

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Moorefield House
Centre ID:	OSV-0001959
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	L'Arche Ireland
Provider Nominee:	Mairead Boland Brabazon
Lead inspector:	Noelene Dowling
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:	4

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 inform a registration decision. This monitoring inspection was unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 October 2016 09:30	26 October 2016 19:00
27 October 2016 09:30	27 October 2016 10:30

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

Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the Inspection:

This inspection was undertaken as a follow up to three previous inspections which had taken place in the centre. The registration inspection took place in May 2015 and a follow up inspection took place in December 2015. Due to the time lapse, an additional inspection was undertaken on 10 May 2016 at which a number of non compliances in governance, safeguarding and staffing were identified.

This inspection was undertaken to ascertain the provider actions following this and inform the registration decision.

The inspection was unannounced and took place over two days. Eight of the core outcomes required to demonstrate compliance with the legislation and regulations were inspected against.

How we gathered our evidence:

The inspector met and spoke with the residents in the day service and in the centre.

Residents who could communicate told the inspector of their activities . They said they felt safe and liked the staff and managers. It was also apparent from

observation that they were comfortable and very familiar with the staff and managers. Residents allowed the inspector to join them at meals.

The inspector spoke with the deputy team leader, the provider nominee, staff and the health and safety officer and met the person in charge on the second day of inspection.

The inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, audits, policies, procedures and staff files.

Description of the service:

The centre is designed to provide care for four adult residents, male and female of moderate to severe intellectual disability with some challenging behaviours and those on the autism spectrum. It is run by a non profit organisation which has two other residential centres in the locality. There are a number of workshops and day services attached.

The premises is a two story detached house with large gardens, including a vegetable garden located in a rural location a number of miles from the office and the other centres which the organisation manages. It is near the local church and a small shop and there is transport available to ensure they have access to other amenities.

Overall judgement of the findings:

The findings of this inspection are impacted upon by the continued unsatisfactory governance arrangements to allow the person in charge to manage more than one centre satisfactorily. There were eight outcomes inspected against in May 2016 and seven moderate non compliances in significant areas found. A total of 12 actions were required and of these five were satisfactorily completed, five were partially completed and one was not. The inspector was satisfied with the progress and the providers plans to address the remaining actions.

This inspection found that:

- Residents had continued good access to activities and meaningful day services (outcome 5)
- There was very good communication with families and regular consultation with the residents in regard to their wishes and preferences (Outcome 5)
- There was good access to healthcare and good medicines management systems which promoted residents' wellbeing and safety (outcome 11 and outcome 12)
- Health and safety and risk management systems were satisfactory which helped to keep residents safe (Outcome 7)
- There was a sufficient number of staff available to support residents and ensure they had good access to all activities (outcome 17)

However, lack of governance arrangements impacted on residents in the following ways;

- The person in charge was unable to carry out the duties effectively due to lack of adequate support arrangements in the centre (outcome 14)
- Safeguarding systems in relation to implementing behaviour support plans which could potentially negatively impact on residents development and wellbeing (Outcome 8)

- Continued delay in accessing necessary speech and language assessments which impacted on residents' communication and safety (outcome 5).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end

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

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

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

Findings:

The action from the previous inspection had been partially but not fully resolved. While staff were very knowledgeable on the residents' means of expression only one resident had a communication passport or pictorial guide to help them communicate. This was a very detailed guide using objects of reference as well as outlining the residents speech patterns and the resident brought this with them on all activities.

Referrals had as required been made to speech and language therapists . The provider informed the inspector that they now had a specialist within the organisation who would be undertaking training with staff in both understanding residents communication and in more helpful ways for staff to communicate with the residents. This is especially pertinent to some residents in this centre.

One resident used a computer and SKYPE to communicate with friends.

The personal plans and complaint procedure were synopsised in a suitable and user friendly pictorial format for the residents.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

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

Findings:

The action from the previous inspection had been partially but not fully resolved. There was evidence that all residents had been referred to pertinent allied specialists including speech and language, psychology and behavioural supports for assessment. However, no resident had been seen by speech and language therapists where this was necessary due to the potential risk with swallowing. The inspectors were informed that this was due to lack of availability of such services in the Health Service Executive (HSE). However, efforts had not been made to source these services elsewhere. Staff were seen to take appropriate precautions in these instances however such as ensuring the residents' food was suitably prepared and were aware of the risk.

