

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0005144
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Una Nagle
Lead inspector:	Julie Hennessy
Support inspector(s):	Philip Daughen
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. 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:
26 April 2016 09:30	26 April 2016 16:00
27 April 2016 09:00	27 April 2016 14:00

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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was the first inspection of this centre carried out by the Health Information and Quality Authority (HIQA) and was announced the day prior to the inspection in order to inform the provider that the fire and estates inspector would be in attendance.

As part of the inspection, inspectors met with residents residing in the centre, the person in charge of the centre, the social care leader and social care workers. Inspectors also reviewed documentation such as personal plans, healthcare plans, training records, fire safety information and risk assessments.

The centre comprised a two-storey semi-detached house. A resident told inspectors that they liked living in the centre and were happy with the service being provided to them. Where residents were non-verbal, staff were observed to support residents to communicate in making choices through the use of picture exchange communication systems. Staff who had commenced working in the centre relatively recently were attending or were scheduled to attend Lámh training (a manual sign system used to support or extend communication). Interactions between staff and residents were observed to be appropriate and relaxed. Arrangements were in place in relation to setting personal outcomes with residents and providing an individualised service based on ability, support requirements and any considerations related to advancing

age.

However, non-compliances with the Regulations were identified in relation to some core outcomes. A major non-compliance was identified in relation to fire safety, due to the wedging open of fire doors combined with issues relating to the fundamental layout and use of downstairs rooms. In addition, where difficulties arose in relation to meeting residents' goals, it was not demonstrated how or whether such issues were adequately progressed. Also, the arrangements relating to the person in charge of the centre were currently under review by the provider in order to ensure active involvement in the governance and management of this centre.

Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector reviewed personal plans for residents residing in this centre.

A comprehensive assessment of the health, personal and social care and support needs of each resident had been carried out. This included assessments of communication skills, independent living skills, leisure activities, participation in the community, home activities, money skills and healthcare needs.

Each resident had a written personal plan. Information was individualised and specific. Personal plans included information pertaining to individuals' likes and dislikes, people important in their lives, personal goals and the supports required to achieve the best possible health and other areas of their lives. Information was in an accessible format.

Other specific plans had been developed based on assessment of residents' support requirements. These included healthcare plans, risk management plans, intimate care plans and behaviour support plans. Interventions were in place to support residents who were non-verbal, including the use of picture exchange communication systems (PECS). Visual schedules, social stories, countdown charts (relating to home visits and day trips) and communication plans outlining individual supports (such as objects of reference) were in place. Staff were observed to implement such interventions in practice.

There was evidence that residents and their representatives were involved in identifying goals that were important to them. Goals were reviewed each quarter and any barriers to achieving goals were documented. Where the local team could not address those

barriers, there was a process in place to allow for barriers to be escalated to the person in charge and the sector manager. However, the effectiveness of this process was not demonstrated. Where residents had identified that they wished to live in a quieter environment and/or with different people, it was not evidenced how or whether this wish would be facilitated. In addition, the system in place did not ensure that the review of the personal plan would be multi-disciplinary. The provider was aware of this gap and was reviewing the system across the service.

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):

This was the centre's first inspection by the Authority.

Findings:

There were organisational policies and procedures in place for risk management, fire safety, health and safety and infection control.

The inspector found that there were arrangements in place in relation to the identification of hazards and the completion of risk assessments. Individual risk profiles had been completed for each resident, which in turn informed the local risk register. The risk register contained a number of key risks, for example in relation to potential issues affecting fire evacuation for one resident and controls in place to prevent medication errors for another resident. However, the system was not sufficiently robust. Not all risks had an associated risk assessment or were included in the risk register. For example, where a resident had a visual impairment, risk assessments had not been completed in relation to the physical environment and safety around hot appliances. It was not clear whether other activities required a risk assessment, such as those associated with the use of transport or accessing the community.

There was a system in place in the organization for the recording and reporting of incidents. A weekly report was submitted by the senior staff on duty to the person in charge outlining significant incidents and specifying whether any incidents required notification. However, the inspector noted an example of an incident of behaviour that challenges where staff had been pushed and hit and an incident form had not been completed.

