

# eDeposit Ireland

## Bethel House - Sonas Residential Service

Item Type	report
Authors	Thompson, Helen;O'Hara, Conan
Citation	Helen Thompson, Conan O'Hara, 'Bethel House - Sonas Residential Service', [report], Health Information and Quality Authority, 2017-02-13, Disability Services Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-06-16 06:20:04
Link to Item	<a href="https://hdl.handle.net/20.500.14765/81217">https://hdl.handle.net/20.500.14765/81217</a>

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Bethel House - Sonas Residential Service
<b>Centre ID:</b>	OSV-0003728
<b>Centre county:</b>	Dublin 16
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd
<b>Provider Nominee:</b>	Lorraine Macken
<b>Lead inspector:</b>	Helen Thompson
<b>Support inspector(s):</b>	Conan O'Hara
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	11
<b>Number of vacancies on the date of inspection:</b>	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: 06 October 2016 08:50 To: 06 October 2016 18:40

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection

This was an unannounced inspection that was conducted in line with HIQA's remit to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The required actions from the centre's registration inspection in early July 2014 were also followed up as part of this inspection.

How we gathered our evidence

The inspectors met with a number of the staff team which included nursing staff, household staff, the person in charge and a clinical nurse specialist in dementia. Also, in assessing the quality of care and support provided to residents, the inspectors spoke with two residents and spent time observing staff engagement and interactions with residents. Additionally, during the inspection process the inspectors were afforded the opportunity to meet with a resident's family representatives to garner their opinions on the quality of the service provided to their sibling. Overall, residents appeared happy and contented in their home and the resident's representatives reported that they were happy with the care and support provided to their relative. As part of the inspection process the inspectors spoke with the aforementioned staff and reviewed various sources of documentation which included the statement of purpose, residents' files and a number of the centre's policy

documents. The inspectors also completed a walk through the centre's premises.

#### Description of the service

The service provider had produced a statement of purpose which outlined the service provided within this centre. The centre was situated within a campus based setting in a suburban area. Activation and recreational facilities, advocacy and religious services were available to the residents within the campus.

The centre was opened in 2001 to provide specialist nursing care, convalescence and palliative care to residents. The aims included the provision of individualised care which promoted the best quality of life for each individual, promoting independence while providing a supportive and safe environment, involving residents in their care, encouraging family contact and offering a range of meaningful and age appropriate activities to residents.

There was capacity for 11 residents and the centre was now home to nine permanent female residents over 18 years of age. At the time of inspection it was also providing respite and convalescent care respectively to two other female residents from other centres under the service provider's remit.

#### Overall judgment of our findings

Eight outcomes were inspected against with five found to be in moderate non-compliance, two compliant and one substantially met.

Significant areas for improvement were identified in the core outcomes of medication management, governance and management, staffing levels, predominantly in the evening period and in residents' social care needs. The use of resources, again with regard to staffing and access to transport needed to be addressed.

The inspector found that residents' healthcare needs and health and safety and risk management were compliant. Residents' safeguarding needs were substantially met with improvement needed in the review timeframe of restrictive procedures to achieve full compliance.

These findings along with others are further detailed in the body of the report and 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):**

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

**Findings:**

Overall, the inspectors observed that the wellbeing and welfare of residents was supported. Their needs were outlined in a personal plan that also reflected their interests and wishes. However, improvement was required in the implementation, review and evaluation of residents' plans, particularly their social goals. Additionally, residents activities and level of community participation required improvement. Accessibility of residents' plans and documentation also needed to be addressed. Residents and their representatives were found to be involved in the assessment and review of their needs. Multidisciplinary support was available to residents as required. Residents were involved and consulted with at times of transition between services.

Each resident was observed to have a folder which was comprised of a medical file and a care plan. The care plan contained assessments of residents' needs with corresponding support plans to underpin staff practices. Dependency assessments were also completed with residents. From a review of plans, discussion with staff and residents' representatives and general observation the inspectors found that the needs and wishes of residents were assessed as required. The assessment of residents' healthcare needs was noted to be strong with corresponding plans subdivided into short and long term goals.

However, residents' social goals were not found to be outlined, implemented, reviewed or evaluated in a systematic manner. Some residents were observed to have minimal facilitation of meaningful activity and community involvement. For example, the inspectors did not observe evidence of implementation or review of a resident's social goals, which were identified in April 2016 with a review scheduled for July 2016. The

goals included an outing for the resident's birthday, to have a massage in a hotel and a trip to the botanical gardens. The resident's outing record showed that over a seven month period from March to September 2016 they had four outings which predominantly involved a drive and shop visit. On one occasion the record stated that the resident attended a film which they enjoyed, however, the inspectors did not observe that this information was integrated into future goal planning. The inspectors did observe that residents attended a number of campus based activities and that a specialised community activity assessment had recently been completed for some residents by the day activity co-ordinator.

Additionally, the inspectors found that a resident's plan was not reviewed in line with the scheduled timeframe. This resident's needs from observation and documentation review were observed to be of a high support.

