

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Belford House
<b>Centre ID:</b>	OSV-0002056
<b>Centre county:</b>	Wexford
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	An Breacadh Nua
<b>Provider Nominee:</b>	Gerard Heaney
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	8
<b>Number of vacancies on the date of inspection:</b>	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:
18 July 2017 12:00	18 July 2017 18:00
19 July 2017 10:20	19 July 2017 15:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

The purpose of this unannounced inspection was to assess the centre's ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This centre was previously inspected in 2014 and a registration inspection was carried out in October 2015 during which the centre achieved full 18 outcome compliance.

How we gathered our evidence:

The inspector met with staff members, including the person in charge, the provider nominee, the deputy person in charge and some staff members on duty the two days of inspection. The inspector also met all eight residents that resided in the centre and spoke more in depth with one resident. Documentation was also viewed as part of the process including a sample of the residents' health and social care plans, risk management documentation including personal risk assessments, a review of the incident and accident system for the service, staff files, training files and provider audits.

#### Description of the service:

Ard Aoibhinn services is a not for profit organisation and is run by a board of directors and delivers services as part of a service agreement with the HSE. The centre consists of a large detached single storey building that accommodates eight residents deemed to have high dependency needs. The centre is located in a central location in Wexford town. It is also situated close to local day services provided by Ard Aoibhinn services and other day service providers.

Each resident had their own bedroom and the provider was in the process of upgrading the bathroom in the centre and had purchased a state of the art accessible bath, which was not in use at the time, but when works were completed would provide an optimum bathing experience for residents with physical and sensory needs that lived in the centre.

The provider is required to produce a statement of purpose which reflects the aims and objectives of the centre. The provider statement of purpose for Belford House outlined their service 'strives to provide a holistic approach to service delivery, designed to meet the current and ever changing needs of each individual service user'.

#### Overall Judgment of our Findings:

Overall, the provider and person in charge had maintained good levels of compliance with the Regulations and Standards in this centre since the previous inspection. Comprehensive assessment of needs were completed for each resident and reviewed at least annually as required by the Regulations. Residents had good access to allied health professional and referrals and timely assessment by those professionals was evident. Improved intellectual disability psychiatry services in the Wexford area were also having a supportive impact on residents requiring those services.

There was also evidence of advocacy and rights promotion for residents. Residents were consulted about their service and their feedback and that of their families and/or representatives was also sought and documented.

The provider had also implemented measures to manage behaviours that challenge and their associated risks by increasing the staffing resources of the centre. Such risks were under consistent review by the management team and behaviour specialist for the service in consultation and review by the resident's psychiatrist. Changes had also been made to the residents' day service provision and evening activities in order to mitigate triggers and reasons that may contribute to behaviours that challenge. While these important actions were being implemented they had not been documented in a formalised behaviour support plan for the assessed need of the resident. An action relating to this is referenced in outcome 5; Social Care needs.

Some improvement was required in relation to the auditing including the six monthly provider led audits as required by the regulations and newly appointed staff had not received all mandatory training as required.

Of the seven outcomes inspected three met with compliance and four met with substantial compliance.

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

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

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The care and support provided to residents was consistently and sufficiently assessed and reviewed through comprehensive assessment of residents' social care needs and support planning to meet needs identified. Some improvement was required with regards to the creation of action plans to achieve goals for residents identified through their key worker meetings.

The inspector reviewed a sample of personal plans which were found to be comprehensive, personalised, detailed and reflected residents' specific requirements in relation to their social care needs.

There was evidence of a comprehensive assessment implemented and ongoing monitoring of residents' social care needs. Residents' assessment of needs included general likes and dislikes, nutrition, intimate care and personal hygiene needs, behaviour support planning, healthcare assessments and a separate personal centred planning file which residents maintained in their bedrooms. Some residents had been assessed as requiring specific supports in relation to risks associated with behaviours that challenge.

