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:	Moonvoy
Centre ID:	OSV-0003284
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Waterford Intellectual Disability Association Ltd
Provider Nominee:	Fiona O'Neill
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 November 2016 11:30	08 November 2016 19:10

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
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:
This monitoring inspection was carried out to monitor compliance with specific regulations and to assess if the provider had addressed the actions from the previous inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with two residents. One resident declined to meet with the inspector. The inspector was supported by staff when communicating with some residents.

Residents spoken with told the inspector they were happy living in the centre and liked staff. They said they could talk to staff or the person in charge if they were unhappy.

The inspector also spoke with the person in charge of the centre and reviewed documentation such as residents' support plans, medical records, accident logs, policies and procedures and staff files.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, the inspector found that the service was provided as described in that document.

The centre was located within close proximity of a town centre and amenities. Residents were supported by staff to access amenities and the centre had the use of the provider's vehicles to ensure residents could access community based activities.

The house contained adequate private and communal space to meet the needs of residents. Residents had individual bedrooms and en suite bathrooms, a kitchen/dining room and a living room. The centre met residents' assessed needs in regard to the physical premises.

The service was available to adults with an intellectual disability, who had low support care needs, including some support with activities of daily living.

Overall judgment of our findings:
Overall, the inspector found that residents were supported to have a good quality life in the centre and the provider had arrangements to promote the rights and safety of residents.

The inspector found the provider had put a system in place to meet the requirements of the regulations. Furthermore, the inspector noted that the addition of a Quality Manager to the organization's staffing complement had the potential to further strengthen this and to address any systems which may result in non-compliances with the regulations.

Good practice was identified in areas such as:
- Residents' rights and dignity (in outcome 1)
- Social care needs (in outcome 5)
- Workforce (outcome 17)
- Governance and management (in outcome 14)

Improvement was required in some areas including:
- The oversight of complaints (in outcome 1)
- The annual assessment of residents' healthcare needs
- Some risk management and fire safety measures (in outcome 7)
- Some systems to ensure residents were protected against the risk of financial abuse (in outcome 8)
- Medicine management (outcome 12)

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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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 ensure residents were treated with dignity, residents' rights were respected, residents were consulted with and residents were supported to make complaints and access advocacy services. Improvement was required to the oversight of complaints in the centre to ensure that a record of investigations into all complaints was maintained.

The inspector observed respectful interaction between residents and staff. Residents spoken with said they liked staff working in the centre and could speak with staff or the person in charge in relation to any aspect of their care and support.

There were mechanisms to ensure residents were consulted with on a regular basis. This included consultation in relation to their individual care and support, mealtimes, activities and changes to the centre.

The inspector was told residents would be supported to access independent advocacy if required. Residents and families had been given information about the independent advocacy service and how to contact them.

There was a procedure for responding to complaints. It included the detail of the person with responsibility for responding to complaints and the details of a separate person to ensure all complaints are responded to and records maintained.

The inspector reviewed the record of complaints received in the centre. Some of the records were not maintained in the folder. The inspector was told it was maintained in

the organisation's head office. The documentation was put in the folder by the person in charge on the day of the inspection. The inspector noted that the person identified in the policy for responding to complaints was also the person who was reviewing complaints to ensure all complaints are responded to and records maintained. The separate person was not carrying out the role of reviewing complaints.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Residents had service agreements which outlined the service provided and the fee charged. The inspector read a sample of these and found the service provided and fee paid were clear.

The service agreements were signed by residents to show they had agreed to the terms and conditions. However, the agreements were not signed by the provider or a person on their behalf. It was therefore not evident the provider had agreed to the terms outlined.

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

Findings:
Residents' social and personal care needs were assessed on an annual basis. However, an annual healthcare assessment had not taken place for residents.

The inspector viewed a sample of residents' social care plans. The inspector noted that goals had been set with residents and residents were supported to achieve goals. Previous goals had been reviewed.

The assessment documentation was being reviewed at the time of the inspection as the provider had recognised that the format did not provide the best possible support for residents and staff to carry out these assessments. The new document was in an 'easy read' format for residents. The inspector was told that meetings were taking place over the coming weeks to complete the assessments with residents, review previous goals and set new goals.

Residents' healthcare needs had not been assessed on an annual basis. Although there was a reasonable rationale for the absence of an assessment for one resident, the rationale for an annual assessment not taking place for other residents was not demonstrated. This was discussed with the person in charge who acknowledged the health assessments should have taken place and said assessments would take place as soon as practicable.

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):
No actions were required from the previous inspection.

