

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cairdeas Services Kilkenny
Centre ID:	OSV-0005054
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Johanna Cooney
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
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 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: 31 January 2017 09:00 To: 31 January 2017 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the second inspection of this centre which is part of an organisation which has a number of designated centres in the region. This was an unannounced monitoring inspection undertaken to ascertain the continued compliance with the regulations and standards.

The centre was granted registration in September 2015 having been inspected in May 2015. The provider had made changes to the resident group and the care and support needs provided in the centre since the previous inspection. All of the relevant documentation required including a revised statement of purpose had been forwarded to HIQA.

How we gathered the evidence:

The inspector met with all residents and spoke with three and they allowed the inspector to observe some of their daily life and routines. Residents who could communicate told the inspector they were very happy living in the centre, it was their home, they lived with their pals, could have a pint when they wished, they enjoyed their activities and meeting their families and they also liked the staff.

The inspector also met with staff members and the person in charge. The 9 actions

required from that inspection of 2015 were reviewed and the provider had made the agreed changes.

Description of the service:

The statement of purpose describes the centre as providing care for 10 residents, both male and female with moderate to profound intellectual disabilities and additional age and behaviour related needs. To this end the inspector found that the care provided was congruent with the residents' needs and the statement of purpose.

The centre is comprised of two units located some miles from each other. One unit is situated on the main campus of the organisation and the second is located in a rural area. Both are single story with adequate space for privacy and also for the use of any specialised equipment necessary to support the residents. The premises are homely, well equipped, spacious and suitable for the current and changing needs of the residents.

Overall judgement of our findings:

The findings of this inspection are influenced by the current governance structures at local level. The person in charge is responsible for a number of centres and it is apparent that this has not allowed for effective systems of oversight and review of residents' care needs. It is acknowledged that some changes had been made and further were planned to address this matter but they had not as yet become embedded in practice.

Good practice was observed in the following areas;

- Residents had good access to healthcare and multidisciplinary specialists which supported resident wellbeing (outcome 5)
- Safeguarding systems were robust and effective which held to keep residents safe (outcome 8)
- Medicines management systems were safe (outcome 12)
- Residents activities were based on their own preferences (outcome 5)
- Numbers and skill mix of staff were suitable which provided good levels of support and continuity for the residents (outcome 17)

Improvements were required in the following areas to improve the overall outcomes for residents;

- Fire safety management systems which could place residents at risk (outcome 7)
- Resident's dignity and privacy were not protected sufficiently (outcome 1)
- Annual reviews and personal plans were not detailed and in some cases implemented which could impact on resident's welfare (outcome 5).

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)

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:

This outcome was not reviewed in its entirety but a number of factors were noted which impacted on residents' privacy and dignity.

There were viewing panels on bedroom doors which were seen to impinge on residents' privacy as there were no screens available on the panels to protect resident dignity. This was a historical feature installed when the unit was first built. Residents in some instances were using commodes as shower chairs which were also undignified.

A resident at some risk of seizure activity had an unsuitable audio alarm which was used inappropriately when the resident should reasonably have expected privacy. This was both intrusive and undignified. The rationale for the use of this and manner of its use had not been reviewed these were also historical practices.

In another instance a resident attended a religious service which was not of the resident's religious denomination. The inspector did not see evidence that this was being undertaken with consultation and agreement.

In other respects it was apparent that the residents had choice in their preferred routines and could, on a day decide to change their plans, go out if they wished or stay home from day services or activities.

It was apparent that staff knew their means of communication and non verbal expressions and responded to this.

Judgment:

Non Compliant - Moderate

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:

A number of improvements were required in systems for assessment, planning, review and implementation of residents' personal plans and support needs. All residents had very good access to multidisciplinary assessments, and services such as physiotherapy, occupational therapy, neurology, psychology and mental health.

However, the required support plans to address the assessed needs was not consistently evident across both units.

