Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Drombanna
Name of provider:	RehabCare
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	13 March 2018
Centre ID:	OSV-0002652
Fieldwork ID:	MON-0021453

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The centre consisted of a domestic style two storey detached premises in a small housing development on the outskirts of the city; transport was provided. Residential services were provided on a full-time basis to a maximum of five residents, both male and female. Residents assessed needs were high and at times required one-to-one staff support. All residents had access to structured day services Monday to Friday; since January 2018 all of these day services were provided off-site.

The following information outlines some additional data on this centre.

Current registration end date:	31/10/2018
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
13 March 2018	09:00hrs to 17:30hrs	Mary Moore	Lead

Views of people who use the service

On this inspection there was limited opportunity for engagement with residents or to illicit their views on what it was like for them to live in the centre. All five residents now attend off-site and community based day services and had already left the centre to attend these services when the inspector arrived. This was a positive outcome for residents to enhance their lived experience.

Inspectors had met with all five residents on previous inspections and found that residents' engaged through observation, gesture and facial expression and some verbal communication. The inspectors found that whatever engagement took place was led by residents and their needs and choices at that time.

Residents and staff were returning to the house in the evening as the inspection concluded. The inspector saw that the house was busy in particular the communal areas given the numbers of residents and staff that were present. The additional presence of the inspector and representatives of the provider added to an already busy environment.

Given residents needs in particular their requirements for quiet and space the inspector was of the view that engagement at this time when residents had clearly not settled into their evening routines was not in their best interest.

Capacity and capability

This inspection was the fifth inspection of this centre by The Health Information and Quality Authority (HIQA). The first inspection was undertaken in September 2014; the last inspection was on the 1 November 2017.

The inspections completed between May 2016 and November 2017 found poor compliance on the part of the provider with their obligations under the Health Act and associated regulations and standards. This inspection again found unsatisfactory progress and inadequate implementation of the action plan response the provider committed to arising from the last inspections.

There are factors impacting on the level of compliance observed in the centre, that is, the number of residents accommodated and the incompatibility of their needs. However, the inspector again concluded that notwithstanding these factors, governance of the centre did not ensure satisfactory regulatory compliance or the consistent delivery of high quality, safe, support and service to residents. Minimal improvement was evidenced on the previous inspection findings. The impact on

quality and safety is discussed in detail in the next section of the report.

The provider accepted this finding and accepted the failure to demonstrate improved regulatory compliance due to inadequate governance both in capacity and oversight.

The provider has a plan and had continued to progress the plan to reconfigure the service and relocate some residents to a new designated centre. The inspector was advised that this plan would be realised within the committed to timeframe. The provider had also recently appointed a person to be person in charge of this designated centre and this designated centre only.

The appointed person had appropriate qualifications in social care, the required qualifications in management and the required experience in a supervisory capacity. The person in charge was employed full-time and planned to work shifts that corresponded to periods when staff and residents were in the house so as to improve supervision. The person in charge has demonstrated her ability in her previous role as a team leader in another designated centre.

The person in charge was aware of the challenges in the designated centre and articulated her commitment to the effective operation and administration of the centre.

Where committed to actions from the previous inspection had been implemented their implementation was not timely. For example on a day-to-day basis the person in charge was supported by a team leader. The provider in the response to the November 2017 action plan had committed to additional team leader supports from the 4 January 2018; the inspector found that this support was not made available on this date and only came into effect on the day of inspection 13 March 2018.

In January 2018 HIQA was advised by the provider that oversight to ensure the quality of service and safety of the residents within the centre would be provided by the integrated services manager and personnel from the provider's business support and performance unit. However, personnel met with from this unit confirmed that this input did not commence until the 12 March 2018. Commitment was articulated to providing support from that date to the person in charge to address the failings in the centre.

Staff meetings were convened; the records of these reflected high staff attendance and discussion of topics relevant to previous inspection findings and the quality and safety of the supports and services. For example incidents, medicines errors, fire safety and the management of behaviours of concern were discussed. However, given these unsatisfactory inspection findings it was not evident how these meetings informed the review of service delivery so as to bring about improvement.

