow up actions of some audits completed.

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 17 and 18 November 2015 and another one was completed on 22 June 2016.

There was no annual review of the quality and care completed yet as this designated centre opened in September 2015 however, information gathering had commenced for the process.

The person in charge and other staff members had responsibility for carrying out regular audits in the designated centre, for example, staff knowledge, housekeeping audit and equipment audit all dated 21 July 2016. Clear follow up on actions were not evident in relation to medication audits for example, a general medication audit dated 26 May 2016 and another medication audit on 21 July 2016. Both of these audits contained areas for improvements however, no follow up was evident within the designated centre and staff available within the designated centre were unable to provide this to the inspector.

The inspector viewed minutes of the person in charge attending the senior management team meeting dated 26 July 2016 areas discussed related to the whole organization including training, budgets and safeguarding and protection.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings) dated 17 June 2016. Issues relating to transport, volunteers, complaints and incidents and staffing were areas discussed during this meeting.

The inspector viewed minutes of regular staff meetings within the designated centre. There was also clear evidence of information sharing between relevant management teams such as, between the senior management meetings and the staff meetings. All meeting minutes were available for staff members to read within the IT system and they were encouraged to do so.

The inspector found there was a clearly defined management structure with lines of authority and accountability identified. The designated centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service. The person in charge was not present during this inspection. however, this person was met by the inspector during an
inspection of another designated centre on May 2016. This staff member was the person in charge for two other designated centres and was supported by another member of staff, this staff member facilitated this inspection.

Judgment:
Substantially 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):
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.

The inspector viewed planned and actual staff rota’s and found they were maintained accurately. For the most part staff members were replaced when required due to absences.

The inspector viewed twenty one staff members training records and all staff had received mandatory training however, refresher training was required for some staff members in the area of fire training and safe administration of medication.

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 was unable to view evidence of staff receiving supervision on the day of inspection. This information was not available within the designated centre. Following the inspection a sample of these were provided to the inspector. The inspector viewed supervision notes between the person in charge and staff members and between a staff nurse and other staff members these contained an executive, education and support function.

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 action identified from the previous inspection and found the action was achieved.

Over the course of the inspection the inspector found the retrieval of schedule 3 documents difficult. 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, weight monitoring. 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
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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments were not conducted at a minimum on an annual basis to reflect changes in need and circumstances of residents.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
Documentation within the location is under review to remove all duplications and inconsistencies. The details provided within the current documentation will be reviewed by the CSM, Deputy CSM and the client’s keyworkers and the necessary amendments made.

**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:**
Residents did not have a personal plan in place no later than 28 days after admission to the designated centre.

2. **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 clients will have the full 23 quality personal outcomes process completed immediately. The review process of these plans, are currently under review by the provider.

**Proposed Timescale:** 01/12/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents' personal plans were not reviewed annually or more frequently.

3. **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:**
Upon completion of the full 23 outcomes, all goals and priorities will be reviewed annually with a personal plan, and then every six months.

**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 new developments for the resident.

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 Outcomes process is currently under review.

Upon completion of the new full process all goals and priorities will be reviewed annually with a personal plan, and then reviewed every six months.

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:
Evidence of pressure relieving mattress being service was unclear within the designated centre

Seating required repair or replacement.

5. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
The leather chair that was in need of repair was removed from the location the day after the inspection.

Provision will be made to ensure that the pressure relieving mattresses are serviced. Internal checking system for the pressure relieving mattresses to be put in place.

Proposed Timescale: 31/01/2017
**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system in place in relation risk management required improvement.

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:**
Risk register to be updated for the location to include the risk of fire on the upper floors and the risk of sharps injuries.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management of sharps within the designated centre required improvement as no guidance was available to staff members.

7. **Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
The provider to include/create a policy on the management of sharps and their disposal in addition to the current mention in the medication management policy.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some PEEPs (personal emergency evacuation plans) required updating.

8. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.
Please state the actions you have taken or are planning to take:
PEEP’s emergency evacuation documentation to be reviewed and updated by staff in the location.

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:
Restrictive practice in use within the designated centre physical, chemical and environmental require improvement. To ensure these were applied in accordance with national policy and evidence based practice.

9. 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:
Behavioural Support Plans and restrictive practices to be reviewed and amended by the staff in the location.

Proposed Timescale: 31/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Lack of evidence that all alternative measures where considered before a restrictive procedure was used.

Information was not evident within the designated centre to ensure the least restrictive procedure, for the shortest duration necessary, was used.

10. 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:
Behavioural Support Plans and restrictive practices to be reviewed and amended by the staff in the location.

Proposed Timescale: 31/01/2017
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Behaviour support plans did not guide staff effectively to consistently respond to behaviour.

**11. 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:**
Behavioural Support Plans and restrictive practices to be reviewed and amended by the staff in the location.

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

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Intimate care plans in place did not reflect current practice.

**12. Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

**Please state the actions you have taken or are planning to take:**
Intimate care plans to be reviewed and updated to reflect that any gender can support a client with intimate care.

**Proposed Timescale:** 30/11/2016

**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 lack of evidence of the implementation of some interventions recommended by allied healthcare professionals for example, physiotherapy.
13. **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:**
Staff to be reminded of their obligations to complete all relevant documentation on a daily basis. This will be discussed at team supervision meetings also.

**Proposed Timescale:** 31/10/2016

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some healthcare plans did not reflect actual practice for example, seizure management plans.

Some interventions in uses were not reviewed nor was guidance available for staff to ensure the intervention was implemented effectively and consistently for example, pressure relieving mattresses.

14. **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:**
A section on oxygen therapy during a seizure to be included in the current seizure management care plans.

System for the checking of the pressure relieving mattresses to be implemented.

**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:**
Maximum dosage for p.r.n. medication was not identified for all p.r.n. medication.

Medication was present without any label identifying the resident's name and the expiry date.

Some prescriptions did not match information provided to staff.
15. **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 medications that require maximum dosage to be amended on the drug kardex.

The medication that required a label, had a label from the pharmacy on the box the day after inspection.

**Proposed Timescale:** 31/10/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Accurate stock balances were not maintained for some medications within the designated centre.

Some stock balance sheets did not contain accurate information.

16. **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:**
Staff reminded to be vigilant with checking stock balances.

Stock balance sheets to be updated.

**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:**
Follow up on actions from audits where not evident for some audits viewed such as medication management.

17. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
Please state the actions you have taken or are planning to take:
Follow up evidence will be available in the future for all audits. The results/issues will be discussed at team supervision meetings. The person conducting the audit will also inform staff directly of any issues.

Proposed Timescale: 30/11/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff members required refresher training in the area of mandatory training.

18. **Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
All staff that require training, were booked onto courses before the inspection date.

Proposed Timescale: 31/12/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some schedule 3 documents were not maintained up-to-date.

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

Please state the actions you have taken or are planning to take:
All documentation will be reviewed, and duplication and inconsistencies addressed. This will be done by the CSM, Deputy CSM and the keyworkers of the clients.

Proposed Timescale: 31/01/2017