There was evidence of failure to update assessments, to review support plans when needs had obviously changed to reflect the care required and delivered, out of date manual handling plans, dependency assessments, swallow care plans and lack of skin integrity care plans where these would be deemed necessary.

It was also apparent in some instances that where reviews had taken place as required they were not comprehensive evaluations of the resident's lives and wellbeing. The quality and content of the personal plans seen differed also with some seen to be reflective of all of the resident needs, personal preferences and timeframes for achievement and others not comprehensive.

There was however evidence that the newly appointed team leader and person in charge were aware of these deficits and were in the process of reviewing all personal plans and assessments. None the less, given the high dependency and changing needs of a number of the residents and despite observation of good primary care practices this cannot be entirely explained by lack of documentation.

Residents preferred activities and social engagements were outlined.

The capacity and preferences of the residents for social activities and occupation

differed according to age and illness. Some residents attended a day service where they undertook various jobs and training activities. These were supported by staff where necessary. Others were primarily centre based. These included access to preferred DVDs, sensory rooms massage or gardening in the centre. They went swimming and had regular visits home supported by staff where necessary. Both units were spacious and bedrooms were very comfortable with televisions, music systems and easy chairs where residents can sit quietly doing their own preferred activities as observed by the inspector.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The actions from the previous inspection had been satisfactorily resolved with the installation of emergency lighting and fire doors in one unit. However, further risks were identified in risk management systems which did not demonstrate adequate oversight of safety.

Crucial fire doors in both units were found to be wedged open. This was explained to the inspector as being due to residents not being able to open the doors independently. Other fire doors did not have self closing devices installed which negated their value. The fire evacuation plan was neither satisfactory nor understood by staff. For example, one resident's evacuation plan had not been revised since early 2015 when the resident was living in another unit. Fire drills held indicated that the slide sheets available could not be used as they were not correctly attached. There were no remedial actions taken to address this.

The inspector found that there was a lack of clarity in regard to these systems with contradictory information provided.

There was no satisfactory plan for a resident who was considered at risk of going absent. The inspector found that one crucial emergency phone number for immediate assistance was not readily available to staff.

Fire safety management systems including the fire alarm, extinguishers and emergency lighting were installed and serviced quarterly and annually as required.

The risk management policy had been revised to comply with the regulations and

included the process for learning from and review of untoward events.

There was evidence that systems were being devised with more detailed auditing and reviews of accident or incidents being undertaken. There were detailed individual risk assessments and management plans for pertinent issues including falls or choking risks evident.

There was a signed and current health and safety statement available. Six monthly audits of the environment and work practices were undertaken. However, given the findings in relation to fire safety these required improvements to be effective. There were policies in place including a detailed emergency plan which contained all of the required information including arrangements for the interim accommodation of residents should this be required.

The policy and practice on infection control and the disposal of sharps was detailed. Staff were observed taking appropriate precautions and using protective equipment including gloves and sanitizers as this was necessary.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The policy on the protection of vulnerable adults was in accordance with the Health Service Executive (SHE) policy to ensure satisfactory screening, implementation of safeguarding plans and adequate review of incidents.

The provider employed a dedicated social work service. There was a suitably qualified and experienced person nominated as the designated person to oversee any allegations of this nature. Records demonstrated that all current staff in the centre had received up to date training in the prevention of and response to abuse. The inspector saw records and spoke with the person in charge regarding an allegation of misconduct and found that the provider had taken the necessary steps to safeguard residents and ensure that systems for supervision and professional conduct were implemented.

There were also pictorial and easy read versions of safeguarding systems for residents. Residents who could communicate informed the inspector that they felt safe in the centre. Staff were able to articulate their understanding and responsibilities in relation to appropriate behaviour. Safeguarding and intimate care plans were in place where these were required.

The inspector found that the systems for the support of behaviour that challenges and the use of restrictive practices were based on national guidelines and undertaken with consistent multidisciplinary guidance and review.

Both mental health and psychology services were available internally and resident's psychosocial needs were very well assessed and supported with ongoing intervention and review. Behaviour support plans were detailed and staff spoken with demonstrated an understanding of and empathy with the underlying causes of behaviour and were seen to implement the plans.

