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:	Upper Woodlands Close
Centre ID:	OSV-0005313
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ann Gilmartin
Lead inspector:	Christopher Regan-Rushe
Support inspector(s):	Anne Marie Byrne
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
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 compliance with National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 February 2017 10:20	13 February 2017 19:00
14 February 2017 08:00	14 February 2017 16:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations

2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

The inspector met with 28 residents, nine staff members and the person in charge (PIC) during the inspection process. One residents spoke one-to-one with inspectors at that resident's request. Not all residents were able to communicate with inspectors. The centre is situated on a campus setting and consists of seven units and all units were visited by inspectors. One resident did not want to meet with inspectors and this was respected for the duration of the inspection.

Inspectors reviewed practices and documentation, including nine residents' files, eight staff files, incident reports, policies and procedures, fire management related documents and risk assessments.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and is located outside Sligo town. The centre provides residential services to people with an intellectual disability, who have been identified as requiring low to high levels of support. The service can accommodate male and female residents, from the age of 18 years upwards. Two of the units provide accommodation for seven residents, two of the units provide accommodation for five residents, one unit provides accommodation for four residents and one unit provides accommodation to one resident. One unit was unoccupied on the day of inspection. Four of the residents were scheduled to transition into the community over the coming months.

The PIC had overall responsibility for the centre. The PIC is supported in her role by the provider. The PIC works directly on the campus in an administrative capacity and regularly visits each centre to meet with staff and residents. All units are bungalows and have a communal kitchen, dining room, lounge and bedroom spaces for residents.

Overall judgment of our findings:

The centre had made some improvements since the last inspection in October 2016. However, inspectors found major non-compliance in all five outcomes inspected. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce.

The findings and their actions are further outlined in the body of the report and 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 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:
Actions from the previous inspection had not been satisfactorily completed; however, some actions were still in progress and not due for completion until March 2017. Inspectors found improvements were required to the development and completion of social care plans.

The centre was in the process of implementing a new residents' personal planning system. This was scheduled for completion on the 12th of February, 2017. However, this had not been achieved in line with the providers agreed timeframe and inspectors found that some residents did not have plans in place for the year 2017. Of the completed personal plans, these considered a wide range of personal goals; however, some personal plans lacked clarity as to how individual goals would be met. Some personal goals did not provide measurable timeframes for achievement. Residents did not have their personal plans in an accessible format.

Residents' social care needs were found to be routine led rather than individualised. Staff told inspectors that often residents were unable achieve their individual social care goals as planned, due to the lack of transport and staff resources. Inspectors were informed by staff that the centre had access to one bus which could not accommodate the mobility needs of all residents. Taxi services were frequently used by the service to accommodate residents' transport needs, however some residents did not like to use this mode of transport and arrangements to support these residents to access the community were unclear.

Staffing levels were found to be inadequate and did not meet the assessed needs of all residents. Staff were frequently deployed from the houses in the centre to cover staff shortages and to support day-care services in other houses. Staff reported that this often meant that residents planned activities were cancelled or could not be achieved due to limited staffing. The PIC informed the inspectors that a business case had been submitted for 18 hours additional social care support for the centre. The outcome of this business case had not been determined at the time of inspection. In addition, there was no plan in place to identify how these additional hours would be allocated for residents' social care.

The centre is supporting four residents to transition into the community. Transition plans were in place for these residents, which identified all supports required prior to, and following their transition. However, the centre had not assessed the impact of resident separation as part of the overall transitioning planning process. Furthermore, there was a general confusion of roles between staff members as to who was responsible for certain transitional planning tasks. Staff and residents informed the inspectors that they were not clear about the centre's overall transition plans and some residents were concerned by this. For example, one resident who asked to speak with the inspectors described her distress at not being engaged in conversations about transition and stated she did not know when she would be moving from the centre.

