Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Suaimhneas
Centre ID:	OSV-0001749
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bernadette Donaghy
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
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 compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 April 2017 10:50	10 April 2017 18:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential

Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

The inspector met with the four residents who lived in the centre, four staff members, the behavioural support specialist and the person in charge during the inspection process. Some residents living at the centre were able to communicate very briefly with the inspector during the inspection.

The inspector reviewed practices and documentation, including three residents' files, three staff files, incident reports, policies and procedures, fire management related documents and risk assessments.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and provides residential services to people with moderate to severe intellectual disability, autism spectrum disorder and complex behaviours that challenge, who have been identified as requiring medium to high levels of support. The service can accommodate male and female residents, from the age of 18 years upwards. At the time of inspection, there were three male residents and one female resident living at the centre. All four residents were identified for transition to the community.

The person in charge had overall responsibility for the centre and is supported in his role by the provider. The person in charge is not based the centre on a full-time basis but is in the centre on a fortnightly basis to meet with staff and residents. The house is a large two-story dwelling which has a kitchen area, dining area, two sitting rooms, a utility, relaxation room, bathroom and bedroom spaces for residents. All bedrooms are single rooms and have en-suite facilities.

Overall judgment of our findings:

This was a five outcome inspection and the provider had completed some of the actions identified in the previous inspection report from August 2016. However, some actions still were not complete at the time of this inspection. Significant improvements were required in this centre, with the inspector identifying four major non-compliance in five outcomes inspected. One of the outcomes inspected was found to be in moderate non-compliance with the regulations. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce.

The findings and their actions are further outlined in the body of the report and the action plan at the end of this 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents were found to have had an assessment of their health, personal and social care needs. Residents were encouraged and supported by staff to engage in regular social activities. However, inspectors found improvements were required to the development of residents' personal goals and the planning for their transition into the community.

Some residents living in the centre were assessed as requiring one-to-one staff support for social care. Adequate staffing levels were in place in the centre to ensure that all residents received this level of support if they chose to access local amenities, dine out, attend local functions or attend leisure activities. Additional staff were allocated to the centre throughout the day to support this arrangement, with additional support hours also available to the centre at weekends. The inspector spoke with staff members who reported that this staffing arrangement enabled each resident to have opportunities to spend their time as they wish. On the day of the inspection, one resident did not want to attend day service, and this resident was supported by staff to remain at home for the day. The centre had access to a bus which was used to bring residents to their day service and on social outings.

At the time of inspection, the provider was in the process of introducing a new personal planning recording system. Staff told the inspector that they were still developing these plans and were unclear when these were to be completed. Staff told the inspector that the personal planning format was not suitable to meet the communication needs of residents living in the centre.

Residents and their families were actively involved in the development and review of personal plans and goals, and action plans were put in place to identify how the centre planned to support the resident to achieve their goals. However, these action plans did not identify those responsible for supporting residents to achieve their goals within agreed timeframes. In addition, some personal plan reviews were not dated and did not indicate when the next review was due. Furthermore, not all action plans were updated to show the progress made by residents towards achieving their goals.

All residents living in the centre were planned for transition into the community. Compatibility assessments and transition plans were developed for each resident to identify the support each resident would require in preparation for their transition. Some residents were planned for transition in January 2017, and residents were engaging in personal development and community visits in late 2016 in preparation for this transition date. However the transition of these residents into the community did not occur on this date. The person in charge informed the inspector that another transition date had not yet been determined. Staff told the inspector that the support activities that were in place to prepare these residents for transition had stopped as the centre was waiting to be informed of the revised transition date. The inspector also found transition plans had not been updated to reflect the change in these residents' transition status.

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

Findings:
Some actions required from the previous inspection were not satisfactorily completed with similar failings identified during this inspection in relation to fire safety and risk management.

A fire safety assessment report was completed in June 2016 which identified 22 areas of remedial works to be completed in the centre by June 2017. The person in charge informed the inspector that these works had not yet commenced as the centre would need to be vacated for the works to be completed. However, the person in charge was unable to inform the inspector if these works would be completed in line with the recommended timeframe for completion.