Findings:
There were systems in place to protect and promote the health and safety of residents, staff and visitors. Improvement was required to the control measure to protect residents from a risk and to the measures to ensure all residents could be evacuated safely from the centre in the event of an emergency.

The risk management policy outlined the measures and actions in place to control risks

in the centre. Risks had been identified by the provider and control measures had been implemented to address or minimise risks.

The inspector noted that the management of risk in the centre did not impinge on the rights of residents and the promotion of residents' independence. For example, a resident had been assessed as independent in staying in the centre in the absence of staff. The provider had implemented appropriate measures to ensure the resident's safety when in the centre alone and had ensured that these measures were agreed with the resident.

Improvement was required to the control measure to ensure residents were not at risk of scalding. The inspector was told a thermostatic control measure had been fitted to the water supply however, the water on the day of inspection placed residents at risk of scalding. The person in charge acknowledged the water was too hot and said they would ensure this was addressed and implement a system for ensuring the water temperature was a maximum of 43 degrees Celsius.

There was a fire safety folder in the centre. The folder contained the system and documents to show all equipment was serviced and regular checks were carried out on all aspects of fire safety. For example, staff carried out checks on the fire doors and escape routes on a daily basis and the alarm system on a weekly basis.

The fire fighting equipment and emergency lighting had been serviced. A service contract was in place with an external company to ensure this was carried out with the frequency required. The record of the servicing of the fire alarm was not available on the day of inspection. The provider submitted this the day after the inspection. The document showed the annual servicing of the fire alarm had taken place in July 2016.

The inspector viewed the fire drill records. All residents and all staff working in the centre had taken part in fire drills. Fire drills were not taking place as frequently as the provider had identified was required. For example, a resident's risk assessment stated that six monthly 'deep sleep' fire drills were required to ensure the resident could be safely evacuated. One fire drill was identified to the inspector as a 'deep sleep' drill and this had taken place at 7am. The inspector also noted that many of the fire drill records did not have dates recorded on the documents and could therefore not ascertain the frequency of fire drills.

The centre had a velux window in the corridor leading from the upstairs landing and stairs to the external exit. The purpose of this was to ensure that smoke would be emitted from the area in the event of a fire thus increasing visibility which would assist in the evacuation of residents. The fire drill records showed that the velux window had failed to open in a number of fire drills. This had been a consistent issue since March 2015. The person in charge told the inspector this had been reviewed on numerous occasions by the fire company who had been employed to address the issue. The person in charge said the company had replaced a part and this had been unsuccessful. The person in charge stated that the company had stated they would be replacing the window. There was no timeline for the completion of this at the time of the inspection.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Measures to ensure that residents received support with any behaviour which may impinge on their quality of life and on other residents were being implemented. Improvement was required to the measures in place for safeguarding residents' finances to ensure residents were safeguarded from the risk of financial abuse.

There were measures in place to keep residents safe and protect them from abuse. Staff and the person in charge were knowledgeable of the procedures for safeguarding residents and reporting any suspected or confirmed allegations of abuse. Staff had received training in safeguarding residents.

Allegations of abuse had been submitted to HIQA and these related to peer to peer incidents. The inspector read the incident records and saw that incidents were taking place between residents. Some of these had been addressed as a resident had been supported to move to a setting which, the provider had determined, was more suited to meeting the resident's assessed needs. However, some incidents were taking place on a frequent basis. The person in charge said the frequency of these incidents had been recognised as potential abuse and that safeguarding plans had been formulated and were being implemented.

The inspector reviewed the allegations, incidents and safeguarding plans and saw that measures were taking place to address the identified concerns. Staff spoken with were knowledgeable of these issues and the measures required to address these. Staff had received training in responding to behaviour that is challenging including de-escalation techniques. Some allegations and incidents related to behaviour that was challenging. While some measures had been implemented it was evident this had not been effective.

The person in charge said the provider had recognised this and had employed the services of a professional with expertise in this area. The implementation of a support plan had commenced prior to the inspection and the inspector noted the focus on meeting residents' needs and upholding residents' rights and dignity.

The provider had notified HIQA of the use of a keypad code to leave the centre. This was in place as a safety measure and residents were supported to learn the code and leave the centre. Staff supported residents who required full time support to leave the centre. There were no other restrictive practices identified.

The inspector reviewed the arrangements for supporting residents to manage their finances. Assessments to identify the support residents required to manage their monies had been carried out. These stated that residents required full staff support in this area. While there were appropriate and safe measures to support residents some aspects of the system did not ensure that all residents finances were safeguarded at all times. For example, receipts were not maintained for money which was given to residents' day programme staff. In addition, some arrangements were not consistent with the support outlined in the assessments which resulted in a risk that had not been identified.