Judgment:
Non Compliant - Major

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:
Actions from the centre's previous inspection report were not satisfactorily completed. Inspectors found that fire safety remained a significant concern.

Additional emergency lighting had been installed at the centre since the last inspection. The centre had completed a number of fire drills across all units and records of the fire drills were maintained.

Staff at the centre reported that they did not use the fire alarm during these drills to alert residents of the need to evacuate. Instead, whistles were being used in all units to alert residents of fire. During drills staff would use whistles to alert residents. Inspectors asked staff how the residents would know that hearing the fire alarm was a trigger for

evacuation and the staff spoken with advised the inspectors that they would rely on the whistle's to also alert residents in the event of an actual fire. There was one main fire exit route from residents' bedrooms, a review of the fire drills conducted in the centre highlighted that the provider had failed to consider how they would evacuate residents from their bedrooms in the event of a fire blocking the fire exit at the end of the bedroom corridor. Personal emergency evacuation plans (PEEPs) were in place for residents and these had been updated since the last inspection. PEEPs included information about the level of support required by residents in the event of a fire. However, these evacuation plans did not consider the evacuation of residents from their bedrooms if the two emergency exits were inaccessible due to fire in the corridor of the bungalows. In addition the PEEPs did not describe the additional staff support that would be required in the event that residents required evacuation from their bedrooms or where residents may be reluctant to evacuate the centre.

There was a bleep system in place to alert staff, across all houses in the centre, of the location of fire once the fire alarm is activated; however, inspectors were informed that this bleep system had not been working for a number of weeks. A system had been put in place where staff in the house where the fire panel was located, were required to telephone the remaining units to alert them of the fire's location. However, inspectors were informed by staff that occasionally the unit where the fire panel was located, was not always staffed. Staff told inspectors that when this occurred they would leave their units to go to the location of the fire panel in order to locate the fire and then alert the other units. Inspectors found written procedures had not been developed to guide staff in the detection and management of fire in the absence of an operative beep system. In addition some staff had not completed or updated their training in fire safety at the time of inspection.

Inspectors noted that the centres fire panel was reporting a communication fault. Staff told inspectors that this had only occurred on the day of inspection, however other staff told inspectors that this had occurred when the bleep system failed some four weeks earlier. This was brought to the attention of the PIC during the first day of the inspection.

The centre had a system in place for the assessment, monitoring and review of resident and organisational risks. Inspectors identified gaps in this risk management system. Each unit within the centre had a risk register in place, specific to the unit. However, the risk management system was found to be ineffective, for example where additional control measures were put in place to mitigate risks, these were noted by the inspectors as having no impact on the overall and residual risk rating.

The PIC had completed a list of work that was required within each unit to reduce falls hazards; however, a date for the completion of these works had not been identified. Residents had experienced a number of falls since the last inspection. Learning from falls was not evidenced in the residents support plans which were found to be inadequate and did not inform staff how to prevent residents at high risk of falls from further falls. In addition, risk assessments had not been completed where residents at risk of falls continued to use sunken shower trays on a daily basis.

The provider had failed to adequately assess all risks evident in the centre and had not

put in adequate controls to prevent the likelihood of harm occurring, these included

- the replacement of missing toilet seats
- lone working risk assessments for staff where required
- poor road coverings and a suitable walkway for residents when using access roads in the centre.
- lack of rails outside the units where there were high steps and trip hazards, which were previously identified during inspection.

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

Findings:
The actions from the centre's previous inspection report were not satisfactorily completed. Inspectors found improvements were required to the management of peer-on-peer incidents, and the safety of vulnerable residents residing in overcrowded units.

Restrictive practices were in place at the time of the inspection. However, there were no risk assessments completed for these. Staff were able to inform inspectors of the restrictive practices in place within each unit; however, evidence reviewed by the inspectors identified a number of restrictive practices were not subject to regular review. For example, one resident had restrictive practices in place that had not been reviewed since they were developed in 2014. Other residents had restrictive practices in place which were not reviewed since 2015.