Regular fire drills were occurring within the centre and involved all residents and staff on duty at the time of the drill. Fire drill records demonstrated that residents could be evacuated from the centre; however, staff informed the inspector that they used whistles instead of the fire alarm during these drills to alert residents and staff to evacuate. Staff told the inspector they knew how to support residents to evacuate from the centre, particularly where residents may be reluctant to cooperate with the evacuation. Personal emergency evacuation plans (PEEPs) were in place for residents; however, these were not reviewed within their specified timeframes.

Staff told the inspector that the assembly point for the centre was located to the rear of the centre. However, in the event that a fire was located at the rear of the centre, there was no alternative fire assembly point identified for residents and staff to evacuate to. The centre had arrangements in place to evacuate residents, who were at risk of absconding, onto the centre's bus. Staff reported that the bus can be parked either at the front or at back of the centre and that there was no alternative evacuation arrangements in place for them to follow, should they be unable to access the bus in the event of a real fire. In addition, some staff members who spoke with the inspector were unclear as to how they would access additional staff support to assist with a night time evacuation, and were not guided on this by the fire procedures displayed. Upon a review of the training matrix for the centre, the inspector identified that a number of staff had not received up-to-date training in fire safety.

There was a risk register in place for the centre which was reviewed and updated by nursing staff. The register was reviewed on a monthly basis; however, some risks which were rated as high over a continuous period, had no formal review completed to evaluate the effectiveness of the control measures in place. Furthermore, staff nurses who spoke with the inspector said they were unclear about how to escalate on-going risk, and were unsure what level of risk ratings warranted them to alert the person in charge.

Incidents were reviewed monthly by an incident review group, and an incident trending report was made available to the centre following this review. Residents' and organisational specific risk assessments were in place; however, the inspector found a large number of these risk assessments had not been reviewed, in line with their scheduled review dates.

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

Findings:
There were systems in place to protect residents from being harmed or suffering abuse. Measures were in place to support residents experiencing behaviour that challenges. Actions required from the centre's previous inspection report were satisfactorily completed. However, improvements were required to the provider's management and on-going review of restrictive practices.

There were residents experiencing behaviour that challenges in the centre. A behavioural support specialist visited the centre twice a week to support and guide staff in the management of behaviour that challenges. The inspector met with the behavioural support specialist, who reported there has been a significant decline in the number of peer-on-peer incidents and episodes of behaviour that challenges, through the on-going review and management of specific behaviours. Behavioural support plans were in place to guide staff on the management of residents' behaviours and these plans were regularly reviewed by the behavioural therapist. Staff demonstrated a good understanding of these plans and of their responsibility in supporting residents with behaviour that challenges. Where residents were assessed as requiring one-to-one staff support for the management of their behaviours, adequate staffing levels were in place to support this need. All staff had received up-to-date training in the management of behaviours that challenge.

There were no safeguarding concerns in the centre at the time of inspection. Staff spoken with were knowledgeable of their requirement to report any safeguarding concerns to the person in charge. Staff also recognised those designated as the safeguarding officers for the centre. All staff had received up-to-date training in safeguarding.

There were a number of restrictive practices in place in the centre. These restrictions included the use of chemical, environmental and physical restraints. Staff invited the inspector to witness the application of an assessed physical restraint during the inspection, and staff were found to apply same in accordance with the guidance documentation available to them. Staff were knowledgeable of the appropriate application of the centre's restrictive practices and informed the inspector of alternatives that were trialled in the past and found to be ineffective. However, the inspector found that guidance documentation was not available for staff to reference for all restrictions that were in place. Furthermore, the inspector found not all restrictive practices were supported by an up-to-date assessment and it was unclear when some restrictive practices were last reviewed. Although some environmental restrictions were in place to safeguard residents at risk of absconding, it was unclear if the impact this restriction had on other residents was assessed and reviewed on an on-going basis.

Judgment:
Non Compliant - Major

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

Findings:
Actions from the centre's previous inspection report were not satisfactorily completed. Improvements were still required to the provider's governance and management systems.

