Health Information and Quality Authority
Regulation Directorate

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

Centre name:	St. Anne's Residential Services - Group G
Centre ID:	OSV-0003950
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 September 2016 12:30	07 September 2016 19:00
08 September 2016 08:30	08 September 2016 14:00

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

Outcome
Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This report sets out the findings of an unannounced inspection of Group G St. Anne's Residential Services. This was the second inspection of this centre by the Health Information and Quality Authority (HIQA).

Description of the service:
There were five residents who had lived together in this house since 2005, with some of the residents moving there from a congregated/institutionalised setting. All of the residents attended a day service with one resident receiving a day service from within the house, which was appropriate to their needs. Residents were active in the local community and attended shops, restaurants/pubs and the church.

How we gathered our evidence:
The inspector met with the five residents who currently lived in this centre. Inspectors also met the person in charge of the centre, staff and the residential services manager. The director of nursing also attended the feedback session at the close of the inspection. The inspector observed staff practices and interactions with residents and reviewed residents' personal plans, training records, meeting minutes

and the complaints log.

Overall judgment of our findings:
There were examples of good practice. There was evidence that residents healthcare needs were being met and in particular residents were receiving coordinated healthcare by consultant specialists for example in the area of psychiatry and neurology.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. On the day of inspection one medication near miss had occurred where staff had identified that a resident had a sensitivity to a particular prescribed medication. There was evidence of appropriate measures been taken to rectify this issue.

Of the nine outcomes inspected two were at the level of major non-compliance:
Outcome 1: Residents rights, dignity and consultation
There were a number of practices which did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space. One resident was using a "jacuzzi" bath which was in the private bedroom of another resident. To access this bath it was necessary to enter the private bedroom of a resident, and go into the en suite room. In addition, at night a staff member was entering residents' bedrooms to check whether the resident was awake or asleep at every hour from 10pm to 8am. While there were safety concerns for one resident to potentially validate the use of these physical checks, for the other residents there was no safety, or other, reasons either documented or outlined to the inspector.

Outcome 8: Safeguarding and Safety
It was not demonstrated that restrictive practices were in line with national policy or the organisation's own policy in relation to restrictive practices. For example, a risk assessment was not always available in relation to restrictions on the residents' home environment. The process for review of restraints also required improvement as there was no record of a reason for each individual restrictive practice.

Improvement was also required to support residents to manage their behaviour and in particular there was no input from a psychologist or behaviour therapist into behaviour support plans. In addition, the directions of the behaviour support plans were not being followed as records were not maintained of behaviours that may challenge, including records of antecedents, behaviours and consequences (known as ABC charts) as required by the behaviour support plan.

Improvement was also required in relation to the process for risk assessment

The reasons for these findings are explained under each Outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

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

Theme:
Individualised Supports and Care

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

Findings:
A single aspect of this outcome in relation to residents' rights, dignity and consultation was reviewed. There were a number of practices which did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

On the previous inspection it was found that the en suite facilities in one resident's bedroom was very small and did not meet the resident's personal care needs. On that inspection it was observed that this en suite contained a bath which was too small and it was noted there was a pattern of incidents/accidents occurring in this en suite while personal care was being provided. Since then a new "jacuzzi style" bath had been provided by the service. There was evidence of a significant reduction in the number of incidents occurring while personal care was being provided. Staff outlined that the resident really enjoyed using this "jacuzzi" bath. However, a multidisciplinary team meeting record indicated that another resident was also using this "jacuzzi" bath and staff confirmed to the inspector that another resident was using the bath. To access this bath it was necessary to enter the private bedroom of a resident, and go into the en suite room. This practice did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

There were documents seen in residents' files which recorded residents sleep record during the night. This meant that a staff member had to physically enter the resident's room to check whether the resident was awake or asleep at every hour from 10 pm to 8 am. While there were safety concerns for one resident to validate the use of these physical checks, for the other residents there was no safety, or other reasons, either

documented or outlined during the inspection .This practice did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Each resident's wellbeing and welfare was maintained by a high standard of evidence-based care and support.

The five residents had lived together in this house since 2005, with some of the residents moving there from a congregated/institutionalised setting. There were four men and one woman. As part of the review of their care the service had referred one of the resident's placement to the admissions/transfer committee. The family of the resident had been involved in this review where it was decided that the centre met their needs and that the resident was happy living in this house.

In relation to residents' assessed needs there were person centred planning folders were available in an easy to read format in words and pictures. This included important relationships for the resident; where the person lived and worked; their interests and dreams. There were separate assessments of residents' healthcare needs and social care needs in the personal planning process.

In relation to healthcare needs, key issues were identified at the beginning of the person centred planning folder. Each resident had a hospital passport which documented the supports the person with a communication difficulty/intellectual disability required if they attended hospital. The personal file contained the "healthcare plans" for residents including communication, nutrition, continence, fitness, mobility, medication and health checks. There was evidence that these healthcare plans were taking into account changes in circumstances and new developments. There was also evidence of up to date

multidisciplinary reviews of residents needs by relevant healthcare professionals like social work or occupational therapy.