The provider had implemented measures to manage behaviours that challenge and their associated risks by increasing the staffing resources of the centre. Such risks were under consistent review by the management team and behaviour specialist for the service in consultation and review by the resident's psychiatrist. Changes had also been made to the residents' day service provision and evening activities in order to mitigate triggers and reasons that may contribute to behaviours that challenge. While these important

actions were being implemented they had not been documented in a formalised behaviour support plan for the assessed need of the resident.

Personal plans also contained information records such as personal risk assessments, support plans, daily reports, allied health professional recommendations and appointment updates, blood test results and other relevant current information to direct staff in the provision of residents' care and support needs.

Residents had identified goals both long term and short term which had been discussed with them and their keyworker fortnightly personal planning meetings. Some goals identified by residents included going on holidays, working on personal goals and improvement in skills they were learning, participation in important family events such as weddings.

While the inspector found residents' personal plans were comprehensive, a more formalised approach to goal setting was required to ensure when a resident identified a goal an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

**Judgment:**

Substantially Compliant

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

On this inspection the inspector found there were appropriate health and safety systems in place to address areas of health and safety including recording and monitoring of accidents and incidents, fire safety management, responding to and analysis of adverse incidents, creation of personal risk assessments, correct manual handling procedures and systems in place for effective management of infection control.

At the time of inspection the provider's risk management systems were meeting the requirements of the regulations. A compliance and risk review was underway within the organisation carried out by an external assessor whereby the provider's current risk management processes were being reviewed with a plan to improve systems if and where required.

Personal risks for residents had been identified and were analysed with control

measures in place to mitigate risks. These risk assessments were maintained in residents' personal plans. Measures to manage risks associated with behaviours that challenge were also included in personal risk management for residents which set out control measures and evidence of reviews to evaluate their effectiveness.

Fire safety policies and procedures were centre-specific and up-to-date. Fire evacuation notices and fire plans displayed in the house. Regular fire drills took place and records reviewed by the inspector confirmed that they were undertaken at least monthly and each drill evaluated the effectiveness of the drill and length of time of the drill. Each resident had a personal emergency evacuation plan in place which set out the specific requirements, supports and equipment necessary for the evacuation of residents. .

The inspector observed some fire evacuation doors were fitted with a press bar mechanism to ensure ease of evacuation in the event of an emergency. Other fire evacuation doors required a key in order to open them. On the first day of inspection it was noted one door could not be easily opened using the key supplied for it. The provider took steps to mitigate this issue by fitting thumb turn mechanisms to that door and another exit door. This improved the fire evacuation procedures and systems within the centre. Therefore, the provider's actions on the first day of inspection addressed the initial non compliance found by the inspector.

Doors throughout the premises were heavy set fire compliant doors. This promoted good fire containment measures in the centre. Door frames in specific locations were fitted with smoke seals and magnetic release mechanisms connected to the fire alarm which provided for adequate smoke and fire containment measures in the centre.

There was a policy on infection control available. Cleaning schedules were in place and these were completed by staff on an on-going basis. The premises appeared clean throughout during the inspection. Hand washing facilities in the centre were adequate. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces. Each resident had their own personal towels for hand drying purposes. Hand soap was supplied in bathrooms and toilets in the centre.

Safe and appropriate practices in relation to manual handling were in place. Appropriate manual handling equipment was in supply in the centre and servicing of equipment was up-to-date. Each resident requiring manual handling supports had an associated manual handling risk assessment which identified risks and support requirements for residents.

**Judgment:**  
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):**

No actions were required from the previous inspection.

**Findings:**

The provider had appropriate safeguarding and safety procedures and reporting mechanisms in place to protect residents from experiencing abuse and to support staff to report allegations or suspicions of abuse. There was evidence of a positive behaviour support approach for the management of behaviours that challenge. Some improvement was required in relation to the documentation of restrictive practice interventions in the centre. One staff member required formalised training in safeguarding vulnerable adults.

There were appropriate measures in place to protect residents being from being abused, measures in place also ensured staff working in the centre understood appropriate procedures for the response to allegations of abuse and detection of signs of abuse. Staff spoken with during the inspection described appropriate steps they would take in response to an allegation of abuse. There was also a policy in place which guided staff on the prevention, detection and response to abuse. Policies and procedures followed the National Safeguarding policy and procedures with regards to safeguarding of vulnerable adults. The person in charge and the house manager for the centre had completed designated person training.