The policy on the use of restrictive practices included both physical and chemical restraint. It clearly defined the exceptional circumstances in which such procedures should be used and how they were to be monitored and overseen. The inspector was satisfied that such practices including the use of chemical restraints were monitored, not used inappropriately, the protocol was followed and robustly reviewed.

All staff had training in challenging behaviours including in MAPA (a specific system for the management of challenging behaviours) where this was relevant to the residents and no such physical interventions were used in one unit.

Judgment:

Compliant

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated that the person in charge was in compliance with the requirement to forward the required notifications to the Authority. All incidents were found to be reviewed internally.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found evidence that residents healthcare needs were being met some improvements were required to ensure there was clarity regarding the nutritional needs of some residents and that recommendations of specialists were being followed.

Overall, there was evidence that residents had good and timely access to general practitioners (GPs) and out of hours service was also available where necessary.

There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, mental health specialists, neurologist dieticians, physiotherapy and psychiatry.

The inspector saw evidence of health promotion and monitoring with regular tests and interventions to manage specific healthcare needs.

The inspector saw from records and speaking with staff that families were kept fully informed and involved in regards to healthcare issues and appointments. Inspectors were informed and saw evidence that if a resident was admitted to acute services staff were made available to remain with them to ensure their needs were understood. Staff were aware of resident's dietary preferences and residents helped staff to do the shopping in some instances. Food was freshly cooked each day and presented according to the residents need.

There was a policy on end of life care and this was pertinent at the time of this inspection. Changes had been made to ensure adequate supports for the residents were made available.

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:

Both actions required from the previous inspection had been addressed. Medicines were appropriately prescribed and any deviations from the prescribed timing of administration were managed appropriately with medical guidance. The policy on the management of medicines was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for and return of medicines were satisfactory.

Where any errors were noted these were appropriately addressed. No controlled medicines were being used at the time of the inspection. However, as this could arise in one unit, the team leader was in the process of ensuring safe storage systems were available.

Although there was a nurse on duty in both units at all times non nursing staff also had medicines training and were also trained in the administration of emergency medication should this arise. The inspector saw evidence that all medicine was reviewed regularly by both the residents GPs and the prescribing psychiatric service. No resident was assessed as having the capacity to self-administer..

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 findings in relation to the outcomes on social care and fire safety indicate that some improvements are required in systems for oversight within the centre. These findings

may be influenced by the fact that the person in charge is currently managing a number of centres. The support systems which included a team leader in each unit to facilitate this have not been entirely effective. The post holder is suitably qualified and with both management and clinical experience which is relevant to the assessed needs of the residents.

The inspector was informed of proposed changes to the governance arrangements at centre level which, if implemented, would address these deficits. Protected time for the team leaders was also being implemented.

The local management team included the regional services manager, person in charge, human resources, social work and psychology department, and training/ quality manager.

The provider nominee had commissioned two six monthly unannounced visits to the centre to review the quality. The reports were detailed and covered area such as the staff training and induction, changes to medicines systems and medication audits. Any issues identified were noted for action. However, the systems for evaluation were not entirely satisfactory as they had not fully identified and remedied the findings outlined in the various outcomes.

The inspector reviewed the annual report for 2015 which had been compiled in an easy read format suitable for residents and found that this covered a range of issues including significant events, complaints, and finances and included the views of relatives and residents which were very positive.

The inspector was satisfied with the proposed changes to governance as outlined by the person in charge.

There was a satisfactory day and night time on-call system in place and staff confirmed that this was effective and responsive.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Both actions from the previous inspection had been addressed with a twilight staff assigned to one unit until 11:pm and access to an additional staff from an adjacent centre to ensure residents care needs at night were attended to. Residents needs indicate that they require fulltime nursing care and this was available.

The inspector was satisfied that the skill mix and number of staff were satisfactory to meet the needs of the residents. There was an induction programme in place which a new employee outlined to the inspector. Staff were supervised on a day-to-day basis by the team leader. There were detailed day-to-day communication systems used to ensure consistency.