There were safeguarding plans in place at the time of inspection. However, where long term peer-on-peer incidents were occurring, there were no safeguarding plans in place to protect residents from this type of incident. For example, in once instance, Inspectors found appropriate safeguards had not been put in place following a peer-on-peer incident, a further incident between the residents had occurred again one month later. In addition, residents involved in long term peer-on-peer incidents did not have a

compatibility assessment completed to assess their suitability to continue living in the same unit. Staff informed inspectors that where peer-on-peer incidents were occurring on a long term basis, there were inconsistencies in the recording of these incidents. Staff demonstrated to inspectors their understanding of their role in the reporting of any safeguarding concern, however, there was a lack of clarity as to who the designated officers for the centre were, with some staff giving the name of a manager who had not been identified as the centre's designated officer.

Some residents presented with behaviours that challenge and the centre was supported by a behavioural support specialist in the management of these behaviours. In two of the units visited by inspectors, residents were found to be residing in overcrowded accommodation. These units accommodated seven residents in total. Some residents in these units presented with behaviours that challenge, however no additional safeguarding measures were in place for these residents. Inspectors observed that these units were experiencing on-going peer-on-peer incidents. This was raised with the person in charge and the provider on the last day of inspection.

Behavioural support plans were in place, however not all plans informed staff how to support the resident when they displayed behaviours that challenge. Some of the residents' behavioural support plans had not been reviewed annually or in line with their scheduled review dates. Inspectors found that safeguarding plans and behavioural support plans were not cross-references and did not suitably support staff to manage or prevent peer-on-peer incidents.

Not all staff had received up-to-date training in behaviours that challenge.

Judgment:
Non Compliant - Major

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 three actions from the centre's previous action plan in relation to this outcome were

not due to be completed until April 2017.

The PIC had the overall responsibility of the centre and was supported in her role by the provider. Inspectors met with the PIC who demonstrated a clear understanding of her role and legislative responsibility. The PIC was based on the campus and had opportunities to regularly visit each unit to meet with staff and residents. However, the PIC told inspectors that she did not have sufficient management time, staffing resources, support and capacity to drive the required improvements in the centre.

There was evidence that some governance and management systems were in place. However, the oversight of these governance and management systems was ineffective. For example, a review of the centre's quality improvement plan demonstrated poor deadline achievement with seven actions overdue with not rationale for this. This action plan, which should have been updated on a weekly basis and overseen at a senior level had not been updated and on the first day of inspection inspectors required the PIC to update this. In addition there was no evidence that this plan had been reviewed by senior managers and actions identified to bring this plan back within timeframes. A significant number of actions were also identified by inspectors as being overdue in audits completed at the centre and from the centre's previous inspection report.

For instance, the inspectors noticed that there were 20 actions identified at the last inspection that were overdue. Management meetings were being held by the PIC with staff nurses, however these failed to address the completion of actions or to provide timeframes for actions to be completed going forward. In addition, where maintenance and improvement works had been identified there was no evidence of the timeframes for their completion.

Six monthly unannounced visits were completed by the provider. These unannounced visits considered the review of areas such as complaints processes, social care and risk management. However, these visits failed to identify areas for improvement in areas such as restrictive practices, behavioural support and fire evacuation. Planned audits were also being completed within the centre, however some of these audits did not have actions plans in place to indicate how areas identified as requiring improvement would be addressed.

Judgment:
Non Compliant - Major

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

Findings:
Actions from the centre's previous inspection report had not been satisfactorily completed. Improvements were required to staff training and the maintenance of Schedule 2 documents.

Planned and actual staff rosters were available in each unit of the centre. However, there were inadequate staffing levels to meet the social care needs of residents. In addition, care staff had recently been assigned the role of completing housekeeping duties. This role had already commenced prior to the inspection date. There was no evidence in place to indicate how these additional housekeeping duties would impact on the delivery of care to residents. The PIC informed the inspectors that although housekeeping processes for the units had not been finalised, the process had already commenced. Staff had not received appropriate guidance or training in advance of this process commencing. Inspectors met with staff and were told that staff did not have sufficient capacity to meet the needs of residents in the centre.

