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:	Bailin
Centre ID:	OSV-0003283
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Waterford Intellectual Disability Association Company Limited By Guarantee
Provider Nominee:	Fiona O'Neill
Lead inspector:	Lorraine Egan
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 1 day(s).

The inspection took place over the following dates and times

From:	To:
01 February 2017 11:30	01 February 2017 19:30

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

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 monitoring inspection was carried out to monitor compliance with specific regulations and to assess if the provider had addressed the actions from the previous inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with four residents. One resident returned to the centre as the inspector finished the inspection. The inspector was supported by staff when communicating with some residents.

Residents appeared happy in the centre. Respectful and positive interactions were observed between residents and staff. The inspector noted staff supporting residents in a manner consistent with their needs and wishes.

The inspector also spoke with the newly appointed person participating in management of the centre and reviewed documentation such as residents' support plans, medical records, accident logs and policies and procedures.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, the inspector found that the service was provided as described in that document.

The centre comprised of a house and an adjoining apartment. It was located within close proximity of a town centre and amenities. Residents were supported by staff to access amenities and the centre had the use of the provider's vehicles to ensure residents could access community based activities.

The centre contained adequate private and communal space to meet the needs of residents. Each resident had an individual bedroom.

The service was available to adults with an intellectual disability, some of whom may also have a physical disability. The objectives of the service included supporting residents to maintain and develop natural supports, community involvement, develop socially valued roles and promote choice.

Overall judgment of our findings:
Overall, the inspector found that residents were supported to have a good quality life in the centre and the provider had arrangements to promote the rights and safety of residents. However, significant improvement was required to the measures to ensure that residents would be evacuated from the centre in the event of an emergency and to the medicine management systems and practices. The findings related to these are outlined in outcome 7 and outcome 12.

Good practice was identified in:
- Governance and Management (Outcome 14)
- Workforce (Outcome 17)

Further areas which required improvement included:
- Assessing the effectiveness of social care plans and ensuring support plans were in place for all assessed needs (in outcome 5)
- The upkeep and accessibility of some parts of the centre (in outcome 6)
- Ensuring staff had the up-to-date knowledge to support residents with behaviour that is challenging (in outcome 8)
- Ensuring that residents received support with managing their weight (in outcome 11)

The reasons for these findings are explained under each outcome in the report and the regulations that were not 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector viewed a sample of residents' health, personal and social care plans. Improvement was required to ensure the effectiveness of residents' social care plans was reviewed and to ensure all residents' assessed needs had corresponding support plans in place.

Residents' social care goals had been identified. The document used to assess goals had been reviewed in the months prior to the inspection. The person participating in management said the provider had recognised that the previous tool did not meet the needs of the organisation in regard to assessing and responding to residents' social care needs.

The documentation in place did not show that residents were being supported to identify and achieve long term goals. The goals identified were short term and there was no evidence that the tool was being used to support residents' personal development. However, the inspector spoke with residents, staff and management throughout the day of inspection and observed residents' interaction with staff and each other. The inspector found that residents had been supported to achieve long term goals.

Furthermore, the inspector found that residents were being supported to identify long term goals on an ongoing basis and it was evident that residents had made significant progress in regard to personal development which was consistent with their needs and wishes. The inspector therefore made the judgment that residents' social care needs were being met. Therefore, the non-compliance with the regulations related to the lack of documenting in residents' personal plans and lack of evidence to show that residents'

social care plans and goals had been assessed for effectiveness.

Examples of goals which were supported and were contributing to residents' personal development and overall quality of life included those related to residents integrating into communities and becoming part of communities, life choices such as retiring, meeting family members for the first time and being supported to build relationships, building friendships and going on holidays for the first time or the first time in many years.

The provider had reviewed the assessment tool for assessing residents' personal needs since the previous inspection. The inspector viewed a sample of these and found they were reflective of the resident and their needs. Improvement was required to ensure that residents had corresponding support plans for all assessed needs.

