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:	Cullen House
Centre ID:	OSV-0005046
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Ann Morahan
Lead inspector:	Jillian Connolly
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
27 September 2017 10:30	27 September 2017 18:30

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the centre. The purpose of this inspection was to identify if the provider had taken appropriate action to respond to findings of the last inspection in November 2016.

How we gathered our evidence:
As part of this inspection, inspectors met the three residents. Inspectors also met with staff and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:
The designated centre is a single house and operated by Nua Healthcare Services. The centre provides services to female residents.

Overall findings:
Inspectors found that residents lived active lives and observed staff to be familiar

with the needs of residents. Residents gave varying accounts of their satisfaction with the service provided. Some residents stated that they were happy with the centre. However, a resident also stated that they were not happy living in the centre, primarily due to the relationship they had with a peer. Inspectors found that the action taken to address these concerns by the provider was not adequate. Improvements were also required to ensure that the risk management policies and procedures were appropriately implemented to ensure that there was an adequate oversight of risk in the centre.

The findings of this inspection are written under outcomes in this report and the actions the provider are required to take are outlined in the action plan at the end of this report.

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

Outcome 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:
There had been no new admissions since the last inspection. The provider had developed a policy for future admissions to the centre which identified the procedure to be followed to ensure that all future admissions would be based on clear and transparent criteria and in line with the statement of purpose of the centre. The procedure also included mechanisms to ensure that existing residents would be safeguarded from abuse by their peers going forward.

The person in charge's role and responsibility in assessing future admissions had changed in the admissions policy. The person in charge confirmed that they had received training in the policy and their responsibility.

Judgment:
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 inspectors found that residents were supported to engage in activities in line with their interests and capabilities. The provider had a system in place for the assessment of residents' health and social care needs. Each resident also had a personal plan in place which aimed to identify the supports residents required to meet identified needs. However, inspectors found that personal plans did not consistently identify the supports residents required and the mechanisms in place to ensure the support was provided.

Residents were supported by residential staff to meet their social care needs. Residents completed a variety of activities which aimed to meet their identified needs. For example, residents partook in voluntary dog walking, pottery classes, delivering vegetables and art and craft classes. They also completed tasks within their home, such as shopping and household chores. Residents told the inspectors that they enjoyed their activities and showed photographs of recent holidays that they had been on. The personal planning system involved identifying, through an assessment, areas in which residents required support, which were called outcomes. Key workers in conjunction with residents were then due to choose three outcomes on a monthly basis to work on. At the end of the month, the three outcomes were reviewed. However, the inspector found that the monthly outcomes did not identify how the individual needs of residents were being met or if they were effective. For example, a resident was identified as requiring support to develop their community inclusion. However, the supports required to achieve this were not clear. In the following three months, the resident was supported to go on two day trips as part of their monthly outcomes. One of the day trips was reviewed and the outcome was that the resident enjoyed the outing. However, it was not clear how this developed their community inclusion. The second outing had not been reviewed.

Inspectors also found that the system did not ensure that residents were consistently supported to meet their identified needs. For example, education on rights and to reduce the restrictions in their life was identified as a need. This was due to be completed via key working sessions. However, inspectors reviewed a sample of key working session and found that this was not occurring.

Residents had access to allied health professionals. However, inspectors found that allied health professionals were not consistently involved in the reviews of personal plans. For example, a resident was identified as having sensory needs. The relevant allied health professional had not reviewed the sensory assessment as part of the residents' annual review to identify if the supports in place were effective.

Judgment:
Substantially Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The centre consisted of one house located in Co. Kildare. The centre consisted of four bedrooms, two bath/shower rooms, a sitting room, a kitchen/dining room and a staff office. Each of the residents had their own bedroom and some were happy to show the inspectors their rooms. The inspectors found that they were personalized, and residents informed inspectors of additional decoration they were planning on undertaking. Staff used the fourth bedroom and conservatory as sleep over rooms.

Overall, the inspectors found the centre to be clean and suitably decorated. There was also sufficient heat and light. There was adequate communal space for three residents. However, inspectors observed that if residents required additional support staff, the kitchen/dining area could present a challenge due to the layout and the number of individuals which would access it at any given time.

There were ample external grounds, which were well maintained. The centre had facilities for the disposal of waste.

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

Findings:
The provider was in the process of developing the systems in place for the assessment and management of risk. However, inspectors found that the system in place, as of the

day of inspection, was not implemented in line with the current procedures. As a result, the effectiveness of the system was not consistently evident.