Judgment:
Non Compliant - Moderate

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:
The system for assessing residents' healthcare needs on an annual basis was not implemented for all residents. However, having reviewed residents' healthcare plans the inspector saw that residents' healthcare needs were being responded to and residents were supported to access health professionals where there was an identified illness or health related need. The inspector therefore made the judgment that the non-compliance with the regulations in relation to this was a non-compliance with Regulation 5 as it related to the assessment of need as opposed to meeting residents' needs. For this reason the action related to this is included in outcome 5.

Residents attended a general practitioner of their choice and allied health professionals as required. Residents were supported to attend appointments and records were maintained of visits and any recommendations made. The person in charge and staff were knowledgeable of residents' healthcare needs.

Residents were supported by staff to purchase groceries and prepare meals. Residents spoken with said they liked the food and also enjoyed eating out. Some residents were supported to go out for dinner on the evening of the inspection. Residents spoken with said they were looking forward to the meal and enjoyed eating out.

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

Findings:
There were policies and procedures relating to the ordering, prescribing, storing and administering of medicines in the centre. Improvement was required to some aspects of the centre's system to ensure that residents were protected by safe medicine management practices.

Assessments to ascertain the level of support residents required with the management of their medicines had been carried out. The inspector viewed a sample of these and found they had been updated where resident support needs had changed. The inspector was told these would continue to be reviewed on a regular basis to ensure they were accurately reflective of residents' needs and supported residents to be as independent as possible in managing their medicines.

Residents were supported by staff to obtain prescriptions for medicines from their general practitioners (GP) and the prescriptions were then brought to the pharmacy to be dispensed. Medicines were then collected and stored in a locked medicine cabinet in a locked press in the centre. Each resident had an individual subsection of the medicine cabinet. Medicines which were prescribed to be dispensed on a daily long-term basis were dispensed by the pharmacy in a pre-packaged individualised system. Medicines prescribed on a short term or p.r.n. (a medicine only taken as the needs arises) basis were stored in their original containers.

The inspector read a number of prescription sheets. Some prescription sheets did not provide adequate clarity of guidance for staff. For example, some medicines on prescription sheets were not clearly legible and the maximum dose and frequency of administration was not detailed for all p.r.n. medicines. A record of the administration of p.r.n. medicines was maintained which clearly identified the reason for the

administration of the medicine and the discussion which took place with the person in charge prior to administering the medicine.

There was no system to ensure that all medicines prescribed on a short term or p.r.n. basis were administered to residents or returned to the pharmacy for disposal. Although a record of the receipt of medicines and return of medicines was maintained these were not reconciled with the administration documentation to ensure there were no discrepancies. The person in charge told the inspector this would be addressed to ensure that all medicines received were either administered to the resident for whom it was prescribed or returned to the pharmacy for disposal.

There were appropriate procedures for the disposal of medicines and the storage of the medicines prior to disposal. Medicines were returned to the pharmacy and a record of the return of medicines was signed by the pharmacy to confirm receipt of the returned medicines.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was management system with clear lines of authority and accountability. The person in charge was present on the day of the inspection and outlined the mechanisms for ensuring all aspects of the service were safe, effective and monitored. Improvement was required to the system to ensure that the provider carried out an unannounced visit to the centre at least once every six months.

The inspector found the person in charge was engaged in the operational management of the centre on a regular and consistent basis. The person in charge met with staff working in the centre on a daily basis and any concerns were addressed. Staff spoken with said they felt supported by the person in charge and felt they could raise any concerns they had about the service provided or the operation of the centre.

The person in charge had implemented a system to audit the service provided. Audits were carried out on a regular and consistent basis and plans had been implemented to address the areas identified as requiring improvement. The audits included record keeping, management of finances, hand hygiene and food and nutrition.

A review of the safety and quality of care had taken place on an annual basis as required by the regulations.

The person in charge told the inspector the organisation had appointed a person to a newly created post of Quality Manager. She said this person will be responsible for auditing the organisation's compliance with adhering to their statutory responsibilities and adhering to their requirement to notify external agencies, for example HIQA and their funding body.

The person in charge had carried out unannounced visits to the centre and reports had been prepared. However, the unannounced visits had not taken place every six months as required by the regulations.

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:
There were appropriate staff numbers and skill mix to meet the needs of residents.

There was a planned and actual staff rota in the centre. A core staff team worked in the centre and this was identified as required by the person in charge to ensure continuity of support for residents and relationships to develop.