Ultimately while the provider has a plan, satisfactory improvement and an acceptable level of regulatory compliance have not been achieved over the course of 4 HIQA inspections between May 2016 and March 2018. This does not reflect governance systems and processes that are appropriate and have both the capacity

and capability to underpin and maintain consistent delivery and oversight of the safety and quality of the service.

The inspection findings in relation to staffing were largely unaltered; deficits in staff training had been addressed. The inspector was advised that there were challenges to recruiting staff and that these challenges were not particular to this centre, staff had been recruited as committed to in the response to the last action plan. However, some staff had subsequently not taken up the offered posts and two staff had also left; there were three vacant staff posts. A further recruitment drive had been initiated.

The inspector was told that it was a challenge to maintain and establish a complete staff team of experienced staff; there was ongoing reliance on relief and agency staff to maintain staffing levels. The review of the staff rota indicated that while consideration was given to continuity of staff an average of eight relief and agency staff were required each week to maintain staffing levels. This resulted in negative impacts on both the quality and continuity of care for this specific group of residents.

The inspector reviewed staff training records with the person in charge and the integrated services manager and was satisfied that a review of staff training had been completed. Records were maintained of the training completed by regular, relief and agency staff. Staff had completed fire safety, safeguarding, MAPA (management of actual and potential aggression) and medicines management training; refresher training was scheduled. Gaps had been identified in first aid training and this was booked to take place. Training for staff in personal planning with residents, professional boundaries and conflict resolution was also planned.

At the time of the last inspection inspectors found that while complainants were listened to complainant satisfaction was not evidenced. The fact that complainants may not have been satisfied at the response to their complaint was reflected in the finding of repeat complaints. This failing was still not satisfactorily evidenced as addressed. The inspector was advised that a meeting was held with the complainant and the meeting invite was seen. However, the outcome of this meeting and whether the complainant was satisfied or not was still not evidenced as the resolution record was not available for inspection. The complaint record had not been updated and was still logged as open and unresolved.

Records required to be maintained in the designated centre and available for the purpose of inspection were not readily available. Records were not maintained so as to facilitate ease of retrieval both of the record and of the information contained therein. For example in addition to the complaint record above the inspector found duplicate behaviour management guidelines, duplicate personal emergency evacuation plans (PEEPS) and an absence of records and correspondence core to residents and decisions about their care and support.

Regulation 14: Persons in charge

The recently appointed person in charge had appropriate qualifications in social care, the required qualifications in management and the required experience in a supervisory capacity. The person in charge was employed full-time.

Judgment: Compliant

Regulation 15: Staffing

The provider was challenged to maintain and establish a complete staff team of experienced staff; there was ongoing reliance on relief and agency staff to maintain staffing levels.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of staff training had been completed. Records were maintained of the training completed by regular, relief and agency staff. Staff had completed the required mandatory training; refresher training was scheduled. Gaps had been identified in first aid training and this was booked. Further training relevant to the needs of the services was booked.

Judgment: Compliant

Regulation 21: Records

Records required to be maintained in the designated centre and available for the purpose of inspection were not readily available. Records were not maintained so as to facilitate ease of retrieval both of the record and of the information contained therein.

Judgment: Substantially compliant

Regulation 23: Governance and management

Satisfactory improvement and an acceptable level of regulatory compliance was not evidenced and have not been achieved over the course of four HIQA inspections between May 2016 and March 2018. This does not reflect governance systems and processes that were appropriate and had both the capacity and capability to underpin and maintain consistent delivery and oversight of the safety and quality of the service.

Judgment: Not compliant

Regulation 34: Complaints procedure

Whether the complainant was satisfied or not was not evidenced; the complaint had not been updated and was still logged as open and unresolved.

Judgment: Substantially compliant

Quality and safety

Residents were not in receipt of a consistently safe, quality service. However, the provider has articulated it's commitment to improving the quality and safety of the service provided to residents and has demonstrated this commitment in their plan to reduce the occupancy in the centre, establish a new designated centre and relocate some of the residents to this new centre by the end of May 2018. The inspector was advised that this plan is on target. The ultimate objective of this plan is to address established issues in relation to the lack of communal space available to residents and the incompatibility of residents needs.