The provider had policies and procedures in place for the safety of residents, staff and visitors. This included a safety statement and risk management policy. There had also been an assessment of the environmental risks in the centre which had been completed by an external contractor. Individual risk assessments had been completed for risks to residents. However, the inspectors found that there was an absence of assessment of the clinical and operational risks within the centre. For example, some residents required clinical supports but the skill set and knowledge of staff had not been assessed to ensure that the risk associated with providing these supports were managed. There had also been a reduction in the time the person in charge was present in the centre. This had not been assessed to evaluate the risk associated with this reduction in management resources and to ensure that there were appropriate control measures in place to ensure the service was safe and effective.

Inspectors reviewed a sample of the accident/incident records and found that they were not adequately reviewed to ensure that identified control measures for associated risks and been implemented prior to the incident occurring. As a result, it was not evident that the control measures were effective in reducing the risk. For example, it was identified that self-harm was a high risk. There had been incidents resulting in injury following self-harm. The reviews of incidents did not address if the control measures were implemented prior to the incident occurring.

The policy also stated that high risks were to be reviewed on a monthly basis at a minimum. This was not occurring in practice.

There were systems in place for the prevention and management of fire. This included the provision of a fire alarm, fire extinguishers, and emergency lighting. Inspectors confirmed that they were serviced at appropriate intervals by an external contractor. There were measures in place for the containment of fire such as fire doors. However, the inspector observed them to be wedged open on arrival to the centre. Staff had received training in fire safety and were aware of the actions to be followed in the event of a fire. Residents also demonstrated that they knew what to do in the event of a fire and confirmed that they had taken part in fire drills. A review of fire drills demonstrated that all three residents could be evacuated to a place of safety with the lowest compliment of staffing.

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 were policies and procedures in place for the prevention and response to allegations and suspicions of abuse. Staff had also received training in safeguarding of vulnerable adults. However, inspectors found that identified safeguarding concerns in the centre had not been adequately addressed and as a result residents were not living in an environment in which they were safe.

Positive behaviour support was a requirement in the centre. In November 2016, inspectors had identified that residents were due to be discharged from the organisation's positive behaviour support team. The provider had responded by stating that the residents' plans had been reviewed and that residents would continue to have support through the walk-in clinics available. There was a high level of restrictive practice in the centre, with one resident being physically restrained 40 times in 2017. The resident had not been supported to attend the walk-in clinic. Incident report forms were not reviewed by the appropriate professionals to ensure that the strategies were effective and that physical restraint was the least restrictive option available and was used for the shortest duration of time. There had not been a robust assessment completed to ensure that the physical restraints were safe and did not cause undue harm or distress to the resident.

HIQA had been notified of a number of allegations or suspicions of abuse in the centre since the last inspection. They had been reported in line with policy to the Health Service Executive and safeguarding plans had been developed. However, inspectors found that the control measures identified in the safeguarding plans were not accurate and adverse events between peers continued to occur in the centre. For example, it stated that residents were supported by specific staffing levels as a safeguard. Rosters confirmed that this was not occurring and staff stated that it was a challenge to implement the safeguarding plans at particular times during the day. A complaint had been submitted by a resident due to conflict they experienced with another resident. The resident had also reported this during the unannounced visit conducted by the provider and to inspectors on the day of inspection. Mediation had been attempted in March 2017 and was unsuccessful. Fundamentally, inspectors found that the provider had not responded appropriately to the ongoing safeguarding concerns in the centre.

Inspectors also found that room searches had also been introduced to the centre as a safeguarding measure. This had not been agreed by the multidisciplinary team.

Judgment:

Non Compliant - Major

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

Findings:
Inspectors reviewed a sample of adverse events and found that not all allegations and suspicions of abuse had been reported as required by regulation 31.

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

Findings:
Residents were supported to attend their general practitioners (GPs) when a need arose. Inspectors also found that residents had good access to additional health-care professionals including, opticians, dentists, chiropodists and audiologists. However, improvements were required to the day-to-day practices of the centre to ensure that the healthcare needs of residents were met and staff had an understanding of the supports they were providing.

Each resident had a health assessment in place. Following this a health management plan was developed which outlined the day-to-day supports to be provided to ensure residents' needs were met. Inspectors identified that the support provided to residents was not in line with their plans. For example, one plan stated that a resident's weight should be measured monthly. This was not happening in practice. There was also

general guidance in place for monitoring residents' blood pressure due to an associated healthcare risk. However, staff were not able to inform inspectors of what would constitute an abnormal reading or the action to be taken if it occurred.

Personal plans had a focus on healthy eating and emphasised the importance of residents being supported to maintain a healthy body mass index (BMI). This was also included in monthly outcomes identified for residents. Residents had been assessed by a dietician and speech and language therapist.

Residents reported satisfaction with the food provided and were supported to be involved in the shopping for and preparation of meals.

Judgment:
Substantially 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 in place for medication management. Staff had received training in the safe administration of medication. Nursing support was available for the administration of inter muscular medication administration. The inspector observed medication to be stored in a secure location and there was a separate location for the storage of medication which was due to be returned to the pharmacy.