In relation to the social care needs of residents, there were plans available in relation to community/relationships, social inclusion and "being happy". All of the residents attended a day service with one resident receiving a day service from the house, which was appropriate to their needs. There was evidence that residents were active in the local community and attended shops, restaurants/pubs and the church.

The person centred planning folders also had the annual person centred planning meeting. There was evidence that in addition to the resident, family and staff were invited to attend this meeting. This planning meeting developed resident goals for the year. In the records seen by inspectors the goals were person centred, appropriate and were realistic. The goals identified what supports the person needed to achieve these goals and also had a timeframe identified to achieve these goals.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The location, design and layout of the centre was suitable for its stated purpose and met residents' needs in a comfortable and homely way.

The centre was a seven day residence and provided a home to five residents with varying support needs. The centre consisted of a detached house on the outskirts of a village.

In terms of layout of the house the front porch led to a hallway. There was a large living room which had a couch and a number of armchairs. There was a separate dining room with dining table and chairs. The kitchen was adjacent to the dining room and there was also a utility room. There was a large enclosed garden with patio area, furniture and swings.

Since the last inspection improvement was noted in particular in relation to residents' bedrooms. On this inspection each resident had their own bedroom which was personalised with soft furnishings of their choice, photographs and personal memorabilia, although some residents preferred a "minimalist" style". Ample space was provided for each resident to store and maintain clothes and other personal possessions. Four of the five bedrooms had en suite facilities and there was also a separate bathroom with bath/shower, wash hand basin and toilet.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Improvement was required in relation to the process for risk assessment.

Since the last inspection the risk management policy had been updated and included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm.

The process for risk assessment required improvement. There was also a local safety statement in place which identified hazards in the centre. These hazards had been separately assessed and risk rated. However, these risk assessments for these hazards had not always been completed fully. For example, there was a risk assessment for the kitchen which identified the hazards as burns and scalds. The controls in place included that "the service user may not be present when cooking was in progress" and "the service user should not be present unless full supervision was available". The inspector observed that in practice staff locked the kitchen door while cooking was being done, and so restricted access to the kitchen. However, this practice was not reflected in the risk assessment.

There were other risk assessments in place that did not reflect the environment where staff were working. For example, there was a risk assessment in place for "minor injuries" for staff and rated the hazard at a low risk. The types of injuries indentified included "cuts" and "scratches". However, the inspector reviewed the incident reporting system from January 2016 to August 2016.There had been 26 reported incidents including staff being scratched, punched, head butted and hit.

In relation to fire safety, the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site. Records indicated that all staff had been trained in fire safety management. There were records of regular fire evacuation drills involving the residents, one of which took place during the course of the inspection.

The centre was visibly clean throughout and staff spoken with were knowledgeable about cleaning and control of infection.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
Restrictive procedures were not in line with national policy, evidence based practice or the organisation's own policy. Improvement was also required to support residents to manage their behaviour.

HIQA issued updated guidance for designated centres restraint procedures in April 2016. This guidance defined a restrictive procedure as "a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values or; requires an individual to engage in a behaviour that the individual would not engage in given freedom of choice".

While walking through the premises the inspector observed a number of environmental restrictions including a keypad on the front door, locks on residents' wardrobes and presses, perspex glass on the television in the living room and the kitchen door locked while cooking. There was also documentation available in the centre in relation to other restrictions including the physical hold of a resident while providing personal care. One resident had "physical holds" in place that had been approved following an assessment by an approved assessor in therapeutic management of aggression and violence

(TMAV).

However, it was not demonstrated that restrictive practices were in line with national policy or the organisation's own policy in relation to restrictive practices. For example a risk assessment was not always available in relation to restrictions on the residents' home environment. For example, the television in the main living room had a perspex screen in front of it. Staff explained that this was to prevent the television being broken but a risk assessment was not in place for this hazard. Another restriction was "cutting off water in identified taps". However, a risk assessment was not in place for this. In relation to physical holds one of the TMAV assessed procedures had not been reviewed since August 2014 which was not in accordance with the review process outlined in the TMAV assessment.

There was a service wide "restrictive practices policy for adults and children – a person centred approach to best practice" approved in 2014. However, this policy did not specify how the use of environmental restraints was to be reviewed. In practice restraints were reviewed by a multidisciplinary team. There were minutes available of team meetings reviewing restraints attended by the clinical nurse manager, assistant director of nursing of the service, the person in charge, occupational therapist and speech therapist. However, there was no record of a discussion around each individual restrictive practice; and there were no official record of discussion of the restrictions in general, the rationale for the restrictions, the current strategies or the risk assessments.

Improvement was required to behaviour support plans. The inspector reviewed personal plans, plans to support behaviour that challenges and risk assessments and spoke with staff in relation to behaviour that challenges. The behaviour support plans were not always developed with input from an appropriately trained and qualified professional. In May 2016 a consultant psychiatrist had recommended psychological or behaviour therapy input as soon as possible.

One behaviour support plan outlined that records were to be maintained of behaviours that may challenge, including records of antecedents, behaviours and consequences (known as ABC charts) where required. Records of ABC charts were available. However, the latest chart was for January 2016 despite a number of recordable incidents occurring.

Staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse. Staff had received training on the organisation's policy for the management of behaviour that challenges.

Judgment:
Non Compliant - Major

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

The person in charge outlined that residents had the option of attending a general practitioner (GP) of their own choice. The inspector reviewed a sample of resident healthcare files and found evidence of regular GP reviews. The GPs requested review of residents' healthcare needs by consultant specialists as required. In particular, there was evidence of residents receiving coordinated care by consultant specialists in the area of psychiatry and neurology.

There was evidence that residents were referred for support as required by allied health professionals including speech and language therapy, physiotherapy, dietetics and occupational therapy. There were clear and up to date guidance available to staff following any such review. For example, there were swallow care plans available following dysphagia (swallow) assessments.

There was a policy and guidelines for the monitoring and documentation of residents' nutritional intake. The inspector noted that residents were referred for dietetic review as required and residents had nutrition care plans as required.

All meals were prepared by staff in the kitchen on site. A copy of the menu in picture format was available on the notice board. Staff were knowledgeable about residents likes and dislikes.

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:
Medication management policies and practices were satisfactory.

There was a comprehensive medication policy that detailed the procedures for safe ordering, prescribing, storage, administration and disposal of medicines.

Medications for residents were supplied by a community pharmacy. Medication prescriptions were transcribed by a nurse in the service and were checked by a second nurse checking the prescription transcribed to minimise the risk of error.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines delivered correspond with the medication prescription records. Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents' medication was stored and secured in a locked cupboard and there was a robust key holding procedure.

A sample of medication prescription and administration records was reviewed by the inspector. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. On the day of inspection one medication near miss had been occurred where staff had identified that a resident had a sensitivity to a particular prescribed medication. There was evidence of appropriate measures been taken to rectify this issue

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There was a clearly defined management structure that identified the lines of authority and accountability.

The person in charge was in charge of two designated centres including this centre. She also had management responsibility for the provision of supports to four independent service users. The person in charge demonstrated that she was involved in the day to day operational management of the centre. The person in charge visited the centre almost daily and demonstrated that she had good knowledge of the residents and their needs. She was a registered general nurse and also had a qualification in management.

The person in charge was supported by a house leader who was qualified and experienced in supporting individuals with an intellectual disability. The house leader was full-time in the centre. Staff with whom inspectors spoke said that they felt supported by the house manager and person in charge and other management.

The annual review of the quality and safety of care in the centre for 2015 was found to be comprehensive and informative. The centre had engaged in consultation with residents and their families on the quality of care provided and this had informed the annual review.

There was a schedule of audits to review the quality and safety of care being providing including an audit of medication records, audit of care plans and a monthly review of incidents.

The service provider had also completed a comprehensive audit as part of the requirement to complete an unannounced visit to the centre at least once every six months.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Based on the assessed needs of residents, there were sufficient staff with the right skills, qualifications and experience to meet those needs.

The inspector saw that there was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff at night. There was also an awake staff on duty at night. There was a nurse employed 19 hours per week to support residents with any changing healthcare needs. All other staff had completed approved courses and had qualifications in healthcare support.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	St. Anne's Residential Services - Group G
Centre ID:	OSV-0003950
Date of Inspection:	07 September 2016
Date of response:	03 November 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of practices which did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Four service users will now be checked at regular intervals throughout the night. One service user will checked at regular intervals also, however following the installation of an epilepsy alarm mattress this service user will be immediately checked if the alarm sounds. This will be reviewed on 07/12/2016 by the Restrictive Practice Committee. Plans of care have been updated to reflect these changes.

The Jacuzzi bath will now be used for one service user only and no other service user will have access to this en suite bathroom.

These actions will be an agenda item for discussion with staff team at next house meeting on 21/11/2016.

Proposed Timescale: 07/12/2016

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:
Improvement was required in relation to the process for risk assessment.

2. 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:
Management of Challenging Behaviour risk assessment has been reviewed and updated. Incidents are reviewed monthly at house meetings.

All risk assessments will be reviewed six monthly or sooner if necessary by the PIC and House Manager.

Proposed Timescale: 28/10/2016

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 behaviour support plan for one resident was not developed with input from an appropriately trained and qualified professional. There was documentation on file for one resident from a consultant psychiatrist recommending psychological or behaviour

therapy input as soon as possible.

3. 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 organisation is currently in process of recruiting a full time psychologist.
The service user has been referred for psychology input.

All restrictive practices will be reviewed in full by restrictive practice committee on 07/12/2016 and the rationale for all restrictive practices will be included in the minutes of the meeting.

The correct use and importance of ABC charts will be an agenda item for discussion with the staff team at house meeting on 21/11/2016

Proposed Timescale: 07/12/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive procedures were not in line with national policy, evidence based practice or the organisation's own policy.

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

Please state the actions you have taken or are planning to take:
All restrictive practices will be reviewed in full by the restrictive practices Committee on 07/12/2016.

The full rationale for all restrictions will be included in the minutes of the meeting and will be signed off by the committee team.

Proposed Timescale: 07/12/2016