Regular staff had received training in relation to infection prevention and control and this training was scheduled for new relief staff. There were facilities in place for the prevention and control of healthcare acquired infection, including adequate hand

hygiene facilities. Cleaning schedules were in place and the centre was visibly clean. However, a system was required to monitor the effectiveness of health and safety and infection prevention and control practices or procedures, such as staff hand hygiene practices and the standard of environmental hygiene in the centre.

With respect to the premises from a fire safety perspective; the building was a standard two-storey semi-detached house with converted garage. There were four bedrooms for residents, including one downstairs en-suite bedroom. The downstairs bedroom was accessed via the dining room and the dining room led directly into the kitchen. The kitchen was a converted garage and also doubled as the utility room, including appliances such as the washing and drying machine. A fire door separated the dining and kitchen/utility.

However, the downstairs bedroom was an 'inner room' as it could only be accessed via the dining room. This bedroom was occupied by a resident with a visual impairment who required prompting from staff to evacuate during practice fire drills. The use of an inner room as a bedroom was not acceptable from a fire safety perspective. A review of fire drill records demonstrated that the occupant of this bedroom responded promptly during such practice fire drills. A risk assessment had been completed to reduce one particular additional risk associated with the individual resident. Fire equipment, emergency lighting and fire doors had been installed throughout the centre. The inspector viewed recent records for servicing of such equipment, including the fire panel. However, the arrangements in place for containing fires were not adequate as fire doors were wedged open with door wedges. The wedging open of fire doors combined with the use of an inner room as a bedroom resulted in a failing being at the level of major non-compliance.

The inspector observed that all internal doors had key-locks. Staff confirmed that there was no risk of residents locking themselves inadvertently into their bedrooms. There was a front-door key lock in a break-glass unit and each staff member also carried a key for use in the event of an emergency.

Each resident had a personal emergency evacuation plan (PEEP). Any mobility or cognitive support requirements were outlined in each resident's PEEP. There was a fire register file maintained in the centre. Weekly checks of fire safety in the centre were completed.

Regular fire drills had been carried out. The most recent day-time drill took place on 18 April 2016 and took two minutes. Two night-time drills had taken place within the previous six months. One took place on 22 October 2015 and the second on 1 March 2016 and took 4 minutes and 5 minutes respectively. Improvement was required to ensure that residents could be evacuated in a timely manner from the centre in the event of a fire.

Staff told the inspector that difficulties in relation to the fire assembly point had been identified and outlined solutions being explored. The fire assembly point was across the road in the housing estate, presenting health and safety concerns during practice fire drills. Steps had been taken to control this risk by ensuring that residents assemble at the front door prior to being accompanied across the road by a staff member. The

inspector found that the suitability of the evacuation procedure and the assembly point required further review to ensure that residents would be evacuated from the centre as a group and brought to a safe location following evacuation of the centre.

Judgment:
Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

There were policies and procedures in place in the organisation for the safeguarding of vulnerable adults, in relation to the protection of residents' finances and personal belongings, supporting residents' during intimate care, supporting behaviours that may challenge and restrictive practices.

The organisation had a committee in place that reviewed requests relating to the use of restrictive practices. Where chemical restraint was in use, it had been sanctioned by that committee. Documentation pertaining to the use of chemical restraint outlined the rationale for its use and what alternatives had been considered if available. Its use was reviewed by the committee on a quarterly basis. Any reported concerns or side effects of such medication were reviewed by the same committee.

However, not all staff had received the required training in relation to safeguarding vulnerable adults or positive behaviour support. Training records indicated that 3 of 22 staff required training in relation to the safeguarding of vulnerable adults and 5 of 22 staff required training in positive behaviour support, including intervention and de-escalation techniques. Training gaps will be addressed under Outcome 17: Workforce. The inspector spoke with members of the staff team, who were aware of what to do in the event of an allegation, suspicion or allegation of abuse. There was a designated person within the service to whom any concerns were reported.

Where residents required positive behaviour support, input from psychology had been provided and guidance for staff in relation to how to support residents was clearly outlined. Guidance included information about residents' routines, interaction protocols,

proactive and reactive strategies and situational management plans. Periodic service reviews were also held, which involved multi-disciplinary input as required.

The inspector reviewed a sample of residents' intimate care protocols and found that they outlined the supports each resident may require while also supporting and promoting independence.