There was also no clarity obtained in relation to a resident's current psychiatric condition despite on-going intervention and the administration of medication for treatment. No reports or records or adequate reviews were available and staff did not have an understanding of the resident's mental health or progress in order to plan for the support of this

While the psychology assessments had not yet taken place for a number of residents a schedule of appointments had been made. Two residents had been seen by the behaviour support specialist. This is further discussed under outcome 8 safeguarding. There were annual reviews held and the inspector saw that the review reports prepared by the staff were comprehensive and took account of most aspects of the residents' life. In this way there was an overview of the care provided and the life of the residents. Both the residents and their representatives attended the review and there was evidence of consultation with all parties as to their wishes and preferences. Multidisciplinary involvement via the community disability services was also evident. The residents had personal plans detailing their preferences and needs for support in a number of areas including health, personal care, familial and interpersonal relationships and activities.

It is expected that following the completion of the psychological assessments the outcomes will inform the personal plans for further interventions to support the residents.

Goals were set following reviews and it was evident that in most cases these were being implemented. The plans were in a pictorial format for the residents. Staff also completed detailed daily plans for activities of daily living and the supports needed.

Inspectors found that residents need for social interaction, meaningful day occupation and familial supports were being well supported. Residents' attended the workshops managed by the organisation which included participating in art, computers, weaving, making cards and music. They participated in the horticulture projects in the grounds. They went to social events, concerns and sporting events. Where one to one supports were required these were made available. They went swimming and attended a range of local events, had meals out and went on holidays with chosen friends within the centre. On the evening of the inspection a resident was going to a local music event. They also participated in fundraising events where their own works and crafts were sold as part of open or community days. Resources were made available for them to meet these social needs.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The inspector found that overall the risk management procedures had improved. There were three actions required from the previous inspection and progress had been made on all actions. They primarily concerned security and evacuation procedures for the residents.

The security system for the front door was in the process of being amended with the installation of a new door and locking system. An additional fire exit door key had been made available as required. However, this key was also unsecured and could easily be misplaced thus preventing resident from emergency egress from this exit. The person in charge agreed to remedy this promptly. The inspector was informed that staff were now scheduled to be present at night on the ground floor to support the resident who was accommodated there in the event of fire.

There was now an agreed system to ensure that the falls alarm was operational on a regular basis.

Systems for the evacuation of residents were effective with regular fire drills held. While there were no difficulties noted the inspector saw that these took place primarily during day time hours which might not be reflective of evening, night time staffing or locations

within the building. This was discussed with the provider who agreed this would occur.

Individual risk assessment and management plans were implemented for each resident. These were pertinent to their needs for example, risk of falls, choking, road safety or injury from hot surfaces. Effective systems such as one to one staff support were implemented to manage the risks. All such information was shared with the staff responsible for the various workshops or activities which the residents attended to ensure the residents consistent safety.

A satisfactory risk management policy was in place and the risk register as very detailed for both environmental and individual and clinical risks for the residents. Fire training had taken place for staff and there was evidence of new staff or volunteers having a detailed fire safety induction.

There was evidence that the fire detection systems and emergency lighting and extinguishers were serviced annually and quarterly as required. The fire upgrading works were continuing as planned. Additional works, at considerable cost were being completed at the time of the inspection which included the completion of the installation of fire doors with self-closing devices and an external fire escape had been installed.

There was an emergency plan and interim accommodation arrangements had made and the policy on infection control was detailed and updated.

Judgment:

Substantially Compliant

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

This outcome is impacted on by the absence of a team leader at the time of the inspection and therefore the oversight of implementation of behaviour support plans and follows up on these.

The specific action from the previous inspection had been partially but not fully completed. Two residents had been referred to and reviewed by behaviour support clinical specialists and clinical psychologists. A report and support plan seen as a result of this which had been prepared in June 2016 was detailed in its guidance for staff to support the resident and in particular to address behaviours which impacted on the resident socially.

However, the inspector could not ascertain if the plan was being implemented and in fact was informed by staff that it was not. The person in charge informed the inspector following the inspection that aspects of the plans were in progress such as the provision of a memory box. As the behaviours impacted on the resident's capacity to enjoy social activities, emotional wellbeing and also had an impact on other residents this discrepancy was of concern

There was also no clarity obtained in relation to a residents' current psychiatric condition despite on-going intervention and the administration of medication for treatment. No reports or record were available and staff did not have an understanding of the resident's mental health or progress in order to provide the necessary supports.

There was no system for recording the type, frequency or duration of behaviours which would allow more effective assessment and monitoring of any interventions the clinicians prescribed.