A plan was in place for the organisation's designated persons to carry out safeguarding vulnerable adults training however, at the time of the inspection, they were awaiting training pack materials in order to provide the training and could not proceed until this occurred. Due to this delay not all staff working in the centre had received formalised training in safeguarding vulnerable adults. However, of those staff that had not received the formalised training they did describe to the inspector a working knowledge of the appropriate reporting procedures to be taken and to whom they should report such allegations to.

Due to the nature of some resident's personal needs, behaviour risk management supports were required to prevent peer-to-peer incidents of aggression. In the months prior to the inspection there had been a number of incidents of peer-to-peer assault notified to the Chief Inspector. To address these incidents the provider and person in charge had implemented strategies to mitigate the risk from occurring. For example, the provider had increased the staffing numbers in the centre to ensure the risk to residents was reduced through greater supervision of residents and provision of more activities in the evening time for residents, for example. At the time of inspection there was evidence to indicate these strategies were working.

Ongoing assessment of behaviours that challenge incidents was in process at the time of inspection. After each incident of behaviour that is challenging an incident analysis chart

was completed by staff. These incident analysis charts were maintained in residents' personal plans and reviewed by a behaviour specialist for the service along with the resident's key worker and manager of the centre. This information was used to develop behaviour support recommendations and planning to support residents within a positive behaviour support framework.

Residents had access to HSE intellectual disability psychiatric services in the Wexford area. This was a new development in the provision of psychiatric services within the region. Staff feedback indicated this was invaluable for residents who required such specific supports. There was evidence of regular, comprehensive review of residents with specific support needs in this area. Residents were supported to attend appointments with their mental health clinician and staff could contact the intellectual disability psychiatric services at any time if an issue arose or for advice or clarification. This was of critical importance for residents living in the centre who could present with behaviours that challenge associated with deterioration in their mental health, for example.

A restraint free environment was promoted in the centre, and overall there were minimal restrictive practices in use. Where residents required PRN (as required) medications as part of an overall challenging behaviour risk management strategy, administration protocols were in place which set out criteria for its use.

While this was evidence of good practice with regards to the management of chemical restraint this same practice was required for all other restrictive practices in the centre. All restrictive practices used in the centre required descriptive criteria for its use and also for when it was to cease. This would ensure it was implemented in a consistent manner, as a last resort and for the least amount of time necessary.

Each resident had a detailed intimate care plan in place which set out specific information regarding each resident's personal hygiene preferences and how staff supported this. These plans also identified residents' levels of independence and specific areas they required supports in order to promote and encourage their independence.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

Residents' healthcare needs were met to a good standard in this centre and there was evidence which indicated they were supported to achieve their best possible health.

Residents' healthcare needs had been identified through a comprehensive assessment of needs and an 'A1 Health check' which provided an assessment framework for a proactive approach to monitoring the residents' health. Residents' healthcare needs were regularly reviewed by allied health care professionals where appropriate and/or required. All residents attended their own General Practitioner and were supported to do so by staff. Out-of-hours services were also provided if necessary.

Allied health professional supports available to residents included doctors, dentists, psychiatrists, chiropodists, physiotherapists, occupational therapist, opticians and orthotic clinicians. These services were available to residents through referral to the HSE.

Residents were fully involved in the menu planning in the centre. Weekly meetings were held with the residents to plan the meals for the following week. Residents' food preferences and choices were known to staff and incorporated in menu and meal planning in the centre. Menu options were displayed using colour picture charts and written format. Food prepared during the inspection smelt appetizing and residents received appropriate and discrete assistance during meals.

Food hygiene systems were in place for the safe preparation of foods, including designated food preparation areas, colour coded chopping boards and labelling of foods and open dates identified. Fridges, freezers and cupboards were well stocked with produce and fresh fruit was also observed available in the centre.

