

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	East Limerick Services
Centre ID:	OSV-0002839
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Provider Nominee:	Norma Bagge
Lead inspector:	Margaret O'Regan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
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 inform a registration decision. 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:
17 October 2017 11:00	17 October 2017 21:00
18 October 2017 10:00	18 October 2017 21:30

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 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
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was an inspection carried out to inform a registration decision and monitor compliance with the regulations and standards.

How evidence was gathered:

As part of the inspection, the inspector met with all 15 residents who were residing in the centre. The inspector spoke with staff who shared their views about the care provided in the centre, aspects of the service which worked well and areas which could be improved. The inspector spoke with the person in charge who was recently appointed to this role and to the deputy person in charge who was appointed to the role since the previous inspection.

The inspector spoke with the provider representative who made themselves available to the inspector and was present for inspector feedback at the end of the inspection.

The inspector examined documentation such as care plans, risk assessments, fire documentation and medication records.

Description of the service:

The provider must produce a document called the statement of purpose that explains the service they provide. This document described the centre as one which 'is committed to providing person centred and person directed service that support life choices of service users.' The inspector was satisfied that the service was overall, person centred.

Accommodation was in four single-storey houses. Between three and five residents occupied each house. Each house had a sitting room, kitchen, single occupancy bedrooms, modified sanitary facilities and laundry facilities. The service was available to both male and female residents.

Overall judgment of our findings:

The houses were generally well maintained. Residents availed of a variety of day services which included services provided by the Brothers of Charity and services provided by local community day centres. However, as discussed under Outcome 5, the activities programme still required further development. Transport was provided to and from the day services.

There had been three changes of person in charge in two years. This had led to an overall lack of leadership and direction. This was further compounded by other changes in staff including changes in care staff and changes in persons participating in management. It was apparent that residents and staff found such uncertainty challenging. Examples of where management deficits were evident included;

- * significant issues for residents and staff with behaviours that challenge
- * significant gaps in care planning documentation and reviews
- * absence of up-to-date behaviour support plans
- * absence of annual report
- * infrequent fire drills
- * an increase in the number of staff with out-of-date mandatory training
- * significant staff turnover
- * absence of documentation of local complaints since January 2016
- * absence of structured staff supervision.

Major non-compliances were found under Outcome 7 (Health and Safety and Risk Management), Outcome 8 (Safeguarding and Safety) and Outcome 14 (Governance and Management). Moderate non-compliances were found under Outcome 5 (Social Care Needs), Outcome 17 (Workforce) and Outcome 18 (Records and Documentation).

The inspection findings are detailed in the body of this report and required actions outlined in an 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:

Admissions, discharges and transfers to the centre were organised through the organisation's admission, discharge and transfer team.

A sample of resident contracts were examined. Those contracts examined set out the services to be provided and the fees to be charged. Details of additional charges were also included.

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:

Residents or their representatives were involved in an assessment to identify residents' individual needs and choices. Assessments had multidisciplinary input. Person-centred care plans were in place. However overall, matters identified on the last inspection remained issues on this inspection. As found in the 2016 inspection, the person-centred plans were not adequately reviewed. For example, plans had not been reviewed within the planned three month, six month and nine month timeframe. Some plans had not been reviewed for over 12 months. Care plans goals were stated but it was not always clear who was responsible for the care plan goal. This was complicated by changes in management and staff in the previous 12 months. Given that plans were not always reviewed on an annual basis, residents and their families missed out on opportunities to be more formally involved in the care planning process.

Residents were involved in an activities programme which included baking, music sessions, walks, art and crafts. Since the last inspection a number of residents had resumed swimming. This was a success; in particular for one resident with mobility issues. On the day of inspection the inspector was present for an impromptu music session. Residents played the guitar and took turns at singing. This was a good humoured get-together involving residents and staff.

Staff and management personnel spoke of aiming for a fuller activities programme for residents. These aspirations were also evident on the previous inspection in 2016. The inspector was aware that there were differences of opinion as to what activities suited residents, different views as to what was meaningful for residents, and what activities improved residents' quality of life. Harnessing the different views required leadership. Such leadership was stymied by the many changes in staff including management staff.