Further appointments were scheduled however for individual residents with clinical psychological services. Staff had up to date training in the management of behaviours that were challenging. The systems for oversight and monitoring to ensure such interventions was understood and implemented were not satisfactory.

Given the high dependency on the voluntary assistants to provide care this oversight is crucial.

Other aspects of this outcome were managed well and residents' protection was prioritised. The policy on the protection of vulnerable adults was in accordance with the national revised policy. As required by previous inspections staff and the designated officers had undertaken the required training in this procedure. The inspector was informed and saw no evidence that any allegations or concerns had occurred or were being investigated.

Staff expressed their confidence in the actions of the person in charge should any abusive incident occur. Residents who could communicate with inspectors stated that they felt safe in the centre. There were detailed personal and intimate care guidelines in each residents plan. Residents had additional supports in long standing relationships with previous staff who also acted as advocates on their behalf.

An external advocate had also been sourced and inspectors saw evidence of active involvement to support one vulnerable resident who did not have any external family members to do so.

Inspectors found that no chemical restraints were being used and no restrictive

practices were being used. No evidence of such was found.

All residents had their own bank account and with staff support managed their finances. A review of a sample of the records pertaining to the management of residents' monies as fee payments and for other purposes indicated that the systems for recording this money and its usage were detailed and transparent. All monies given for residents use were dated and the expenditure was recorded and receipted for the finance office. Records were available for review at any time.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The statement of purpose had been forwarded to the Authority as part of the application for registration. It was found to be centre-specific and compliant with the requirements of the regulations, with a minor amendment required which was in relation to the changes to significant personnel which had taken place.

Admissions to the centre and care practices implemented were congruent with the statement as a service for residents with moderate to severe intellectual disability and autism.

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):

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

Findings:

The inspector found that improvements had been made in the staff knowledge of the residents' healthcare needs and how to support them.

It was evident that the organisations nurse and person in charge had made efforts to ensure that staff were aware of and understood the residents' underlying medical conditions and the requirement for the support plans in relation to this.

There was assessments undertaken for pertinent issues and detailed support plans implemented for residents with specific needs such as cholesterol, blood pressures and prescribed support garments. There was evidence of referrals to dieticians and physiotherapists and staff explained the exercises they undertook with residents where this was prescribed. Chiropody, dentistry and ophthalmic reviews were evident. Regular blood tests, vaccinations and medication reviews were evident.

The lack of assessment by speech and language therapists is detailed and actioned under Outcome 5 (Social Care).

There was evidence that meals were nutritious and that residents had access to a healthy diet. Staff, including the new assistants /volunteers were able to tell the inspector of the residents' dietary needs and preferences. Meals were social occasions in both the workshops during the day and the centre as observed by the inspector. Staff and residents shared their meals.

There was a revised policy on end of life care which outlined supports with advanced planning arrangements. A detailed pain identification and management chart was incorporated as part of this policy. There was no resident who required this care at the time of this inspection although the organisation had in the recent past support a resident at end of life care very well in another centre. There was access to community nursing and palliative care should this be required.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

No actions were required from the previous inspection as systems remain satisfactory. The policy on the management of medication was centre-specific and in line with

legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for all medication including controlled medication were satisfactory although none were being used at the time of this inspection. There were appropriate documented procedures for the handling, disposal of and return of medication.

Medication was dispensed in systems which assisted the non nursing staff to do so safely. The community nurse employed by the provider undertook medication management training with staff. This included a competency assessment and new assistants were inducted promptly.

Both the pharmacist and the nurse undertook regular audits of administration and usage. Where any errors occurred there was a prompt and satisfactory response to avoid repetitions.

The inspectors saw evidence that medication was reviewed regularly by both the residents GP and the prescribing psychiatric service.

Judgment:

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):

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

Findings:

There were two actions required from the previous inspection. There were specifically the arrangements to allow the person in charge to manage more than one centre satisfactorily and to ensure there was oversight of the delivery of care in such circumstances.

The inspector found that while improvements were evident the arrangements in the centre for oversight and direction were not satisfactorily resolved in the absence of a team leader . This is demonstrated by the findings in Outcome 8 (Safeguarding and Safety).The post of team leader in this centre is significant as the duties included the day to day oversight of the live in assistants and implementation of the residents care plans. The post holder will report to the person in charge who is also responsible for 2

other centres. However, the process of recruitment for a suitably qualified and experienced team leader had commenced and is on-going.