Since the last inspection the provider put a community- based day service programme in place for two residents. Over the course of HIQA inspections, challenges and obstacles to meaningful engagement and community integration had been the overarching theme of the supports provided to these residents with little evidence of a programme of personal development. The provider representative said that while new, it was happening with no significant challenges reported.

There was also evidence available to the inspector that the provider did act to protect residents further to concerns raised in relation to the quality and safety of the supports received by residents. Ultimately however, as discussed in the previous section a regular team of experienced staff is required so that residents needs are adequately and appropriately responded to.

Notwithstanding the provider's plan, the assessed risk of the impact of peer-to- peer behaviours was currently rated by the service as of moderate risk. A high level of

peer-to-peer physical interaction incidents continued in the centre; 23 such incidents had been reported to HIQA since the last inspection and informed the timing of this inspection.

The design and layout of the environment limits the effect of behaviour management strategies, however, other deficits were identified that did not provide assurance as to the robustness of behaviour management strategies.

For example, the inspector found that while behaviour management guidelines were in place they were not all informed by input from the behaviour therapist. There was evidence that the behaviour therapist came to the centre, met with staff, discussed behaviour management strategies and reiterated the requirement for their consistent implementation. However, one core behaviour management plan had not been devised in consultation with the behaviour therapist. It was stated on the record that the behaviour management plan was not a clinical document and was managed and updated by the centre staff. The specific peer-to-peer issue relevant to this plan was described at a staff meeting of February 2018 as of high risk.

While the plan was detailed, given the peer-to-peer challenges in this centre, this finding did not provide assurance as to the evidence base and adequacy of the plan. The provider in the response to the last action plan had stated that behaviour management plans were developed in consultation with the multidisciplinary team including the behaviour therapist.

This was of further concern in the context of the regulatory requirement to ensure that the behaviour management plan was reviewed as part of the overall personal planning process to ensure that residents were transferred in a planned and safe manner and in accordance with the resident's assessed needs and personal plan. The inspector was advised that a transfer to another designated centre was agreed and was hoped to be complete by the end of March 2018. However, there was no explicit evidence available to the inspector to substantiate that the transfer was in accordance with the resident's needs. There was no explicit evidence of the completion of compatibility assessments to ensure that peer- to-peer negative interactions would not become a feature in the receiving designated centre. There was explicit evidence that the proposed transfer was not compatible with the resident's needs and that the arrangements in the proposed receiving designated centre were currently not suited to the resident's needs. Given these findings the provider was requested to review as a matter of priority this proposed transfer.

Training records indicated that all staff had attended training in safeguarding and de-escalation and intervention techniques. Incidents and behaviour management were discussed at staff meetings. However, the inspector was advised that an investigation of a recent incident had found that there were deficits in staff knowledge of behaviour management guidelines and intervention techniques.

Further to the last inspection findings, the provider had made a decision to remove one environmental restriction in use; that is restricted access to the main kitchen. However, on reviewing records completed by staff the inspector saw further incidents since then where staff had locked doors to protect both themselves and

residents from harm. There appeared to be improvement in the recording and reporting of these unplanned restrictive practices. However, these unplanned restrictive practices had previously not been noted by inspectors and may indicate an escalation in behaviour and risk or deficits in staff knowledge of agreed interventions including reactive interventions. While a record of each such event was created, there was no collective log that facilitated oversight, analysis and learning. The records seen by the inspector were fragmented; some were duplicated and did not lend themselves to review.

On the day of inspection the person in charge and the integrated services manager had commenced the process of creating an additional recreational space for residents. While recognising this initiative, this also raised the question why this intervention had not been considered in a timelier manner.

Improvement was noted in medicines management systems; however, this did not appear to impact on the safety of medicines management practice. The inspector noted the medicines audit to be completed by the pharmacist had been completed. Systems of supply had been reviewed and limited to a one week supply; a medicines identifier was supplied by the pharmacist.