Some residents were assessed as at risk of developing pressure sores. Although residents had pressure relieving devices in place there was no support plan showing the devices or interventions required. In addition, some pressure relieving devices had been set based on a resident's weight in October 2015 and the last recorded weight for the resident was December 2015. The resident was identified as requiring weight monitoring at six monthly intervals. The person participating in management did not have any detail regarding if the mattress setting would require adjusting should the resident's weight change.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The centre was a detached house with an adjoining apartment and was located in a housing estate on the periphery of a large town. Improvement was required to ensure the centre was kept in a good state of repair and to the measures to ensure all parts of the centre were accessible to all residents.

The centre comprised of a house with an adjoining apartment. The main house had five bedrooms, a sitting room, a kitchen cum dining room, a multisensory room and four en

suite bathrooms. One bathroom was shared by two residents. The adjoining apartment comprised of a kitchen cum living room, a bedroom and an en suite bathroom.

Residents had individual bedrooms which were personalised and decorated in line with the resident's preference. All bedrooms had adequate storage space.

The communal space in the main house comprised of a living room, a kitchen cum dining room and a multisensory room. The multisensory room was also used as a room to meet with visitors in private.

Some walls and doorways were damaged. The inspector was told the damage was caused by wheelchairs which were used by some residents. The provider nominee said the centre was painted and repaired on a regular basis, however damage continued to be caused. The person participating in management told the inspector the doorways were a standard size. The damage to the doorframes raised concern that the centre did not fully meet residents' needs in regard to accessibility.

There was adequate ventilation, heating and lighting in the centre. The centre was warm on the day of inspection and staff told the inspector that the centre was maintained at an appropriate temperature.

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:
There were systems in place to protect and promote the health and safety of residents, staff and visitors. Improvement was required to ensure the system for evacuating residents in the event of an emergency was effective.

The risk management policy outlined the measures and actions in place to control risks in the centre. Risks had been identified by the provider and control measures had been implemented to address or minimise risks.

There was a fire safety folder in the centre. The folder contained the system and documents to show all equipment was serviced and regular checks were carried out on all aspects of fire safety. The fire fighting equipment, fire alarm system and emergency lighting had been serviced.

The inspector viewed the fire drill records. Fire drills were taking place on a regular basis. The records did not detail which residents and staff members had taken part. Some records showed that five residents were present. However, it was not evident that all staff had taken part. The person participating in management said that the document had been reviewed as they had recognised the document used did not contain adequate detail. They said the new document would be used in the centre and that a record of all residents and staff taking part would be maintained.

Each resident had a personal evacuation plan which outlined the procedure for evacuating the resident in the event of a fire. Three documents stated the resident would remain in bed if there was a fire at night, staff would ensure the bedroom door was closed and would await the fire service to come to the centre to evacuate residents. The rationale for this related to the support needs of residents, some of whom required two staff to support them to evacuate.

The provider nominee said the centre had been compartmentalised. A letter from a fire consultant who had been employed by the provider was emailed to the inspector on the evening of the inspection. The letter stated that the building was designed on the principle of reduced travel distances of minimum 10m single direction and 20m in two directions; sub-divided into two compartments along with 30 minute protected corridors; and, an early warning fire alarm system. The letter also stated the response time for the fire services to reach the building would be 15 minutes based on the location of the centre from the fire station. The letter further stated that, based on these measures, residents could remain in their rooms safely for 30 minutes once maintenance procedures were kept up to date in the centre.

The inspector noted that some maintenance procedures had not been kept up to date. Fire doors, including some residents' bedroom doors, had not been maintained to an adequate standard. Some doors contained significant damage to the door frame which would render them ineffective in the event of a fire. Furthermore, some doors did not close fully and some doors contained paint on the cold smoke seals which had the potential to impact the effectiveness of the cold smoke seal. This was brought to the immediate attention of the provider nominee. The provider nominee outlined the measures which were in place to ensure residents were protected until the doors were fixed. These included the compartmentalisation of the centre, an early detection fire alarm system and two staff at night, one of whom was awake. However, the inspector noted that some of these systems were reliant on an evacuation not being necessary until such time as the fire services could come to the centre. The provider nominee was requested to submit information showing the plan for residents to remain in their bedrooms until the fire service would come to the centre had been completed by an expert in fire safety and that the fire service were aware of the plan.