Judgment:
Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

Residents had access to their own general practitioner (GP) and medical consultants where required. Reports following such reviews were in residents' files. Residents had access to allied healthcare professionals, including speech and language therapy, occupational therapy, psychology, dietetics and dentistry. However, assessments had not been completed for two referrals made in 2014. One referral pertained to social work and the other to occupational therapy. In addition, the inspector reviewed a report dated 11 February 2016 from an occupational therapist that recommended a targeted behaviour support plan. It was not clear whether this recommendation meant that a referral to psychology was required in relation to the completion of such a plan.

Where residents had communication needs or difficulties with swallowing, an assessment had been completed by a speech and language therapist. Where residents had dietary requirements or nutritional needs, assessments had been carried out by a dietician and other healthcare professionals as indicated. Based on the sample reviewed on the day of inspection, healthcare plans were in place to support residents identified healthcare needs. There was evidence that relevant risks, such as the risk of choking, were monitored and any incident recorded. Input from allied health was sought in relation to preventing related incidents. Staff demonstrated that they were aware of and understood how to implement the recommendations made by allied health professionals. Residents who were non-verbal were supported to make choices in relation to meal planning and meal selection when eating out by using a picture exchange communication system (PECS). Residents were supported to participate in meal preparation on an individual basis.

Each resident had an individual 'hospital passport' that contained key information should a resident be admitted to the acute hospital sector. Information contained in the hospital passport was specific to that resident and included information about allergies, their medication, communicating with the resident in relation to healthcare matters and any relevant risks.

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):

This was the centre's first inspection by the Authority.

Findings:

There were written policies and procedures in place relating to the ordering, administration, storage and return of medication.

Medicines were ordered from the pharmacy on a monthly basis. Medicines were checked on arrival in the centre and a visual check was also completed prior to administration of any medications.

Medicines were stored safely in the centre. The key to the medicines cupboards was kept in a pad secured via key code. Psychotropic medication was counted daily. The inspector completed a random count of a sample of psychotropic medication and found the count to be correct.

There were arrangements in place for the safe administration of medicines. Staff had received training in relation to medication management. A 'biodose' system was in use in the centre.

There was a system in place for the administration and oversight of PRN "as required" medication. The administration of psychotropic medication was reviewed on a three-monthly basis by each resident's psychiatrist, or more frequently as required. The inspector observed that residents had an individual medication management plan in place and a PRN protocol, where PRN was prescribed.

The inspector reviewed the organizational and local policy regarding the withholding of any medicines that may need to be withheld. Neither policy adequately addressed likely scenarios where the prescriber may request a medicine to be withheld or a dose adjusted. Staff confirmed that the training that they had received did not facilitate them

to withhold or adjust the dose of a medication. As a result, it could not be demonstrated that residents would always receive medication as prescribed.

Staff outlined the procedure in place for the segregation and return of any medicines that are used or out-of-date. Used or out-of-date medicines were segregated from other medicines and a log of returns to pharmacy was maintained.

The inspector reviewed a medication audits that had been completed by the person in charge dated 9 February 2016. Identified actions had been addressed. However, the system in place for carrying out medicines management audits required development as the audits did not consider all parts of the medicines management cycle. This will be addressed under Outcome 14: Governance and management.

Good practice was demonstrated in relation to medication errors. Errors were recorded and reported, including dispensing errors from the pharmacy. Corrective action was taken following any such errors and where required, this involved relevant third parties. Staff supported family members and residents to self administer medicines when in the family home.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

There was a clearly defined management structure in place in the centre. A social care leader oversaw the day-to-day running of the house houses and worked full-time in this centre. The social care leader reported to the person in charge. The person in charge reported to the sector manager who in turn reported to the provider nominee.

The person in charge was suitably qualified and experienced to fulfil the role of person in charge. He had 10 years experience as a social care leader and a year in the role of person in charge. There were suitable deputising arrangements in place with the sector manager deputising in such an event.

The person in charge was responsible for more than one designated centre. The person in charge was responsible for six centres, comprising eight houses across Cork city and surrounding suburbs and into East Cork. Based on the current remit and geographical spread of centres, the person in charge said that he would visit centres on a monthly basis with regular phone contact in between visits. The person in charge received weekly written updates from the senior person on duty.