The inspector acknowledges the significant amount of work evident from speaking with staff, a review of governance meeting minutes and team meetings records. Both the person in charge and the deputy provided additional support in the unit during this time of transition. In this way the provider attempted to mediate for the lack of direct line management on a day-to-day basis.

The role and responsibilities of the potential house leaders had been redefined in order to ensure future arrangements were satisfactory. There were structured and formal reporting systems evident.

There was evidence that both HIQA and internal action plans were being monitored and issues addressed. Referrals for assessments had been prioritised although arrangements to procure these had not been made. Fire management systems were substantially progressed. Residents needs were discussed at team meetings and coordinator meetings also focused on residents and actions required.

As part of the registration process the person in charge and the provider nominee demonstrated their knowledge of the regulatory responsibilities and had an in-depth knowledge of and relationship with the residents.

There was an appropriate day and night time on-call system in place.

The governance structure now also includes the post of community director which is a pivotal role in the local management structure.

A further audit/unannounced visit had been commissioned by the provider in compliance with the regulatory responsibilities. This would inform the annual report for 2016. This audit was a detailed overview of the service in terms of resident's welfare and care needs. The provider nominee also undertakes visits to the centre to meet the residents and generally monitor their welfare.

The inspector saw that surveys had been sent to residents and to family members prior to the previous inspection and these helped to inform the report for 2015 which was satisfactory.

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):

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

Findings:

The inspectors were satisfied that the number of staff were satisfactory. The centre was staffed by a mixture of assistants (who volunteered for one year) and two fulltime employed staff. However, as in the previous inspection improvements were required to ensure there was a system for oversight for staff in the centre to implement residents plans.

The new assistants are recruited in late summer each year. The inspector saw and staff confirmed that they had a detailed induction programme which was designed to lessen the impact of change on the residents when the volunteers were finished completing their term of duty.

The staff roster was available and outlined the daily responsibilities for each staff which was linked to the daily scheduling sheet for each resident. This ensured that the resident's activities and primary care needs were consistently provided.

The inspector noted that the three new assistants in the centre were all male and primarily is it the assistants who undertake the overnight duties. As this is a mixed unit the inspector was informed that when a female staff is not available a member of the management team undertakes the night duties to ensure needs are met appropriately.

A review of the training records and a sample of staff files showed a commitment to ongoing training with all mandatory training up to date. This included the detailed induction and mandatory training for the new assistants. One staff outlined this training process and was able to tell the inspector the process for management of a number of emergencies.

There were two staff on at all times with a minimum of two sleep over staff at night and one was assigned responsibility for monitoring of the falls alarm.

Good practice in recruitment was found. Staff files reviewed during this inspection were compliant with Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities Regulations 2013. The volunteer files had evidence of Garda Síochána vetting and clearance from police in their country of origin. The volunteer programme is co-ordinated by a designated staff member.

Weekly meetings took place attended by person in charge or house leader when available. From a review of the documentation the inspector found that the meetings focused on residents' care and reporting of any changes. Supervisions systems were evident on an annual basis. The staff were observed to be respectful and very supportive of the residents at all times during the process.

Judgment:

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:

Noelene Dowling
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 L'Arche Ireland
Centre ID:	OSV-0001959
Date of Inspection:	26 and 27 October 2016
Date of response:	22 November 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 02: Communication

Theme: Individualised Supports and Care

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

Systems to support residents' communication needs were not consistently implemented.

1. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

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

Communication aids will be developed to support resident's needs and ensure implementation of same.

Proposed Timescale: 30/11/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Specific assessments by speech and language therapist or current mental health assessments which would guide the personal care plans were not provided.

2. Action Required:

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

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

The Provider and the PIC will ensure that Speech & Language and following up on mental health assessments take place to guide personal care plans.

Proposed Timescale: 10/02/2017

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:

Fire drills were not held at different times of the day or evening to reflect the staffing levels and location of residents.

3. 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:

Fire drills will be carried out at various times of the day and all documentation will reflect the details of the drill i.e. what staff were present & location of residents.

Proposed Timescale: 30/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Behaviour support plans and monitoring systems for residents were not consistently implemented.

4. 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:

Implementation of Behavioural Support Plans and monitoring will be discussed at team meetings and the PIC will see that all behavioural plans are implemented.

Proposed Timescale: 06/12/2016

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:

There were no suitable arrangements to ensure the person in charge could satisfactorily manage more than one centre.

5. 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 vacancy of House Leader will be filled and in the interim the Deputy PIC has moved to support this centre while the role is vacant. The PIC will support & supervise the house leader role.

Proposed Timescale: 21/11/2016