There was a plan to transfer residents within the centre. This was being proposed to facilitate a better quality of life for residents whose current living arrangements were less than satisfactory. However, while this plan was not finalised, the inspector was concerned that the impact of such changes had not been fully explored. For example, a resident deemed to require extra support with their physical needs did not have an occupational therapy assessment to explore ways of assisting with their physical needs but rather, the resident had been discussed at a multidisciplinary meeting two months earlier with a view to transferring the resident to a different house.

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 designated centre comprised four houses; three of which were located close together in a courtyard setting. These houses had a fire alarm system in place; however, a review of this fire alarm system, carried out by an external fire safety specialist in July 2015, found that the system was "unsuitable" and "unreliable". Subsequent to the HIQA October 2016 inspection, an external fire safety engineer report was commissioned. The fire safety engineer report identified significant deficiencies in the fire detection and containment systems in place for these three houses. At the time of this inspection (October 2017) plans were underway to upgrade this system in the three houses adjacent to each other. Work on this project was scheduled to commence on 1st November 2017 and was expected to take approximately seven weeks to complete.

A separate fire safety engineer report was commissioned in November 2016 for the fourth house, located several kilometres from the other three houses. The report stated "significant remedial works" were required to upgrade this building to the required standard. The report referred to works being, "incorrectly installed or provided without the necessary certification". This recommended upgrading work in house number four had not taken place.

Fire exits in the houses were seen to be unobstructed. However, it was unclear if one fire exit in house number four was to continue as a fire exit in the event of the proposed resident transfer materialising. Fire drills had not been conducted for over six months. Given the needs of residents and the presence of new staff in the service, the frequency of fire drills was inadequate.

Two staff had not received fire safety awareness training updates.

Risk registers were in place. However, the outcome of a recent investigation indicated risks for both residents and staff. It was unclear whether or not this risk;

- * was adequately assessed
- * had appropriate control measures in place to mitigate against the risk
- * provided learning to prevent a similar situation.

An emergency plan was displayed throughout the centre providing directions and contact information in the event of emergencies such as loss of power, heating or water. This emergency plan was implemented at the time of inspection as there had been a power cut the previous day. The person in charge informed the inspector that the emergency plan was to be reviewed in the aftermath of this event.

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):

No actions were required from the previous inspection.

Findings:

There were gaps in the behaviour support plans in place. For example, an interim plan dated 13 June 2017 was only signed by one member of staff. It did not appear to have been reviewed as planned and did not give adequate guidance on how to support the resident. There was a reported incident between two peers on 15 June 2017. The action recorded for this incident was "to follow the resident's support plan". However, this appeared to be the interim plan referenced above which gave no specific guidance to staff and was not signed as having been read and understood by staff. At the time of inspection, no other behaviour support plan was on file for this resident.

In another instance there was a well prepared support plan in place which was signed by staff who understood the plan. However, this plan was dated July 2016; 15 months since last update. In the interim, there had been issues which warranted a review of this plan.

Training updates had recently been provided for staff in relation to safeguarding residents and the prevention, detection and response to abuse. However, at the time of inspection, some staff were awaiting these training updates. In addition there was a lack of training updates for staff in relation to responding to behaviour that is challenging and to support residents to manage their behaviour

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):

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

Findings:

A record of incidents occurring in the centre was maintained. Notifiable incidents were notified to the Chief Inspector within three days of occurring. A quarterly report was provided to the Health Information and Quality Authority (HIQA) to notify the Chief Inspector of incidents occurring in the centre as required by regulation.

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:

This was a nurse-led service. Nurses were assisted in the roles by social care staff and care workers. Residents' healthcare needs were met through timely access to general practitioner (GP) services. Residents had access to allied health services which reflected their diverse care needs. This included physiotherapy, dietetic and occupational therapy. Also available to residents was psychological and psychiatric support. Residents were assessed for dementia support if there was an indication for this. The psychiatry team offered support in this regard

Residents were actively encouraged to take responsibility for their own health and medical needs. For example, residents were supported to eat healthily, exercise and socialise. End-of-life care was provided in a manner that met the needs of the resident and in line with best practice. This included staff remaining with a resident if they were admitted to an acute hospital at the end of their life. When a resident died last year, residents and staff attended services and supported the deceased's family at the time of the funeral. This was described to the inspector in a sensitive manner by a number of staff members.

On the day of inspection there was a power cut. Residents were facilitated in a nearby nursing home where they were provided with comfortable surroundings, shower facilities and a hot meal. The person in charge had developed key links with the wider community since taking up her role four months previously. One such valuable link was with the nursing home providers who were able to support residents in a time of crisis, such as the extended power outage mentioned above. The person in charge also developed important contacts with members of the primary care team; namely the

public health nursing service and the occupational therapy department.