Some residents attended slimming clubs in their locality and were supported to do so by their key worker, for example. Residents requiring modified consistency meal provision were also appropriately supported in the centre. Speech and Language guidelines for food and liquids consistency was identified in residents' personal plans and staff were familiar with these guidelines and implemented them as prescribed.

**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:**

This inspection found safe medication management systems were in place and carried out in line with the organisation's medication management policies and procedures. Prescribing and administration practices were in line with best practice guidelines and legislation.

Residents' medication was supplied in a monitored dosage blister pack system. Each resident had the opportunity to meet with their pharmacist both within the centre and/or the pharmacy as they wished. Audits by the supplying pharmacist were also carried out in the centre and reviewed and audited practices to ensure they were in line with legislative medication management practices.

Staff involved in the administration of medications had attended safe administration of medication and buccal midazolam (emergency medication for the management of seizures associated with epilepsy) training which included competency assessments prior to staff being deemed competent to administer the medication.

Staff who spoke to the inspector were knowledgeable about the resident's medications and demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements.

Residents' medications were stored and secured in a locked cupboard in a room secured by a key-code to enter. Medication keys were held by the staff on duty. A functional medication management fridge was also available for the storage of medicines which required refrigeration. There were none such medicines prescribed to residents at the time of inspection. Appropriate secure storage and documentation procedures were in place for the management of controlled medications similarly none were prescribed for residents at the time of inspection.

Medication administration charts reviewed were clearly written and distinguished between PRN (as required), short-term and regular medication. Each medication documented on the charts were signed by the residents' prescribing doctor.

**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):**

No actions were required from the previous inspection.

**Findings:**

The provider had ensured a competent and accountable governance structure to manage the centre. Systems were in place to support and promote the delivery of safe, quality care services, however, some improvements were required in relation to the auditing of procedures in the centre.

The person in charge for the centre worked full-time and had been employed in the service for 11 years. As found on the previous inspection, she had the required experience and knowledge to ensure the effective care and welfare of residents in the centre. The person in charge also demonstrated a commitment to her own continued professional development and had recently completed a degree in management.

A deputy person in charge managed the centre on a daily basis. They were also appropriately skilled and qualified to carry out their role and they facilitated the inspection in a pleasant and effective manner throughout the process. Both the person in charge and deputy person in charge demonstrated an excellent knowledge of the needs and personalities of the residents. Both demonstrated a commitment to upholding the rights of residents and supported residents to avail of advocacy services where required or requested by the resident.

The nominated provider, and the person in charge were actively engaged in the governance and operational management of the centre, and based on interactions with them during the inspection, they had knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities appropriate to their respective roles and responsibilities.

An annual review of the service had been completed. An unannounced visit of the designated centre, as required by the Regulations, had also been completed. Some improvement was required with regards to the template used as part of the six monthly audit process for the centre. While the audit assessed compliance against the regulations it lacked a descriptive narrative to evidence how the service was or was not achieving compliance. Improvement was also required in relation to the action plan that arose from the audits and the identification of who was responsible to complete the action and within what timeline.

The provider was also required to review the overall continual auditing system within the centre to ensure all key risk areas were assessed and evaluated. For example restrictive practices were not identified through a restraint register for the purposes of auditing of practices and control measures in place to ensure they were the least restrictive, used for the least amount of time necessary and reviewed or discontinued following a review.

**Judgment:**

Substantially Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

The provider had ensured appropriate staffing resources in the centre to meet the assessed needs and risk management requirements in the centre. Staff were appropriately supervised and a training was afforded to staff to meet the assessed needs of residents. There were some gaps in newly appointed staffs files relating to mandatory training requirements.

As referred to in the opening paragraph the provider had ensured appropriate staffing resources in the centre to meet the assessed needs of residents. Staffing levels reflected the statement of purpose and size and layout of the centre. An actual and planned staff rota was maintained. Staffing levels on both days of inspection reflected the staff rotas and also provided for the management of an identified risk management procedure whereby additional staffing were required.