The centre had plans in place to ensure all staff received supervision by April 2017. Systems were in place to provide staff with refresher training, however not all staff had received up-to-date training in manual handling.

Not all schedule 2 documents were maintained by the centre.

Judgment:
Non Compliant - Major

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:

Christopher Regan-Rushe
Inspector of Social Services
Regulation Directorate

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 Health Service Executive
Centre ID:	OSV-0005313
Date of Inspection:	13 and 14 February 2017
Date of response:	07 April 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:
The provider failed to ensure personal plans:
- Were in place for all residents which reflected their assessed needs.

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

- Provided clarity on how personal goals would be met
- Had been reviewed at least annually.

1. 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:
The PIC and staff will ensure all residents' personal plans will be reviewed in full on a regular basis to ensure that all residents needs are assessed. Clear details/actions will be included in the individual plans indicating how the goals will be met for each resident. All Personal plans will be reviewed annually. The initial review will be complete by the 30.04.2017.

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:
The provider failed to ensure residents had access to their personal plans in an accessible format.

2. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
The PIC will ensure residents' personal plans will be made available in an accessible format to all residents in the centre and, where appropriate, the plans will also be made available to their representatives. This will be completed by the 30.4.2017.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put in place arrangements to meet the individualised social care needs of residents.

3. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

Following a review of residents individualised social care needs and to ensure these needs are met, an additional 39 hours will be provided to Woodlands Close for all residents on a weekly basis commencing 14/04/17. The PIC will ensure an evaluation of the participation of residents in social activities will be conducted on an individual basis over a six week period and this will be reflected in the resident's personal plans. Ongoing review in relation to the effectiveness of the 39 additional hours will take place and consideration given for further hours if required. Decision will be made on this as per timescale below

Proposed Timescale: 26/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure residents were provided with adequate information about transition plans, including:
- the roles and responsibilities of those involved in planning for residents' transition
- clarity to staff and residents on the centre's overall plan for the centre
- Impact assessed the transitioning process

4. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
The Provider will ensure all residents identified for relocation have been provided with supports as they transition between residential services. For residents who are remaining in the centre a plan has been developed with the Multidisciplinary team to inform, support and assess the impact of the transitioning process with residents as part of the overall decongregation plan for the centre. Staff will be fully informed in relation to the transitioning process for 2017 and future years. This process will be fully supported by the Decongregation Project Team, which was recently established.

Proposed Timescale: 30/04/2017

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 provider failed to ensure the risk management system adequately assessed and controlled all risks

5. 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 provider will ensure that existing risk management systems are reviewed within the designated centre. The assessment, management and ongoing review of risks, including a clear plan for responding to emergencies will now be included in the overall system. This will be completed for all houses under this designated centre by the below date.

Proposed Timescale: 07/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put in place evacuation arrangements where the centre's escape routes are not accessible to residents and staff in the event of a fire.

6. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
The provider will ensure adequate arrangements for evacuating all persons in the designated centre have been developed and this is now included as part of each residents personal emergency evacuation plans.

Proposed Timescale: 05/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put adequate systems in place to alert staff of a fire within the centre.

7. Action Required:
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
The responder units on the bleep system within the designated centre to give a warning of fire was recently serviced and are now in working order.

Proposed Timescale: 14.02.17 Complete

Proposed Timescale: 14/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure the fire alarm was maintained in working order.

8. 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 fire repeater panel for the designated centre has been serviced and in working order.

Proposed Timescale: 14.02.17 Complete

Proposed Timescale: 14/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure:
- Fire drills were conducted using the centre's fire alarm system
- All staff receive up-do-date fire training

9. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
The provider will ensure all fire drills will be conducted using the fire alarm system.
All staff will receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.
This will be fully completed by 12.5.2017.