The provider nominee outlined some difficulty in receiving the further information post inspection and this was not received until eight working days post inspection. The provider nominee informed the inspector that the fire doors and cold smoke seals had been ordered and were due to be replaced two weeks post the inspection. In addition, a further letter from the fire consultant the provider had employed was received. The letter stated that, due to the nature of the centre and its design, the fire authority would

be aware of the centre and that some residents would require assistance for escape. The letter also stated that the evacuation strategy would be to evacuate all residents when it is safe to do so, otherwise wait for the fire services to arrive. The inspector noted that evacuation if it was safe to do so was not included in the residents' personal evacuation plans. Furthermore, staff spoken with on the day of inspection had stated they would not attempt evacuation. They said they would close the bedroom doors as outlined in the personal evacuation plans and await the fire service to evacuate the residents.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Improvement was required to the measures in place to ensure staff had all required information to support residents with behaviour that is challenging.

There were measures in place to keep residents safe and protect them from abuse. Staff and the person in charge were knowledgeable of the procedures for safeguarding residents and reporting any suspected or confirmed allegations of abuse.

Allegations of abuse had been submitted to HIQA and had been investigated. An investigation was taking place at the time of the inspection. The inspector received an update from the designated contact person. Appropriate measures had been taken which included safeguarding residents from the risk of abuse.

Some residents required support with their behaviour that was challenging. The inspector reviewed the support plans and saw that some residents had plans which outlined the proactive strategies staff were to follow to ensure the resident was supported and prevent the behaviour escalating. However, these plans did not contain an outline of how staff should support the resident if the behaviour did escalate. In contrast, some plans outlined how staff should react if residents' behaviour escalated

however, the plans did not outline how staff should proactively ensure behaviour did not escalate.

Some residents were using bedrails and lapbelts. Assessments had been carried out and risk management plans were in place. There were no other measures in place which were identified as restrictive.

Judgment:
Substantially 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:
Residents were supported to enjoy the best possible health. Each resident's healthcare needs were assessed on an annual basis and measures implemented where required. Improvement was required to ensure all residents were supported to achieve and maintain a healthy weight.

Residents attended a general practitioner of their choice and allied health professionals as required. Residents were supported to attend appointments and records were maintained of visits and any recommendations made. The person participating in management and staff were knowledgeable of residents' healthcare needs.

The inspector reviewed a sample of residents' healthcare plans and saw that each person had an annual health assessment. This was carried out by the resident's general practitioner and included a blood test. This appeared to be an effective measure in the early detection of illness. A resident had been diagnosed with an illness as a result of the blood test result and was receiving treatment.

Residents were supported to attend healthcare appointments. This included optical and dental reviews.

Improvement was required to the measures for supporting residents to achieve and maintain a healthy weight. Although staff were knowledgeable of residents' dietetic needs it was not evident that all residents were receiving required support. For example, the monitoring of residents' weight and referral to dietetic services was not in place for all residents.

Speech and language therapy (SALT) services were accessed by residents. Some residents had been assessed as requiring a modified diet. Staff spoken with were knowledgeable of residents' needs. The inspector observed part of a mealtime and saw residents supported consistent with their assessed needs. The food served smelled appetising and was presented in a manner consistent with each person's needs and preferences.

An occupational therapist (OT) was employed by the service provider and residents were supported to access the OT. In addition, residents were supported to access OT services from the service provider's funding body where required. Some residents had been attending an external OT for many years and this was supported by staff.

Judgment:
Substantially Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
There were procedures for the ordering, prescribing, storing and administration of medicines to residents. Improvement was required to ensure that prescription sheets contained all required information, to the procedure for cleaning the medicine press and to the procedure for storing p.r.n. (a medicine only taken as the need arises) medicines in the centre.

The inspector viewed a sample of medicine prescription sheets. The prescription sheets contained the resident's name, address, date of birth, a photograph of the resident and the general practitioner's (GP) name. All medicines were signed as prescribed by the GP or a prescribing practitioner. The sheets also contained the name of prescribed medicines, the dose of the medicine and the prescribed time of administration.