Medicines were stored securely and the storage areas were organised. Prescriptions were clear and legible and staff maintained a record of medicines administered; there were no deficits in the sample reviewed by the inspector. Medical authorisation was in place for medicines required to be administered in an altered format; that is, crushed. Discontinued medicines were signed and dated as such by the relevant prescriber. The maximum daily dose of PRN (as required) medicines was stated and there were protocols governing their administration. The sample of administration records reviewed indicated that staff adhered to the protocol both in terms of daily and weekly maximum dose.

However, incident records reviewed by the inspector indicated that the pattern of medicines errors identified on previous inspections continued; this did not indicate improvement, did not provide assurance that medicines management practices were safe and that residents received their medicines as prescribed. Between 3 June 2017 and 1 November 2017 there were 12 recorded medicines related incidents. There were 10 errors identified between 1 November 2017 and 13 March 2018. These errors were identified primarily through the counts of medicines completed daily by staff in the centre; the count discrepancies indicated that medicines had not been administered to residents as prescribed; lack of staff vigilance and preoccupation with other tasks were cited causal factors. Staff were advised at the most recent staff meeting that the incidence of medicines errors was significantly higher than that found in other centres and that the provider was very concerned about this.

It was clear from the above failings that the actions identified by the provider in response to the last action plan were not sufficient to address the identified failings. It was unclear what oversight and accountability was in place for medicines management practice; the inspector was concerned to find eight loose pharmacy issued medicines labels in the medicines cabinet. The issue of medicines oversight

was a recommendation of the December 2017 medicines audit.

At the time of the last inspection inspectors had found that the arrangements in place regarding evacuation did not demonstrate that all residents could be evacuated in the event of a fire; this failing had not been adequately addressed. The inspector reviewed the records of simulated drills convened since the last inspection; staff had failed to evacuate one resident on each occasion. The personal emergency evacuation plans (PEEPS) had been reviewed but did not provide assurance that every reasonable effort would be made so that residents could and would be evacuated in the event of fire. Staff were still advised to leave the resident in the centre and rely on the presence of fire resistant doors to protect the safety of the resident until emergency services arrived.

Again there was reference in records seen of prompts that could be used such as social stories, visual and physical prompts to promote evacuation but there was no evidence that these had actually been trialled. There was differing opinion recorded between staff as to the prompts to be used or that could be used but ultimately there was no agreed corrective plan. The PEEPS were brought to the attention of the provider's representative; the provider's representative was requested to provide confirmation to HIQA within a specified timeframe that adequate and evidenced based arrangements would be put in place to demonstrate that every reasonable effort would be made to evacuate residents. This confirmation was received and was satisfactory.

A fire drill for 11 staff employed had been undertaken on the 6 December 2017 in response to the failing of the last inspection where staff spoken to indicated that they had not participated in a fire drill despite working in the centre for a year. Training records indicated that deficits in fire safety training also identified at the time of the last inspection had been addressed. There were certificates in place attesting to the inspection and testing of the fire detection system, the emergency lighting and fire fighting equipment at the prescribed intervals.

A centre-specific risk register was in place along with risk assessments relating to individual residents. The range of completed risk assessments was broad; they were noted to have been recently reviewed. However, the inspector was not assured that risk management systems for some core risks had adequately identified the actual level of risk or the actions required to control the risk. For example the inspector noted that a generic fire safety risk assessment completed in January 2018 did not acknowledge the risk created by the fact that adequate arrangements were not in place to evacuate all residents; it was recorded that all occupants could escape to a place of safety in a reasonable time. A further generic fire safety risk assessment completed in December 2017 rated the risk of fire to occupants as of medium risk (yellow); again there was no reference to the practical failure to evacuate all residents during simulated drills. No resident-specific risk assessment was seen for the risk of failure to evacuate in the event of fire.