However, based on the current arrangements as outlined, it was not demonstrated how the person in charge was facilitated to ensure the effective governance, operational management and administration of the designated centres concerned. For example, the person in charge did not attend staff meetings or residents' personal planning meetings. In addition, systems for monitoring the safety and quality of care on an on-going basis required improvement. Examples were provided of where audits required development under outcomes 7 and 12 in the context of infection control, health and safety and medicines management. The provider nominee confirmed during the meeting following the inspection that the role and remit of the persons in charge across the service was currently under review across the service.

The social care leader had commenced in the centre in October 2015 and was qualified and experienced in the field of social care. The social care leader demonstrated that she knew residents, their needs and abilities well. Staff told the inspector that they could bring any concerns to the social care leader.

There were systems in place for the completion of an annual review and bi-annual visits of the quality and safety of care within the service.

The provider had carried out a six-monthly unannounced visit of the centre on 9 December 2015 and reviewed four areas as they related to social care needs, health and safety, safeguarding and safety and medicines management. Actions were identified in an action plan. Inspectors followed up on a sample of actions and found that they had been completed. However, the unannounced visit was limited in scope and findings in the unannounced visit indicated that improvement was required to ensure that the safety and quality of care and support being provided in the centre was fully reviewed. For example, issues for residents identified on this inspection and by residents' in their personal plans relating to satisfaction with whom they lived were not explored. Key outcomes such as residents' healthcare needs and the governance of the centre were not explored.

An annual review of the centre had been completed on 18 November 2015. The review was limited in scope as it reviewed 4 of 18 outcomes. The review did however invite and consider parents experience of the service, including in relation to staff attitudes and approach, the quality and safety of care provided to their loved one and level of satisfaction with consultation. The provider was aware of the gaps relating to the six-monthly unannounced visit and annual review and was in the process of addressing same.

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):

This was the centre's first inspection by the Authority.

Findings:

There was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff on duty at night.

Based on observations, a review of the roster and these inspection findings, it was demonstrated that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs and abilities of residents.

A sample of staff files was reviewed and found to be in line with the requirements of Schedule 2 of the regulations. There was evidence of effective recruitment and induction procedures; in line with the policy. Staff who had commenced working in the centre in the previous few months told the inspector that they had received a comprehensive induction to the centre. Residents' files reflected that while a changeover of staff in late 2015 had been unsettling for some residents, that residents had been supported through this period. A core staff team currently provided continuity for residents.

Staff were observed to be supervised appropriate to their role on an informal basis. Regular staff meetings were held and items discussed included health and safety, medicines management, residents' needs, complaints/compliments, safeguarding and documentation. Staff told the inspector that they could add to the agenda if they wished to do so. However, a formal supervision system was not in place for all staff to improve practice and accountability. The provider was in the process of addressing this by introducing systems for appraisal and supervision and training for persons in charge and managers was currently being delivered.

Training records indicated that core staff had received mandatory training and training relevant to their role including training in medicines management, first aid, food safety, fire safety, infection control and nutrition. Two staff were currently attending Lámh training (Lámh is a manual sign system used to support or extend communication) and the social care leader was scheduled to complete this training. Training for two new relief staff was required in relation to all mandatory training and had been scheduled.

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:

Julie Hennessy
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:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0005144
Date of Inspection:	26 April 2016
Date of response:	20 May 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The review of the personal plan was not multi-disciplinary.

1. Action Required:

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

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:

The Service will ensure that all personal plans are reviewed by the appropriate multidisciplinary clinicians.

Proposed Timescale: 29/07/2016

Theme: Effective Services

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

It was not demonstrated that personal plan reviews assessed the effectiveness of each plan. Where residents had identified that they wished to live in a quieter environment and/or with different people, it was not evidenced how or whether this wish would be facilitated.

2. 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:

Plans will be reviewed to ensure that the service users wishes are reflected in their goals and Barrier Forms are included in the review of the plans.

Proposed Timescale: 30/06/2016

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 for recording and reporting of incidents required review. The inspector noted an example of an incident of behaviour that challenges where staff had been pushed and hit and an incident form had not been completed.

3. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The PIC will ensure that all staff are reminded to complete incident report forms in relation to all incidents and will conduct regular reviews in this regard.