Some prescription sheets did not contain all required information. For example, the route of administration of medicines and the maximum dosage of p.r.n. medicines. Furthermore, some prescription sheets were difficult to read and erasing fluid had been used on one prescription sheet. Two medicines were written on the lines containing erasing fluid and each one was signed by a different medical prescriber. It was therefore not evident that the medicines documented were the medicines prescribed by these medical practitioners.

The inspector viewed a sample of medicine administration records. The majority of medicines were documented as administered at the time of administration. However, one administration record did not match the actual time of administration.

The centre had three presses for storing medicines. All presses were locked and the keys were held by staff on duty. One medicine press was viewed by the inspector. The medicine press contained the medicines prescribed for two residents. The press was not adequately clean and contained a sticky substance on one shelf. The person participating in management said that they were responsible for cleaning the press every Monday but been absent the previous two days.

The presses contained residents' regular and p.r.n. medicines. Regular medicines were packed in pre packaged containers by the pharmacy. Some medicines, including p.r.n. medicines, were in the original containers. All containers contained a label stating the details of the person for whom the medicine was prescribed. A large amount of p.r.n. medicines were in the presses. These medicines were not used on a regular basis and the person participating in management said that they had recognised that there was an excess of medicines required in the press.

There was no system for ensuring that the number of p.r.n. medicines which were received in the centre corresponded with the number which were administered or disposed of. The person participating in management said they had recognised this and intended to implement a stock checking system to ensure that all medicines received were accounted for.

Staff were knowledgeable of when to administer p.r.n. medicines and there was an on call system for staff to discuss the administration of p.r.n. medicines with a suitably qualified manager. The person participating in management had commenced documenting p.r.n. plans which would outline the signs and symptoms a resident displayed and the circumstances for administering p.r.n. medicines to residents. The inspector viewed a sample of these and found they required improvement to ensure the direction provided was specific. For example, the p.r.n. plans did not include the way the staff would ascertain the resident required pain relieving medicine. The person participating in management outlined their intention to address this by ensuring there was a pain assessment in place for each resident which would be used in conjunction with a comprehensive p.r.n. plan for administering pain relief.

There were no medicines which required strict control measures.

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):
No actions were required from the previous inspection.

Findings:
There were clear lines of authority and accountability. The person in charge reported to the Director of Service who reported to the Board of Management. The person in charge held the role of person in charge of other centres and there was no evidence this impacted on the governance of the centre. A clinical nurse manager had been appointed to the centre in recent months and this person had been identified as a person participating in management of the centre.

The clinical nurse manager was present on the day of the inspection. She was knowledgeable of her role, the residents and their needs and the systems in place. The inspector found she was committed to the care and support of residents and meeting residents' needs. She acknowledged that some systems required review and said she was committed to improving the systems in the centre. She worked in the centre Monday to Friday and was responsible for meeting the clinical needs of residents, compiling and reviewing assessments and support plans, overseeing the management of medicines and supporting and supervising staff.

The role of provider nominee was held by the Director of Service. She attended the centre on the day of inspection, provided information and responded to the inspector's queries. She presented as knowledgeable of the centre and the residents. She had worked in the organization since 2000 and had held other roles prior to undertaking the role of Director of Services.

The provider nominee outlined the mechanisms for ensuring the Board of Management were aware of the governance of the designated centres. The Board of Management was comprised of family members and friends and two external members, one of whom was an accountant. The Board met a minimum of eight times a year and discussed areas including health and safety, complaints, strategic planning and staffing.

There was an emergency on call system in the evenings, overnight and at weekends. This role was shared between the Director of Services (provider nominee) and the two Assistant Director of Services, one of whom held the role of person in charge of the centre. Staff contacted the on call system with queries or if they required support. There were reporting mechanisms to ensure that all three managers received comprehensive handover of information to ensure continuity of care when they were fulfilling the role.

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:
There were appropriate staff numbers and skill mix to meet the needs of residents. The staffing complement had been amended to meet the needs of residents and provide effective oversight.