Regulation 13: General welfare and development

The provider had since the last inspection put a community based day service programme in place for two residents. Previously over the course of HIQA inspections challenges and obstacles to meaningful engagement and community integration had been the overarching theme of the supports provided.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was insufficient evidence to demonstrate that residents would be transferred in a planned and safe manner and in accordance with the resident's assessed needs and personal plan. The completion of compatibility assessments to ensure that peer-to-peer negative interactions would not become a feature in the receiving designated centre were not evidenced. There was explicit evidence that the proposed transfer was not compatible with the resident's needs and that the arrangements in the receiving designated centre were currently not suited to the resident's needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management systems for some core risks had not adequately identified the actual level of risk or the actions required to control the risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The arrangements in place regarding evacuation did not demonstrate that all residents could and would be evacuated in the event of a fire. There was reference in records seen of prompts that could be used such as social stories, visual and physical prompts to promote evacuation but there was no evidence that these had actually been trialled. There was differing opinion recorded between staff as to the assistive tools to be used or that could be used but ultimately there was no agreed corrective plan.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Incident records seen indicated that the pattern of medicines errors identified on previous inspections continued; this did not indicate improvement, did not provide assurance that medicines management practices were safe and that residents received their medicines as prescribed. The provider itself had stated that the incidence of medicines errors was significantly higher than that found in other centres and that the provider was very concerned about this. It was clear that the actions identified by the provider in response to the last action plan were not sufficient to address the identified failings. It was unclear what oversight and accountability was in place for medicines management practice.

Judgment: Not compliant

Regulation 7: Positive behavioural support

One core behaviour management plan had not been devised in consultation with the behaviour therapist.

There were deficits in staff knowledge of behaviour management guidelines and intervention techniques.

Records of unplanned restrictive practices where staff locked internal doors to protect themselves and residents may indicate an escalation in behaviour and risk or deficits in staff knowledge of agreed interventions including reactive interventions. While a record of each such event was created, there was no collective log that facilitated oversight, analysis and learning.

Judgment: Not compliant

Regulation 8: Protection

The assessed risk of the impact of peer-to-peer behaviours was currently rated by the service as of moderate risk. A high level of peer-to-peer physical interaction incidents continued in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Drombanna OSV-0002652

Inspection ID: MON-0021453

Date of inspection: 13/03/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Background

Recruitment and Selection of staff for the service is governed by the organisation's Staff Recruitment and Selection Policy. Where relief and agency staff are required the organization ensures that same staff are used regularly and have up to date training in terms of mandatory training requirements.

Action

- The recruitment programme has yielded three permanent posts, one specific purpose post and one relief post were filled, and this was completed by 30 April 2018.
- There are currently no vacancies outstanding in the service.
- Regular relief staff employed by RehabCare will continue to be used to provide cover for periods of staff leave and to provide additional support during the upcoming transition period within the service.
- Every effort will be made to ensure use of agency staff will be kept to a minimum.
- There is currently a review of staffing for three services in the are operated by RehabCare, with a view to reconfiguring staff teams to ensure each staff team has experienced staff members, this will be complete with changes implemented by 30/06/2018

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Background

- The organization adopts a standardised approach to record keeping at individual and service level, this approach is line with documents required by regulation.

Action

- A care worker with extra responsibilities commenced supporting the service on

30/04/2018. Their role is to oversee updating all records, organize a clear filing structure to enable easy retrieval of all documents and to implement a system to ensure going forward all records are maintained to the required standard, this will be complete by 15/06/2018.

- Going forward weekly Manager/Team Leader audits will be in in place to ensure all records are up to date.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Background

There is an operational line management structure in place to oversee the management of the service. The organization has a Business Support Unit available to provide support to services during periods of transition and when operational difficulties arise. The organization is also committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service. The Quality and Governance Directorate with subject matter experts are actively supporting the service, in terms of risk management, medication, safeguarding etc.