Proposed Timescale: 12/05/2017

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:
The provider failed to ensure all staff had up-to-date training in behaviours that challenge.

10. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
The Person Charge will ensure that all staff are to receive training in the management of behaviour that is challenging by the 12.5.2017.

Proposed Timescale: 12/05/2017
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure the regular review of restrictive practices to ensure that these remained the least restrictive and were in use for the shortest duration necessary.

11. 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:
The PIC will carry out a complete review in the use of restrictive practices within the centre. The PIC will confirm that all alternative measures are considered before a restrictive procedure is used. If a restrictive procedure is used it will be for the shortest duration necessary.

Proposed Timescale: 12/05/2017
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure behavioural support plans adequately guided staff to support residents with behaviours that challenge and were linked to safeguarding plans in the management of peer-on-peer incidents.

12. 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:
The provider has requested that the Clinical Psychologist and Behaviour Therapist conduct a comprehensive review all behaviour support plans in the designated centre to ensure plans adequately guide staff to support residents with behaviours that challenge and these are linked to safeguarding plans in the management of peer-on-peer incidents.

Arrangements have been put in place for all staff to receive training in the management of behaviour that is challenging. These actions will be completed by below date.

Proposed Timescale: 28/04/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all staff had received up-do-date training in safeguarding

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

Please state the actions you have taken or are planning to take:
All staff within the designated centre will receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse by the below date.

Proposed Timescale: 13/04/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure adequate measures were taken to ensure all residents were protected from abuse

14. 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:
Additional staff have been rostered since the 06.03.17 within one area of the designated centre to address a safe guarding concern and this will be kept under

continuous review by the PIC and MDT

All staff within the designated centre will receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse by the below.

Proposed Timescale: 13/04/2017

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 provider failed to ensure the governance and management systems in place were effective in monitoring and achieving the delivery of scheduled works within agreed timeframes

15. 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 Provider has clearly defined management structure for the designated centre has been identified which will reduce the current PIC's areas of responsibility. This will be operationalised by the below date. This new management structure will be responsible for the monitoring and management of all deadline achievements.

Proposed Timescale: 19/05/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure unannounced visits to the centre identify all areas for improvement.

16. 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:
An unannounced visit to the designated centre was conducted on the 02.02.17

Going forward an unannounced visit to the designated centre will be conducted 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.

Proposed Timescale: 02.02.17 Complete and ongoing

Proposed Timescale: 02/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put in place a management structure which was proportionate to the accountability and responsibility for the service provision.

17. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
A clearly defined management structure for the designated centre has been identified which will reduce the current PIC's areas of responsibility. This will be operationalised on the 19.05.2017. Weekly meeting of PIC's and nurse managers and senior management are taking place since 07 February, 2017. A performance and management review of all Quality improvement Plans takes place each Friday by the senior management team. Attention is focused on ensuring deadlines set out for completion of actions in Quality Improvement Plans are achieved.

Proposed Timescale: 19/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all requirements as set out in Schedule 2 of the regulations were maintained by the centre.

18. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
Information and documents as specified in Schedule 2 will be obtained for all staff working within the designated centre by the below date.

Proposed Timescale: 28/04/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure adequate staffing levels were in place to meet the social care needs of residents.

19. 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:
Following a review of residents individualised social care needs and to ensure these needs are met an additional 39 hours will be provided to Woodlands Close for all residents. on a weekly basis commencing 14/04/17.

The PIC will ensure an evaluation of the participation of residents in social activities will be conducted on an individual basis over a six week period and this will be reflected in the resident's personal plans.

Proposed Timescale: 20/04/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received up-to-date training in manual handling.

20. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Staff are scheduled to attend manual handling training by the below date.

Proposed Timescale: 12/05/2017