The person in charge had responsibility for the centre and was supported in his role by the provider. The person in charge was not based in the centre on a full-time basis. He was also responsible for the running of four other centres, overseeing the care delivery to approximately 95 residents, and supporting staff working in these centres. The person in charge also held the role of safeguarding officer and acting director of nursing for the service. He informed the inspector that, due to time constraints and external demands associated with his role, he now only has capacity to visit and that he has not attended staff meetings in recent months. The provider and person in charge informed the inspector that plans were in place to reconfigure the size and management arrangements for the centre; however, no timeframe for when this would be commencing was identified.

The person in charge had assigned some interim managerial duties to nursing staff with regards to roster development, personal planning development and risk management. However this interim arrangement was found to be ineffective. Some residents in the centre required one-to-one female staff support at all times. Upon review of the roster, the inspector observed that female nursing staff were allocated to care for this resident on a daily basis, with little time to conduct the administrative duties assigned to them. During the inspection, the inspector observed several gaps in the timely review of documents such as risk assessments and personal plans. Staff nurses informed the inspector that all efforts were made by them to carry out these administrative duties; however, they did not have sufficient time allocated to enable them to complete these .

There were some governance and management systems in place; however, some were

found by the inspector to be ineffective. For example, a fire safety assessment report was completed for the centre in June 2016. This identified remedial works which needed to be completed by June 2017. The person in charge informed the inspector that these works had not yet commenced as the premises would need to be vacated for the duration of the works. The person in charge told the inspector that the commencement of these works was largly dependent on the transition of residents to the community. However, the person in charge had not been informed of when residents would be transitioning and there was no alternative management plan in place which supported the completion of remedial works by June 2017.

There were a number of action plans that staff were working from at the time of the inspection. These action plans were generated from the findings of six monthly audits, quality improvement projects and previous inspection reports. The centre demonstrated poor deadline achievement in relation to completion of actions. For example, a quality improvement audit which was completed in February 2017, identified 61 actions for completion. The inspector found that 18 of these were overdue. In addition, the annual service review for the centre which was completed in July 2016, did not have an action plan in place to demonstrate how the centre planned to address areas of non-compliance.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Actions from the centre's previous inspection report had not been satisfactorily completed. The inspector found improvements were still required to staff training. Further improvements were also required in relation to the maintenance of Schedule 2 documents.

Planned and actual staff rosters were available in the centre and were found to be maintained to a high standard. The provider used agency staff and the inspector found that there was consistency in the allocation of these agency staff members within the

centre. There were four staff members rostered throughout the day to deliver care to the four residents residing in the centre. Where residents required one-to-one staff support, this was consistently provided to them. Staff supervision had commenced and was in progress at the time of the inspection.

There was a training matrix in place which demonstrated all training and refresher training delivered to staff. However, the inspector observed that not all staff had received up-to-date training in manual handling.

Not all Schedule 2 documents were maintained by the centre.

Judgment:
Non Compliant - Major

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:

Anne Marie Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0001749
Date of Inspection:	10 April 2017
Date of response:	19 May 2017

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 provider failed to ensure personal plans included:
- the date they were last reviewed
- the names of those responsible for pursuing objectives in the plan
- the timeframe the goals were to be reviewed or achieved by

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

And were updated to reflect the progress made by residents towards achieving their personal goals

1. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
The PIC will ensure all residents' personal plans will be reviewed to ensure that all residents needs are assessed, provide clarity on how personal goals will be met and reviewed at least annually by the below date.

All residents individual goals were reviewed and evaluated same completed 9th of May 2017.

New personal goals will be agreed and formulated, have identified dates to commence and to be achieved, goals will be broken down into steps to give guidance for staff of what will be required to support each resident in achieving each goal, individual Key workers will be identified in relation to who is responsible for supporting resident in achieving and evaluating of personal goals

Proposed Timescale: 12/06/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure residents' personal plans were available in a suitable format which met the communication needs of residents.

2. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
The PIC will ensure residents' personal plans will be made available in an accessible format to the residents and, where appropriate, their representatives by the below date.

Proposed Timescale: 12/06/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
The provider failed to provide updated information on the services and supports required for residents as they transition from the centre.

3. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
All transition plans will be updated to include information on the services and supports required for residents as they transition from the centre.