There was evidence that staff supervision systems had commenced with the team leader.

Team performance meetings had been held on two occasions in 2016. The purpose was to ensure reviews, assessment and personal plans were up to date. The findings indicated that this system required improvements in order to implement the actions identified at these meetings. The inspector was informed that team leaders would undertake such meetings more frequently.

Staff spoken with had a good understanding of the residents' needs and preferences. Examination of a sample of personnel files showed good practice in recruitment procedures for staff with all the required documentation sourced and verified prior to taking up appointments. This included persons provided by external agencies. Where agency staff were used there was evidence that consistent personnel were used for continuity of care. Care assistant staff had qualifications or FETAC level five as the minimum requirement.

A review of files and the training matrix showed that there was a commitment to mandatory training with all of the staff allocated to the centre having undertaken fire safety, manual handling, medicines management and challenging behaviour training within either a one year or two year time frame as dictated by the policy. In addition staff had also had training in dementia and sign language which were pertinent to the needs of the residents.

Judgment:

Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
Centre ID:	OSV-0005054
Date of Inspection:	31 January 2017
Date of response:	06 March 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:

Residents privacy and dignity were being negatively impacted upon by viewing panels in bedroom doors and the use of inappropriate equipment and listening devices.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

- Risk assessments have been reviewed audio device no longer in use.
- Glass panels have been covered to ensure privacy
- Referral sent to O.T re: assessment for specialised equipment.

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

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

Residents' religious denomination were not respected.

2. Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

The individual is currently being supported to attend a service in accordance with his religious denomination.

Proposed Timescale: 28th Feb 2017 and ongoing

Proposed Timescale: 28/02/2017

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:

Reassessments were not consistently undertaken to reflect obvious changes in residents care needs.

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:

Individual's assessments/plans are currently being reviewed and updated to reflect changing needs.

Proposed Timescale: 30/04/2017

Theme: Effective Services

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

Comprehensive annual reviews of residents personal plans had not taken place consistently and changes were not reflected in a number of personal support plans available.

4. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

Systems have been put in place to ensure ongoing regular review of documentation takes place.

Proposed Timescale: 30/04/2017

Theme: Effective Services

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

Some necessary support plans were not available or not reflective of needs in some cases,

5. Action Required:

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:

Research has been carried out to explore best practice in relation to individual needs; plans have been revised to reflect this.

Proposed Timescale: 31/03/2017

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:

Systems for the identification and management of risk were not robustly implemented; This included residents going absent and access to emergency support staff.

6. 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:

- Emergency protocols have been reviewed and updated
- Emergency contact numbers have been displayed prominently.

Proposed Timescale: 30/03/2017

Theme: Effective Services

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

Systems for the management of fire were not effective in the following respects

- Fire doors in both units were found to be wedged open
- Fire doors did not have self closing devices installed
- The fire evacuation plan was not understood by staff.
- Equipment identified or use in the event of evacuation was not deemed suitable.

7. Action Required:

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

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

- A full review of fire emergency practices has taken place.
- Fire door devices are being installed
- A more suitable emergency exit door has been ordered.
- Fire safety procedures have been reviewed at a recent team meeting.

Proposed Timescale: 30/04/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was lack of clarity regarding the additional nutritional needs of some residents and the recommendations of specialists.

8. Action Required:

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

Individual plans have been reviewed and will be monitored closely.

Proposed Timescale: 28/02/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The current arrangement for the person in charge to manage more than one centre was not satisfactory to ensure good operational management and oversight.

9. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

A process of restructuring of designated centres is currently being undertaken, new PIC'S will be appointed.

Proposed Timescale: 30/06/2017

Theme: Leadership, Governance and Management

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

The content and detail of the unannounced visits did not provide sufficient information on the standards of care.

10. 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:

A review of the documentation for unannounced visits will take place.

Proposed Timescale: 30/04/2017