Following the last inspection, the provider had introduced guidance for the circumstances in which PRN medicines (medicines only taken as the need arises) could be administered. This was overseen by the prescriber. The provider had introduced a system in which staff had to contact the on-call manager prior to administering PRN medicines.

Of the sample of prescription records reviewed, inspectors confirmed that they contained all of the necessary information, including the name, date of birth and address of the resident. There was also a signature for each individual medication. The maximum dosage of PRN medicines to be administered in a 24 hour period and the route of administration were also stated.

Of the sample of administration records, inspectors confirmed that the times medication was administered correlated with the time prescribed.

Residents had been assessed for their ability to self-administer.

There were stock checks conducted of the medication held in the centre.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors reviewed the Statement of Purpose and confirmed that it contained all of the information as required by Schedule 1 of the regulations.

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:
The provider had governance systems in place. However, inspectors found that these

systems did not adequately assess if the care and support provided in the centre was safe and effective and met the needs of the residents.

There had been a change in the management structure in the centre since the last inspection. There had been a new regional manager appointed the week of this inspection. There had also been a change to the Director of Operations. The person in charge had also taken responsibility of a second centre and, as a result, their time in the centre had been reduced. The provider had appointed an additional deputy team leader in their absence. The Director of Operations was nominated as the contact person for HIQA and they reported to the Chief Operating Officer.

There had been five audits completed in the centre since the last inspection. They focused on areas such as restrictive practice, record management, use of resources, personal planning and contracts for the provision of services. Inspectors reviewed the reports generated from the audits and found that they had identified deficits in the service provision in February 2017 which had not been addressed as of the day of inspection. For example, it identified that risk assessments were not being reviewed monthly and residents' weights were not being monitored at appropriate intervals. As evidenced in this report, these had not been addressed.

There had also been an unannounced visit completed in the centre by a person nominated on behalf of the provider. However, inspectors found that the information gathered did not adequately reflect the practices of the centre. For example, it stated that each resident had a multi-element behaviour support plan. They did not. It further stated that there had been three allegations or suspicions of abuse in the centre. This information did not match that submitted to HIQA or identified by inspectors on this inspection.

The provider was not due to complete an annual review of the quality and safety of care since the last inspection.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that the staffing available in the centre throughout the day was not in line with the assessed needs of residents. Residents were identified as requiring specific staffing supports to safeguard them. These staffing levels were only available from 9.00 to 17.00. The centre also did not have sufficient permanent staff employed, which resulted in a high level of relief staff being used. Considering the complex needs of the residents living in the centre, inspectors determined that this presented a risk to the continuity of care to residents.

Inspectors were provided with records of training and found that staff had completed mandatory training such as manual handling. Additional training had also been provided in first aid, infection control and food hygiene.

Staff received formal supervision and stated they found it was a beneficial forum. Inspectors reviewed a sample of minutes from these supervisions and found that it was an opportunity for staff to raise concerns and management to identify areas for improvement in practice.

Team meeting also occurred in which the individual needs of residents were discussed and policies and procedures were reviewed.

There were no volunteers in the centre as of the day of inspection.

Inspectors did not review staff files on this inspection.

Judgment:
Non Compliant - Moderate

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:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0005046
Date of Inspection:	27 September 2017
Date of response:	17 October 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:
Reviews of personal plans did not consistently take into account the effectiveness of the plan.

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 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PIC and DOS to facilitated a review of Personal Plans [1 Nov 2017]
All staff to receive refresher training on Personal Planning implementation [30 Nov 2017]

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Relevant members of the multi disciplinary team were not consistently involved in the reviews of personal plans.

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

Please state the actions you have taken or are planning to take:
The PIC and DOS to facilitated a review of Personal Plans [1 Nov 2017]
Personal Plans will be reviewed by the MDT [07 Nov 2017]

Proposed Timescale: 07/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plan did not adequately identify the supports residents required to ensure their assessed needs were met.

3. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
The PIC and DOS to facilitated a review of Personal Plans [1 Nov 2017]
PIC to complete a Comprehensive Needs Assessment on all resident residing in the Centre [24 Oct 2017]
Personal Plans to be updated to ensure the supports required to meet the assessed needs are planned [07 Nov 2017]

Proposed Timescale: 07/11/2017

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 risk management system in place were not implemented in line with the current procedures. As a result, the effectiveness of the system was not consistently evident.

4. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
The PIC undertook a review of the Risk Management System in Centre to ensure it is in line with current Policy [16 Oct 2017]
The new Policy and Procedure on Risk Management has been circulated to the PIC [09 Oct 2017]
The PIC completed training on the new Policy for Risk Management [17 Oct 2017]
The training will also encompass training on the development of the Centre Specific Risk Management Register [17 Oct 2017]
The new Centre Specific Risk Management Register will be developed and implemented in the Centre [31 Oct 2017]
The new Centre Specific Risk Management Register will be discussed at the team meetings with all staff in November 2017 and December 2017 [24 Dec 2017]

Proposed Timescale: 24/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed fire doors to be wedged open.

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

Please state the actions you have taken or are planning to take:
The PIC conducted briefing with all staff in centre in relation to fire doors being wedged open [16 Oct 2017]
Fire Doors being wedged open will be on the agenda for the next Team Meeting [24 Oct 2017]

Proposed Timescale: 24/10/2017

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:
All efforts had not been made to identify and alleviate the cause of residents' behavior.

6. 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:
Revised Behaviour Support Policy will be released to the Workforce and Implemented as part of the Providers Overall review of the Safeguarding Policies. [23 Oct 2017]

Behaviour Supports will be reviewed on an ongoing basis by the PIC and Behavioural Specialist to ensure every effort to identify and alleviate the cause of Residents behaviour is made. This will be in line with Behaviour Support Policy [07 Nov 2017]

Continue to review Restrictive Practices in the Centre by the PIC and Director of Services to justify its use and to ensure it is used for the shortest duration [07 Nov 2017]

Restrictive Practices will be reviewed on an ongoing basis by the PIC and Behavioural Specialist. Any restrictive practices will be applied in line with Policy on Restrictive Practice [07 Nov 2017]

Statistics on restraints to be monitored weekly by Director of Services. Persons in Charge will report weekly to the DOS and PN. [Due Date: 23 Oct 2017]

Proposed Timescale: 07/11/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received training in positive behavior support.

7. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is

challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
Provide training and development for the Person in Charge and staff team in Positive Behavioural Support [07 Nov 2017]

Proposed Timescale: 07/11/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not demonstrated that restrictive practices had been adequately assessed and reviewed to ensure that they were implemented appropriately, the least restrictive and were used for the shortest duration of time.

8. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
MDT to discuss Restrictive Practice in regards to one resident was held [03 Oct 2017]
Continue to review Restrictive Practices in the Centre by the PIC and Director of Services to justify its use and to ensure it is used for the shortest duration [07 Nov 2017]
Statistics on restraints to be monitored weekly by Director of Services. Persons in Charge will report weekly to the DOS and PN. [Due Date: 23 Oct 2017]

Proposed Timescale: 07/11/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding concerns in the centre had not been adequately addressed.

9. 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:
Safeguarding Review was held with the Centre's Designate Officers to review all safeguarding plans in Centre [17 Oct 2017]

PIC to complete a Comprehensive Needs Assessment and impact assessments for each resident residing in the Centre and this will be reviewed by ADT committee and PIC [24 Oct 2017]

Proposed Timescale: 17/10/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All allegations and suspicions of abuse had not been reported as required by regulation 31.

10. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
The PIC is to review all incident reports to ensure all safeguarding issues are identified and acted upon [17 Oct 2017]
PIC will ensure all allegations of abuse are reported in line regulation 31(1) (F) [17 Oct 2017]

Proposed Timescale: 17/10/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to the day to day practices of the centre to ensure that the healthcare needs of residents were met and staff had an understanding of the supports they were providing.

11. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
All staff to receive Training on Healthcare needs for residents residing in the Centre [30 Nov 2017]

Proposed Timescale: 30/10/2017

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:
Deficits identified through audits had not been adequately addressed. The unannounced visit was not consistently reflective of the practice of the centre.

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

Please state the actions you have taken or are planning to take:
The Unannounced visit process has been revised to ensure accuracy and is consistently reflective of practice in the centre. This system was implemented in September 2017.

The Centre's unannounced visit report will be reviewed to ensure Deficits identified are adequately addressed [07 Nov 2017]

Proposed Timescale: 07/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have sufficient permanent staff employed. This resulted in a high level of relief staff being used.

13. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
A Full review of staff team has been completed by PN and PIC which included a review of the Roster [17 Oct 2017].
Following the review of the roster excessive annual leave was granted at the one time. The PIC will now ensure annual leave is granted in line with policy to ensure the staffing ratios are as per the Statement of Purpose [07 Nov 2017

Proposed Timescale: 07/11/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing available in the centre throughout the day was not in line with the assessed needs of residents.

14. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
PIC to completed a Comprehensive Needs Assessment for each resident residing in the Centre and this will be reviewed by Provider Nominee and DOS [1 Nov 2017]

A Full review of staff team has been completed by PN and PIC which will included a review of the Roster to ensure it meets the assessed needs of the

Proposed Timescale: 01/11/2017