A copy of the staff rota was also available in a picture format in the houses to inform residents in an accessible way the staff on duty for both the day and night time shift. Two 'waking' night staff worked in the centre and four staff worked in the centre during the day and evening time when residents were in the house.

Safe recruitment practices were also in place to ensure staff employed in the centre were suitably experienced and vetted. The inspector reviewed a sample of staff files and found that they met the requirements of Schedule 2 of the regulations.

Records were maintained of staff training. Staff had attended training in areas such of management and response to behaviours that challenge, occupational first aid, infection control, safe administration of medication and administration of buccal midazolam (emergency medication for the management of seizures). Certificates of attendance were maintained in staff files and a training matrix was maintained. While training was available to staff there were gaps in mandatory training for a recently recruited staff member. The person in charge was required to address this as soon as possible.

A supervision process was implemented in the centre whereby staff were afforded supervision meetings with the deputy person in charge. A documented record of the meetings was maintained and items discussed pertained to a range of areas such as sick leave, annual leave and training opportunities and goals.

Residents spoken with said they liked staff and identified their keyworkers telling the inspector they met with them regularly. Staff were observed to interact with residents in a pleasant way and were responsive to them during periods when they required support and guidance.

There were no volunteers attending the centre at the time of inspection. Students on placement from the local IT worked in the centre including student nurses. Systems were in place for students to be appropriately vetted and supervised during their work placements.

**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:***

Ann-Marie O'Neill  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by An Breacadh Nua
<b>Centre ID:</b>	OSV-0002056
<b>Date of Inspection:</b>	18 July 2017 and 19 July 2017
<b>Date of response:</b>	27 July 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:**

While important actions were being implemented to address a risk associated with behaviours that challenge they had not been documented in a formalised behaviour support plan for the assessed need of the resident.

**1. Action Required:**

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



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

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

A formalised behaviour support plan will be compiled and will include actions currently being implemented for the identified resident.

**Proposed Timescale:** 30/09/2017

**Theme:** Effective Services

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

While the inspector found residents' personal plans were comprehensive, a more formalised approach to goal setting was required.

**2. 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:**

Goal setting in the Person centred planning documentation will be reviewed and updated. The new document will outline a more formalised approach to goal setting which will include details of person responsible, actions taken and time frames.

**Proposed Timescale:** 30/09/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Some improvement was required in relation to the documentation of restrictive practice interventions in the centre

**3. 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:**

The centre will develop a "Restrictive Practice Register" that provides a record of all restrictive practices that may be used. This register will provide details of the control

measure, the purpose and review date of the measure.  
In addition the oversight committee that has been established will be involved in monitoring and reviewing all restrictive practises at the designated centre.

**Proposed Timescale:** 30/10/2017

**Theme:** Safe Services

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

One staff member required formalised training in safeguarding vulnerable adults.

**4. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Formal training in this area will be scheduled for September and October 2017. The staff member identified will be attending this training.

**Proposed Timescale:** 31/10/2017

**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:**

Some improvement was required with regards to the template used as part of the six monthly audit process for the centre. While the audit assessed compliance against the regulations it lacked a descriptive narrative to evidence how the service was or was not achieving compliance. Improvement was also required in relation to the action plan that arose from the audits and the identification of who was responsible to complete the action and within what timeline.

The provider was required to review the overall continual auditing system within the centre to ensure all key risk areas were assessed and evaluated.

**5. 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 template currently used for unannounced inspections will be adapted to take account of including a "descriptive narrative" of the overall inspection. It will also clearly

outline the actions that need to be taken following the inspection, timeframes for this, and persons responsible for the actions. 31/12/2017

The Organisation has employed a project worker to look at all areas of Risk management including Health & safety aspects. This work is being completed within the company and across 3 other companies in the region. On completion it is planned to have comprehensive systems in place for all aspects of Risk Management including auditing. This is a yearlong project that will conclude in June of 2018

**Proposed Timescale:** 31/12/2017

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There were some gaps in newly appointed staffs files relating to mandatory training requirements .

**6. 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 staff member will receive Fire training by the end of October 2017

**Proposed Timescale:** 31/10/2017