The inspector spent time in the company of staff and residents and saw positive and respectful interactions. Staff spoken with were knowledgeable of the residents and their role in supporting residents. Staff were observed interacting with residents in a manner consistent with residents' support plans.

Information required by the regulations had been obtained for staff working in the centre. This included Garda vetting, evidence of the person's identity and evidence of accredited training or qualifications. Many support workers had qualifications in social care.

Staff had received all required training. This included training in manual handling, the prevention, detection and response to suspected or confirmed allegations of abuse, fire prevention and control, supporting residents with behaviour that is challenging, safe administration of medicines, hand hygiene, first aid and food and nutrition.

There was a formal system for supervising staff. Records of formal supervision meetings showed these meetings took place regularly and actions were agreed and reviewed. The person in charge provided day to day supervision and support for staff and visited the centre on a regular basis.

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:

Lorraine Egan
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[1]

Centre name:	A designated centre for people with disabilities operated by Waterford Intellectual Disability Association Ltd
Centre ID:	OSV-0003284
Date of Inspection:	08 November 2016
Date of response:	27 January 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person nominated to ensure that all complaints are appropriately responded to and a record of all complaints are maintained was not carrying out this role.

1. Action Required:

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

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
MA-24 Management of Complaints will be reviewed. The procedure will clearly name the individual who will review all complaints within the service to ensure the correct process has been followed, that all documentation is in order and complainants are satisfied with the outcome. Documentary evidence of this review will be maintained. The named person will review all of the complaints for 2016 to date and will ensure that they have been appropriately responded to and a record of how complaints are dealt with is maintained.

Proposed Timescale: 31/01/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not signed the service agreements and it was therefore not evident the provider had agreed to the terms outlined.

2. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
The Service Provision agreement document will be updated to include a space for the Provider to sign. Pending this documentation change, and the gradual introduction of same across the organisation the Provider will sign all existing contracts.

Proposed Timescale: 31/01/2017

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:
A comprehensive assessment, by an appropriate health care professional, of the health needs of each resident was not carried out on an annual basis.

3. 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:
All agreeable service users will have had their annual health assessment by 18th January 2017. One has been completed and the family of another has made a GP appointment to accompany the person.

Proposed Timescale: 18/01/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system in place in the designated centre for the assessment, management and ongoing review of risk did not include all risks.

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:
A new thermostatic controller will be fitted to ensure that the water temperature does not exceed 43 degrees Celsius.

Proposed Timescale: 23/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not taking place in line with the frequency identified as required to ensure that, as far as is reasonably practicable, residents are aware of the procedure to be followed in the case of fire.

5. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The documentation in use will be amended to reflect:

a. The people participating in fire drills.
b. The time and date of the fire drill will be in a 'required information' column.
c. A specific time frame for 'deep sleep' drills between 05:00 and 06:30.
d. The Fire Book will have a schedule page which reflects the residents Emergency Egress Risk Assessments. This will plan the frequency of the fire drills and ensure that all service users needs are met. This schedule will include general, deep sleep and independent fire drills if required.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for maintaining all building fabric was not adequate.

6. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The repairs to the Velux window were completed on the 22nd December. Maintenance of Equipment procedure will be updated to reflect that a person is designated as being responsible to ensure that all repairs are completed in a timely manner. This will include a documented system which logs all repair requests from staff and all contact with Approved Suppliers of services involved in maintenance to WIDA equipment.

Proposed Timescale: Repairs to the Velux window were completed on the 22nd December 2016. The changes to the procedure will be completed by 31st January 2017.

Proposed Timescale: 31/01/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some measures to protect residents from financial abuse were not implemented.

7. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
Day services have been contacted to request receipts for all monies provided to them

by staff on behalf of service users. Staff have reviewed assessments and care plans to ensure that these reflect what is happening in relation to service users finances.

Proposed Timescale: 31/12/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some systems were not adequately robust to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed.

8. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
a) A prescription kardex was returned to a GP requesting that it was rewritten to ensure all writing was legible, and that clear direction was available to staff re the maximum dose and frequency of administration of PRN medication.
b) SD-05 Service Users Medication will be updated to reflect a new audit of all PRN medications being reconciled every month against the log of PRN medications which have been administered.

Proposed Timescale: 31/01/2017

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:
An unannounced visit to the designated centre had not taken place at least once every six months.

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

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

The registered provider will ensure that the unannounced inspections are completed within the required time frame. Proposed Timescale: 28th February 2017 and ongoing thereafter
Proposed Timescale: 28/02/2017