The provider had reviewed the centre's staffing needs. A staff nurse had been employed in the centre on a daily basis. The provider reallocated resources to employ a clinical nurse manager Monday to Friday and a social care worker Saturdays and Sundays.

There was a planned and actual staff rota. A core staff team worked in the centre. Staff spoken with said that a consistent staff team had been identified as a required measure to ensure residents had an improved quality of life. The provider had put measures in place to ensure staffing was consistent, for example staff who worked in the centre regularly worked additional hours when colleagues were on planned or unplanned leave.

The inspector spent time in the company of residents and staff and saw positive and respectful interactions. Staff spoken with were knowledgeable of the residents and their role in supporting residents. Staff were observed interacting with residents in a manner consistent with residents' support plans.

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:

Lorraine Egan
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Waterford Intellectual Disability Association Company Limited By Guarantee
Centre ID:	OSV-0003283
Date of Inspection:	01 February 2017
Date of response:	10 March 2017

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Social care plan reviews did not assess the effectiveness of the plan.

1. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PPIM will document the effectiveness of the PCP's by documenting all steps taken and goals achieved in the PCP document.

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:
Residents' personal plans did not include support plans for all assessed needs.

2. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The PPIM will complete support plans for all assessed needs of residents.

Proposed Timescale: 30/04/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The size of the doorways in the centre did not adhere to best practice in promoting accessibility.

3. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
The only service user who independently uses a powered wheelchair can access all areas of the house. Material is being sourced by the Registered Provider and the PIC to prevent damage to all areas of the walls and doors from this persons wheelchair. Their independence is not impacted by the size of the doorways and they can access all areas of the house independently.

Proposed Timescale: 30/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the centre had not been kept in a good state of repair.

4. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
Action in addition to the regular decoration of the service will be taken to prevent the marking of walls and doors by service users who use wheelchairs independently. The Registered Provider and the PIC are sourcing materials to protect these areas from further damage and these will be put in place where they are required throughout the centre.

Proposed Timescale: 30/05/2017

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:
It was not evident that all staff had taken part in a fire drill in the centre.

5. 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:
Documentation will be in place which details all service users and staff taking part in fire drills.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Doors for containing fires had not been maintained to an adequate standard.

6. 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:
All doors have been replaced or repaired and all are to the correct and effective standard of maintenance.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for evacuating all persons in the designated centre and bringing them to safe locations were not adequate.

7. 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 PPIM will review all Personal Evacuation Plans to ensure that they state that all service users should be evacuated if it is safe to do so.

Proposed Timescale: 15/03/2017

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:
Residents' support plans were not adequately comprehensive to ensure that staff had up to date knowledge to respond to behaviour that is challenging and to support residents to manage their behaviour.

8. 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:
Staff have recently been trained in Studio 3 Low Arousal method of supporting service user who may display challenging behaviours. The implementation of this method involves the use of individual Stress Support Plans. These plans detail all interventions including the pro-active and reactive strategies. The PPIM will complete these new

documents for all service users.

Proposed Timescale: 30/04/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate health care to manage weight had not been provided for all residents.

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

Please state the actions you have taken or are planning to take:
The residents who cannot use a traditional scales will be supported by the PPIM to source one in the community. This had previously been available through the Public Health Nurse however the device has not been available recently. The PPIM will organise that all service users who are overweight are referred to a dietitian, and that they are reviewed by the dietitian.

Proposed Timescale: 30/04/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some practices relating to the prescribing and administration of medicines were not adequately robust to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed.

10. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The PPIM has checked all prescription sheets and those that required correction have been corrected by the relevant GP's and they are all legible.
The time of administration of medications, if different from the prescribed time, is now being documented on the prescription record sheet by all staff involved in administering medications.

The PPIM will put a system in place whereby the medication cupboards are checked each night by the night staff and cleaned as required. The PPIM has returned all excess PRN medications and they ensure that these are only ordered as required. The PIC will put in place a system for checking the number of PRN tablets used against stock level. A detailed Care Plan will be put in place by the PPIM for all PRN medications which includes the way staff would confirm that the resident requires pain relieving medication.
Proposed Timescale: 30/04/2017