Actions

- Full time Manager in service. Full time Team Leader to support PIC and supervision of Staff Team. Care worker with extra responsibilities for three months available to support PIC, supervision of Staff Team. RehabCare behavior therapist will work closely with the staff team to ensure the implementation of all recommendations for forward planning. Weekly meetings between PPIM and PIC.
- Team Leader or Manager will be on site seven days a week to provide support and supervise staff team.
- Ongoing Support is being provided from the Business Support & Performance Manager.
- An internal six monthly visit place on May 1st.
- Going forward the PIC and PPIM will meet regularly, review of actions arising from this report and any internal audits will be a standard agenda item until all actions are closed out.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Background

- All complaints are recorded on RehabCare's online reporting system and the organisation's policy guidelines are followed locally. The Complaints Policy and Procedure is provided to families and explained to residents using social on a regular basis including what to do if the complainant is not happy with the outcome of their complaint.

Action

- Revised organizational Complaint's Policy was issued on 28/03/2018, the policy requires that complainant's satisfaction with the outcome of their complaint is

documented.

- All complaints to date have been closed and evidence of this is now available in on the Complaint's Management Database, this was completed on 05/04/2018

- Going forward the PIC will record whether or not the Complainant is satisfied with the outcome of their complaint in the "comments" section of the online report.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

Background

- The organisation's policy on transitions and discharges guides staff practice when supporting residents to transfer to a new home. All transitions will be planned in consultation with residents and their representatives. In the absence of a recognized tool the organization has developed a process for assessing resident compatibility.

Actions

- By July2018 the two female residents will have moved out of the service, there is a transition plan in place for each of these residents, which includes family consultation, compatibility with each other and other residents has been assessed by the Behaviour Therapist and is deemed appropriate. Plans and Compatibility assessments were completed on 08/05/2018.
- By July 2018 two new male residents will transition into the service. There is a transition plan in place for each of these residents, which includes family consultation, compatibility with each other and other residents has been assessed by the Behaviour Therapist and is deemed appropriate. Plans and Compatibility assessments were completed on 08/05/2018.
- One existing resident remains to be discharged from the service as their needs are not compatible with the current residents or with the planned new residents. A decision has yet to be taken on where the resident will transition to, a decision will be made and plans put in place by 31/07/2018.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Background

All risks in the service are assessed, these risks pertain to each individual resident and generic workplace risks. The risks are rated and control measures proportionate to the risk are identified and implemented into practice. A log of all risk assessments held in the service is maintained in the Risk Management Framework, significant risks are escalated to the service risk register.

Actions

- All Risk assessments will be reviewed by the PIC to ensure all risks are appropriately assessed, this will be complete by 15/06/2018
- The Local Risk Register will be updated by 15/06/2018
- Risk Assessments and the Risk Register will continue to be reviewed on a regular basis by the PIC to ensure all risks are identified, adequately risk rated and proportionate control measures are in place.
- Control measures have now been implemented to address fire related evacuation risks.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Background

Within the service there are systems in place to ensure all fire equipment is serviced and in working order. Daily and weekly checks are completed to ensure exists are not obstructed etc. Each resident has an individual PEEP which identifies their support requirements in the event of a fire. A fire risk assessment is completed and regularly reviewed. Regular fire drills are facilitated to ensure there is adequate preparation in the event of a real fire.

Actions

- All individual PEEPs have been updated with input from the Behaviour Therapist and Business Support & Performance Manager, this was complete by 22/03/2018.
- Aids were identified to support and encourage Residents to evacuate. These aids are outlined in PEEPs and are available within the service, this was complete by 22/03/2018.
- Risk Assessment for the event of fire and Risk Assessment for smoking was developed and communicated to staff team at staff meeting, this was complete by 12/04/2018
- Regular fire drills are planned with different scenarios and different staff on duty. The first of which took place on 16/03/2018.
- Resident's bedroom and extra room for activities have been moved downstairs as per Fire Officer's advice. This was complete by 27/03/2018.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Background

- The organisation's Medication Management Policy governs the management and administration of medication within services. The policy has been developed and is regularly reviewed to ensure it is in line with international best practice. Within the policy there is guidance on the completion of regular medication audits at service level.