Regular health checks were accessed by residents and included, medication review, blood levels profiling and routine health screening. The inspector was informed residents had a monthly weight check. However, the documentation did not confirm this. One resident who had a history of weight loss did not have a recorded weight check since June 2017. This is actioned under Outcome 18 (Records and Documentation).

The centre had access to good quality equipment such as hoists, pressure relieving mattresses and walking aids.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Individual medication plans were reviewed by medical personnel. In general, the processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation. However, some of the prescriptions charts examined did not state the name of the GP. This is actioned under Outcome 18, Documentation.

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:

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

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

Findings:

The management systems in place did not adequately ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. An annual report had not been completed. This was also a finding in the last inspection carried out in October 2016.

The arrangements in place to ensure staff exercised their personal and professional responsibility for the quality and safety of the services that they were delivering was compromised. The organisation's structured staff appraisal system had not been implemented. There was a similar finding on the last inspection.

Six monthly unannounced inspections of the centre were carried out by the provider. The inspector saw that a number of the action plans had been implemented; however, some actions were still outstanding such as the review of person centred plans.

There was a management structure which identified the lines of authority and accountability. Residents could identify the person in charge. The person in charge was in post four months at the time of this inspection. The person in charge demonstrated knowledge of the legislation and her statutory responsibilities. It was evident she was committed to ensuring the service met the needs of residents. She spoke of changes she implemented since taking on the role and of plans she had for further improvements in the quality of the service. She was engaged in a consistent way in the governance, operational management and administration of three of the four houses that made up this centre. She was less involved in the fourth house and this was an area the person in charge had identified for improvement. These findings were similar to those of the October 2016 inspection when there was a different person in charge.

There had been three changes of person in charge in two years. This had led to an overall lack of leadership and direction. This was further compounded by other changes in staff including changes in care staff and changes in persons participating in management. It was apparent that residents and staff found such uncertainty challenging. Examples of where management deficits were evident included;

- * significant issues for residents and staff with behaviours that challenge
- * significant gaps in care planning documentation and reviews
- * absence of up-to-date behaviour support plans
- * absence of annual report
- * infrequent fire drills
- * an increase in the number of staff with out-of-date mandatory training
- * significant staff turnover
- * absence of documentation of local complaints since January 2016
- * absence of structured staff supervision.

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<p>Judgment: Non Compliant - Major</p>

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:
During the inspection staff members were observed engaging with residents in a caring and warm manner. Since the previous inspection there had been an increase in staffing levels in the centre. At the time of inspection the staffing arrangements in place were meeting the primary care needs of residents. However, recent changes in the needs of the residents had resulted in increasing the workload on staff. While staff had prioritised the needs of residents, shortcomings were identified in other areas such as documentation as highlighted under Outcome 5 and Outcome 18.

The inspector reviewed the staff training list for the centre and noted that staff were due refresher training in the areas of fire safety, moving and handling and safeguarding.

Staff meetings were held approximately monthly. Issues such as residents needs, events, training and policies were discussed. Staff rosters were maintained within the centre.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational

policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

Findings:

Records were maintained in the centre. However, as found on the previous inspection, they were not always accurate or up to date. This related in particular to some of the person centred plans. Signatures and dates were missing from some documentation, no review dates were documented and the barriers to progress were not stated. These gaps in documentation compromised the reliability of the information in the documents.

As discussed under Outcome 8 behaviour support plans were not always available or up-to-date.

As found on the previous inspection, the name of the resident's GP was not always clearly stated on the prescription chart.

There were gaps in the records maintained of residents weight.

There was significant duplication in the record keeping resulting in it being difficult to access information and difficult to assess its accuracy.

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:

Margaret O'Regan
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 Limerick
Centre ID:	OSV-0002839
Date of Inspection:	17 and 18 October 2017
Date of response:	16 November 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 names of those responsible for pursuing objectives in the plans of care were not always recorded. Neither were timescales always documented.

1. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out

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

of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

- PIC has been scheduled for PCP training on 23rd and 24th November 2017.
- Keyworker has been assigned to each resident.
- File review is currently taking place with Keyworker and member of the Quality Department. This will be completed by December 2017.
- This file review will include the identification of the status of each person centred plan and agree a timeframe for a new plan to be developed in line with procedure.
- The keyworker will be the named person responsible for ensuring goals and objectives are achieved.
- Goals will be timebound as per procedure. Barriers to achieving goals will be escalated by PIC where appropriate.
- A schedule for the quarterly and annual review of PCPs will be set and monitored by the Person in Charge.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

Some care plans had not been reviewed within the planned three month, six month and nine month timeframe. Some plans had not been reviewed for over 12 months.

2. 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:

- A timetable has been set up for the full review of each individuals file (My Profile My Plan) with a member of the quality department and the keyworker.
- This process commenced on 19th October and will be completed by end of December 2017.
- This file review will include the identification of the status of each person centred plan and agree a timeframe for a new plan to be developed in line with procedure.
- As part of this process each current plan will be reviewed as part of the annual review process to ensure that the status of priorities are identified and carried forward where appropriate. The will be completed by the end of January 2018.
- A schedule for the quarterly and annual review of PCPs will be set and monitored by the Person in Charge.
- PIC has been scheduled for PCP training on 23rd and 24th November 2017.
- Care Plans will be updated with CNS for age related care who has recently been appointed and/or relevant member of MDT, nurse and keyworker taking a person centred approach. This process has commenced with one care plan updated todate. All plans will be updated the end of March 2018.

Proposed Timescale: 31/03/2018

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 outcome of a recent investigation identified risks for both residents and staff health and safety. However, it was unclear what the learning had been from this investigation and what control measures were in place to mitigate against the risk.

3. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- Head of HR, Designated Officer and Director of Services have meet to discuss this risk.
- Head of HR is consulting with members of the Senior Management Team to carry out a risk assessment of risk to staff in relation to allegations of abuse against staff members that are proved to be unfounded. This will outline further mitigations to support staff.
- Designated Officer met with staff at staff meeting on 12th October 2017 following the completion of the investigation in order to support staff.
- Senior Psychologist has outlined strategies and protocols for staff to support them in supporting residents in times of challenging behaviour as part of safeguarding plans. These protocols have been updated on 10th November 2017.
- PIC will brief staff on updated protocols at meetings on 22nd and 23rd November 2017 and all staff will briefed by end of November. Sign in sheet will evidence this.
- Senior Psychologist will continue to provide support to PIC, staff and residents as part of her weekly engagement with this service.
- PIC has requested that the coordinator of the MAPA training meet with staff to provide training in relation to supporting staff using MAPA Skills (crisis development model). Planned dates are 22nd and 23rd November 2017.

Proposed Timescale: 31/12/2017

Theme: Effective Services

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

Work was scheduled to commence in the weeks post inspection to upgrade the fire safety arrangements as per the recommendations of an external fire safety consultant. However, at the time of inspection this work remained uncompleted.

4. 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:

- Fire Safety Upgrade has commenced on 1st November 2017.
- This work will take approximately 10 weeks to complete.
- Fire Safety upgrade works will address recommendations of the external fire safety consultant

Proposed Timescale: 31/01/2018**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Two staff members had not taken part in fire safety awareness training updates.

5. 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:

- Staff who require training in Fire Safety have been identified.
- Staff currently on roster will be scheduled for training on 27th November and December (date to be confirmed).
- Staff currently on leave will be addressed on return from leave.

Proposed Timescale: 31/12/2017**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no documentation to confirm fire drills took place regularly. It was unclear when the last fire drill took place. Staff reported it was between six and nine months. Some new staff had not participated in a fire drill in the centre.

6. Action Required:

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

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

- A fire drill has been scheduled for 19th November in one designated centre which has three houses.
- A fire drill is scheduled for 4th house on 20th November 2017.
- Fire drills, including one night drill, will be scheduled for 2018 to ensure that a fire drill takes place quarterly in line with the organisation's Safety Statement.

Proposed Timescale: 30/11/2017

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:

There was a lack of training updates for staff in relation to responding to behaviour that is challenging and to support residents to manage their behaviour.

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:

- PIC has requested that the coordinator of the MAPA training meet with staff to provide training in relation to supporting staff using MAPA Skills (crisis development model). Planned dates are 22nd and 23rd November 2017.
- Outstanding training on MAPA will be scheduled as a priority.

Proposed Timescale: 31/01/2018

Theme: Safe Services

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

Behaviour support interventions were not clearly set out and were not reviewed in a timely manner or as part of the annual personal planning process.

8. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

- Behaviour Support plans, where appropriate, will be updated with relevant member of behaviour support team (including CNS for age related care), nurse and keyworker taking a person centred approach.
- All plans will be updated the end of March 2018.

Proposed Timescale: 31/03/2018

Theme: Safe Services

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

Training updates had recently been provided for staff in relation to safeguarding residents and the prevention, detection and response to abuse. However, at the time of inspection, some staff were awaiting these training updates.

9. 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:

- Currently all staff are upto date in safeguarding training.
- Staff due for training will have training completed by the year end.

Proposed Timescale: 31/12/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

An annual review of the quality and safety of care and support in the designated centre had not been conducted.

10. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

- Head of Quality and Risk is supporting the Person in Charge to complete the annual review for 2017. Meeting has been scheduled for 12th December 2017.
- This review will be completed by the year end.

Proposed Timescale: 31/12/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Effective arrangements were not in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

11. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- Support and Supervision procedure in place.
- Head of HR to provide training to PIC and PPIM on 27th November 2017 on this procedure.
- Staff will be scheduled for Support and Supervision following training following this training.

Proposed Timescale: 31/03/2018**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The management systems in place in the centre did not adequately ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. There had been three changes of person in charge in two years. This had led to an overall lack of leadership and direction. It was apparent that residents and staff found such uncertainty challenging. Examples of where management deficits were evident included;

- * significant issues for residents and staff with behaviours that challenge
- * significant gaps in care planning documentation and reviews
- * absence of up-to-date behaviour support plans
- * absence of annual report
- * infrequent fire drills
- * an increase in the number of staff with out-of-date mandatory training
- * significant staff turnover
- * absence of documentation of local complaints since January 2016
- * absence of structured staff supervision.

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:

- Provider Nominee, Head of HR, Head of Quality, Head of Psychology and Head of Finance are providing ongoing support to PIC in order to support PIC in addressing

deficits in governance and management in the centre.

- PIC also engaged with Integrated Services team for peer support.
- Plan is in place to address issues for residents and staff with behaviours that challenge including developing a risk assessment, training for staff in MAPA, updating of protocols around supporting residents with challenging behaviour and the review and update of behaviour support plans.
- Care Plans will be updated with CNS for age related care who has recently been appointed and/or relevant member of MDT, nurse and keyworker taking a person centred approach. This process has commenced with one care plan updated to date. All plans will be updated the end of March 2018.
- Annual report will be completed by 31st December 2017.
- Fire Drills will take place on 19th and 20th November and fire drills will be scheduled for 2018 including night drill.
- Dates have been identified for staff whose training is out of date.
- Process for the management of complaints will be reviewed by PIC with Head of Quality and Risk to ensure that complaints are managed in line with procedure.
- Plan to introduce support and supervision has been agreed. Head of HR to provide training to PIC and PPIM on 27th November and training will be rolled out to staff.

Proposed Timescale: 31/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staff did not have appropriate refresher training. For example, four staff required updated moving and handling training, two staff required fire safety awareness training and some staff required safeguarding training.

13. 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:

* Training will be arranged for staff to ensure that the mandatory training is provided in line with policy.

Proposed Timescale: 31/01/2018

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Records in relation to each resident as specified in Schedule 3, were not accurately maintained and available for inspection. These included person centred plans, behaviour support plans, weight checks and medicine prescription charts.

14. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- A timetable has been set up for the full review of each individuals file (My Profile My Plan) with a member of the quality department and the keyworker. This will include ensuring that the weight check is in place.
- Medicine prescription charts have been updated to include the name of the GP.
- This process commenced on 19th October and will be completed by end of December 2017.
- This file review will include the identification of the status of each person centred plan and agree a timeframe for a new plan to be developed in line with procedure.
- As part of this process each current plan will be reviewed as part of the annual review process to ensure that the status of priorities are identified and carried forward where appropriate. The will be completed by the end of January 2018.
- A schedule for the quarterly and annual review of PCPs will be set and monitored by the Person in Charge.
- PIC has been scheduled for PCP training on 23rd and 24th November 2017.
- Care Plans will be updated with relevant member of behaviour support team (including CNS for age related care), nurse and keyworker taking a person centred approach. This process has commenced with one care plan updated. All plans will be updated the end of March 2018.

Proposed Timescale: 31/03/2018