Proposed Timescale: 20/05/2016

Theme: Effective Services

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

The system in place for the identification of hazards and assessment of risks required review. As detailed within the findings, not all risks had an associated risk assessment or were included in the risk register.

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 service will ensure that all risks identified by the Team members are assessed, that a Risk Management Plan is completed and included in the Risk Register.

Proposed Timescale: 20/05/2016

Theme: Effective Services

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

There was no system in place to monitor the effectiveness of infection prevention and control practices or procedures, such as staff hand hygiene practices or the standard of environmental hygiene in the centre.

5. 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:

All staff will receive Hand Hygiene Refresher Training. Staff will abide by the requirements contained in the Services Infection Control Policy.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

The fundamental design and layout of the premises required review as a downstairs inner room was used as a bedroom.

6. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

A plan has been completed to ensure safe egress from the downstairs bedroom. Agreed renovations will begin week commencing 23rd May 2016.

Proposed Timescale: 03/06/2016

Theme: Effective Services

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

The arrangements in place for containing fires were not adequate as fire doors were wedged open with door wedges.

7. Action Required:

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

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

All wedges have been removed from the Centre and a visual check of all fire doors will be carried out at the beginning of each shift.

Proposed Timescale: 19/05/2016

Theme: Effective Services

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

The suitability of the evacuation procedure and the assembly point required further review to ensure that residents would be brought to a safe location following evacuation of the centre.

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:

The Emergency Evacuation Plan has been revised to include new evacuation route and a new assembly point has been identified.

Proposed Timescale: 19/05/2016

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:

It was not demonstrated that where a resident requires services provided by allied health professionals, access to such services was provided or arranged. Assessments had not been completed for two referrals made in 2014. In addition, clarification was required in relation to a recommendation for a behaviour support plan made by the occupational therapist.

9. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

All files and plans will be reviewed to ensure that referrals and recommendations from Allied Health Professional are tracked and implemented.

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:

It was not demonstrated that residents would always receive medication as prescribed. Satisfactory arrangements were not in place to ensure that staff were trained and competent to respond to an instruction from the prescriber to withhold or adjust the dose of a medicine.

10. 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 Local Policy will be revised to include the procedures to be followed in relation to the withholding or adjustment of medication in line with the Services Medication Management Policy. This adjustment will be discussed at the Staff Team Meeting.

Proposed Timescale: 01/06/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

It was not demonstrated how the person in charge was facilitated to ensure the effective governance, operational management and administration of the designated centres concerned.

11. Action Required:

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

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

The Provider and the Person in Charge have agreed new structure to ensure that the PIC will have responsibility for a number of residential services. This will be kept under review.

Proposed Timescale: 01/06/2016

Theme: Leadership, Governance and Management

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

Systems for monitoring the safety and quality of care on an on-going basis required improvement. Examples were provided of where audits required development under outcomes 7 and 12 in the context of infection control, health and safety and medicines management.

12. 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:

The system of audit of internal controls on the policy implementation outside of the six monthly unannounced inspections is currently upgraded for areas such as medication audit and will be broadened to include other policy areas such as infection control procedure.

Proposed Timescale: 31/07/2016

Theme: Leadership, Governance and Management

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

The annual review was limited in scope and did not ensure that all aspects of quality and safety of care and support in the designated centre were reviewed and that such care and support was in accordance with standards.

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:

The format of the Annual Review has been amended to ensure that it will include a review of the quality and safety of the Service. This new format will be used for the next review scheduled for July 2016.

Proposed Timescale: 29/07/2016

Theme: Leadership, Governance and Management

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

As detailed within the findings, the unannounced visit was limited in scope and findings in the unannounced visit indicated that improvement was required to ensure that the safety and quality of care and support being provided in the centre was fully reviewed.

14. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The scope of the six monthly Provider Unannounced inspections have been revised to include additional outcomes.

Proposed Timescale: 13/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Training for two new relief staff was required in relation to all mandatory training.

15. 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:

The PIC has organised mandatory training for relief staff.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

A formal supervision system was not in place for all staff to improve practice and accountability.

16. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

The Services are introducing formal Staff Supervision and a Staff Performance Appraisal System. Managers have received an overview of the policy on 05/05/2016 and will implement the system for all staff in the Centre.

Proposed Timescale: 01/07/2016