- All incidents and near misses are reported and monitored on the organisation's incident management system. The PIC monitors incidents and ensures corrective actions are taken. These incidents are reviewed at team meetings in order to share learning amongst the staff team.

- Within the Quality and Governance Directorate responsibility for developing the organisation's medication policies and procedures in line with best practice is led by the Quality and Practice Officer, who holds a nursing qualification. The Quality and Practice Officer is available to support the service to ensure the policy is implement effectively at local level.

Actions

- Going forward the following actions will be implemented to ensure the organizational policy on safe administration of medication is complied with.
- Internal medication audit took place on the 01/05/2018. Recommendations are being implemented.
- Two members of staff must now administer medication at all times, this was implemented into practice on 16/03/2018.
- Management to supervise daily, a sample of the administrations of medication.
- All staff who administer medication will be re assessed, to assess their competency, where required staff will be retrained, the assessments will be complete by 15/06/2018.
- Safe administration of medication was discussed at length at staff meeting on the 12/04/2018. Staff were advised that there will be no tolerance to medication errors that staff need to adhere to medication policy and in the event they do not, manager will be dealing with this in a formal capacity.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Background

- The organisation's Positive Behaviour Support Policy guides staff practice when supporting Residents in this regard. Organisational policy requires that all staff must complete a 2-day MAPA Foundation course and an annual refresher thereafter throughout their employment with RehabCare. This training equips staff with the skills required to support Residents who experience behaviours that challenge.

- Behaviour management plans are in place where necessary and staff are knowledgeable and competent in the implementation of these plans. These plans are periodically reviewed and monitored to ensure they are meeting the needs of the Resident.

Actions

- Going forward the Behaviour Therapist will be involved in developing and reviewing all residents' Behaviour Management Guidelines which will be reviewed at minimum yearly or more frequently as needed.

- The Plan that the Behaviour Therapist had previously no input in, will be reviewed and updated by the Behaviour Therapist, this will be completed on 15/06/2018.
- Behaviour Therapist, Integrated Services Manager and Residential Service Manager will be reviewing all incidents once a month. The first of these review meetings took place on 16/04/2018.
- Restrictive Practices log is available and used within the service to monitor the use of restrictive practices in the service.
- Daily management supervision of staff team is now in place in the service to ensure that Restrictive Practices are used correctly, as last resort and as agreed by the Restrictive Practices Committee.
- Behaviour Therapist attended Team meeting on the 16 of March 2018 to discuss Restrictive Practices and the importance of using MAPA techniques when necessary to prevent peer to peer incidents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Background

The organisation's policy on Safeguarding Vulnerable Adults which is in line with national HSE policy governs staff practice in this area. The organization has a zero tolerance policy to all forms of abuse and when issues arise the organization is committed to taking corrective actions to ensure all residents and staff are protected from all forms of abuse. The governance of the policy is overseen by Senior Social Worker / Safeguarding Lead supported a number of regional designated officers.

Action

- It is intended that by 31/07/2018 the current group of residents will no longer be all residing in the house, this will address the compatibility issues that are causing the significant number of incidents.
- As an interim measure extra staff are on each shift and management supervision of staff team is provided on a daily basis to support with peer to peer Safeguarding incidents.
- Monthly review of incidents with Behaviour Therapist, Integrated Services Manager and Residential Service Manager to identify learning points and adaptations to practice, the first of these meetings took place on 16/04/2018. These will be communicated to staff team at Team Meetings.
- Adjustments to the house have been taken to create an extra room for activities in order to keep Residents involved in Safeguarding incidents, separated. This was completed on 27/03/2018
- Second car is available since 2017 to facilitate individual trips and extra activities.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	1st May 2018
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	15th June 2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Not Compliant	Orange	30th April 2018

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Not Compliant	Orange	31st July 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	15th June 2018
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	22nd March 2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate	Not Compliant	Orange	15th June 2018

	and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	5th April 2018
Regulation 07(1)	The person in charge shall 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.	Not Compliant	Orange	15th June 2018
Regulation 07(4)	The registered provider shall ensure that, where	Not Compliant	Orange	15th April 2018

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31st July 2018