Proposed Timescale: 31/05/2017

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 provider failed to put systems in place for the assessment, management and ongoing review of risk to include:
- review of risk assessments in line with their scheduled review dates
- ensure staff were appropriately supported in the on-going review of risks within the centre

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 provider will ensure that existing risk management systems are currently being reviewed within the designated centre. The assessment, management and ongoing review of risks, including a clear plan for responding to emergencies will now be included in the overall system. This will be completed by the below date.

Emergency Response alarm has been installed in this community home to respond to emergencies.

Training on risk management and risk assessment was provided to staff working in the community home on 15 -5-2017 and 17 -5-2017. Risk rated high and are unable to ber addressed will be forwarded through the person in charge to be escalated onto the service risk register.
Guidance was provided on the process involved in escalating risk to senior management

Proposed Timescale: 21/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put in place effective fire systems in relation to:
- appropriate use of the fire alarm as part of fire drills
- adequate fire assembly points for the centre
- adequate fire procedures to guide on alternative assembly points and the use of the centre's bus in the event of a fire
- put in place adequate arrangements for remedial works to be completed within the centre in accordance with the findings of the risk safety assessment report.

5. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The provider has ensured that adequate fire procedures to guide on alternative assembly point and the use of the centre's bus in the event of a fire is in place. The Bus is parked at all times at the front of this community home during night time hours. This allows an alternative assembly point to be in place for this community home.

All indivdiual Personal Emergency Evacuation Procedure (Peeps) are reflective of the alternative fire evacuation strategies and fire drill was completed with staff and all residents on 24/04/2017 and report and learning from same is reflected in the Fire Register. All staff are to use the fire alarm system for fire drills with immediate effect.

Fire Assembly point sign to the front of the house has being erected.

Arrangements will be put in place that all staff will receive suitable training in fire prevention, emergency procedures, home layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents have been put in place. This training is scheduled for 12th & 19th May 2017.

The provider has ensured that a Fire risk assessment has being completed by external company on this community house & completed works will take place by the below date.

Proposed Timescale: 30/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all staff had received up-to-date refresher training in fire

safety

6. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
All staff requiring fire training will complete same on the below date.

Proposed Timescale: 19/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure residents' personal evacuation plans:
- were reviewed within their scheduled review dates
- guided on the alternative evacuation arrangements where the centre's bus was inaccessible to residents in the event of a fire

7. 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:
All PEEPs have being updated.

Fire Assembly point sign to the front of the house has being erected.

Transport available at all times in this community home for emergency evacuation.

Proposed Timescale: 01/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that where restrictive procedures are in place, these are applied and supported by a risk assessment and on-going review.

8. 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:
All PRN chemical restraints prescribed have individualised protocols identifying rationale for use, alternative strategies to be implemented & possible side effects identified, same reviewed & signed on 19/4/2017 by MDT & GP.

Risk assessment have being completed on environmental restrictive practices & effect on residents. At all times restrictive practices are implemented for immediate health and safety of individuals with the least restrictive option for the least amount of time. This was completed on 12/4/2017

Self audit tool on restrictive practice to be completed and reviewed by Senior Psychology team by below date.

Proposed Timescale: 03/06/2017

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:
The provider failed to ensure that the person in charge was adequately supported to effectively govern and manage the centre.

9. 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 has ensured that from 9th May 2017 a supernummary Acting Clinical Nurse Manager 1 was appointed to this designated centre. The overall responsibility for the management of this centre will lie with the Person in Charge.

Proposed Timescale: 09/05/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put management systems in place in the centre to ensure that the service provided is consistent and effectively monitored to include:
- adequate arrangements to ensure the continuous monitoring and review of action plan deadlines and the completion of remedial works.

10. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Provider has ensured that from 9th May 2017 a supernummary Acting Clinical Nurse Manager 1 was appointed to this designated centre. The overall responsibility for the management of this centre will lie with the person in charge. The person in charge will meet with the Clinical Nurse manager on a weekly basis to review action plan, to ensure deadlines are met & the completion of remedial works.

Proposed Timescale: 30/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all information required of Schedule 2 of the regulations was maintained for all staff.

11. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
Information and documents as specified in Schedule 2 will be obtained for all staff working within the designated centre by the below date.

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all staff had received up-to-date training in manual handling

12. 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 will have up to date training in Manual Handling by the below date.
Proposed Timescale: 30/06/2017