The inspectors observed that plans were not available in an accessible format to the residents or their representatives. In general, there was little accessibility observed in documentation.

Residents were found to be supported at times of transition with evidence of communication observed between all services that were involved in supporting the resident's needs and wishes. This finding was endorsed by a resident's family members.

There was evidence observed of members of the multidisciplinary team's involvement in the assessment and review of residents' needs as appropriate. Also, the resident and their representatives were noted to be involved in the planning and review of their needs.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall, inspectors found that there were systems in place to promote the health and safety of residents, visitors and staff.

The centre had a health and safety statement which outlined the responsibilities of the various post holders within the organization. There was a policy in relation to the unexpected absence of a resident.

The centre carried out health and safety audits weekly. Inspectors reviewed the incident reporting procedure and a sample of incidents. Inspectors found that there was a clear system of recording and follow up. Incidents were reviewed monthly by the health and safety committee.

The centre had a policy in place for risk management which included the four risks specified in the regulations. The risk register clearly outlined the risks in centre and the controls in place to control the risk. The risk register included environmental risks, behaviour, restraint, manual handling and fire. The centre also completed individual risk assessment for manual handling, fire and falls.

There was certification and documentation to show that the fire alarms, emergency lighting and fire equipment were serviced on a regular basis. Staff also completed checks on the exits, alarm panels and equipment. The fire evacuation map was on display in a prominent location. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident which recorded the residents' mobility and cognitive understanding. The centre completed monthly fire drills.

There were procedures in place for the prevention and control of infection. The centre had household staff in place. Inspectors spoke to household staff and walked around the centre and found that all areas were clean and hygienically maintained. There was personal protective equipment, hand wash gels and facilities located throughout the centre.

**Judgment:**  
Compliant

### **Outcome 08: Safeguarding and Safety**

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

**Theme:**  
Safe Services

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

No actions were required from the previous inspection.

### **Findings:**

Overall, the inspectors found that there were measures in place in the centre to protect residents from being harmed or suffering abuse. Residents were observed to be treated in a warm manner with their privacy maintained. When required, there was a positive

behaviour support approach evident for residents that engaged in behaviour that was challenging. The centre promoted a restrictive free environment for residents but some improvement was required to fully meet regulatory requirements.

There were measures in place to safeguard residents and protect them from abuse. There were guidelines to inform and underpin staff practices around the observation of any bruising with residents. Also, staff knowledge was found to be good as they outlined the process and reporting mechanisms for responding to potentially abusive situations with residents.

Residents' personal and intimate care needs were outlined in plans which informed staff practices and supports provided.

The inspectors observed that a restrictive free environment was promoted for residents. However, there was recognition of the need to ensure residents' safety, especially given their high support and complex medical needs. Some residents required the usage of mechanical restraints, for example, lap straps and bed rails to meet their safety needs. The usage of restrictive procedures with each resident was identified, risk assessed and tracked on the centre's risk register. The inspectors saw evidence that the resident's family was communicated with, informed of and gave consent for the restriction. There was evidence of multidisciplinary involvement and review of the restrictive procedure. However, it was noted that the review process was not consistently completed in line with the stipulated timeframe of three monthly.

During the inspection staff were observed to treat residents in a warm and respectful manner with positive interactions noted. The inspectors observed that residents appeared contented in their home. The centre had all the policies in place that were required by regulation.

**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:**

Overall, the inspectors found that residents in this centre were supported to achieve and enjoy the best possible health. Also, residents' needs were observed to be supported as they altered and progressed, for example, required specialist palliative interventions and supports.

From a review of residents' files the inspectors observed that their healthcare needs were responded to in a timely manner and assessed with support plans drawn up, implemented, reviewed and evaluated. Residents' assessed healthcare needs were further differentiated as requiring long term or short term interventions. For example, short term supports included acute healthcare needs such as a fracture or vomiting. The inspectors particularly noted that the orderliness of residents' files further outlined and supported their medical needs.

Residents were observed to be facilitated with health screening and monitoring programmes, for example, bowel screening and skin integrity assessments. Additionally, in keeping with their needs, recording and observation charts were completed for residents. Specialised assessments, for example, pain scales were also observed to be utilised. As appropriate, residents were found to be provided with end of life care, which included advance care planning. The inspector noted that the team utilised best practice guidance from the hospice service.

There was evidence that residents were supported by a multidisciplinary team approach which included psychiatry, physiotherapy, clinical nurse specialist (CNS) in dementia, occupational therapy and a chaplain. The inspectors spoke with the CNS in dementia who outlined the type of support she provided to residents. There was also evidence that residents were referred to and supported by allied health professionals which included haematology, rheumatology, ophthalmology and chiropody.

The inspectors observed that residents were well supported by their general practitioner (GP) who was available from Monday to Friday to review residents in their home. Out of hours supports were also facilitated. On the day of inspection the inspectors noted that a resident's GP participated in a case conference review with the resident herself, her family representatives and the supporting staff team. Subsequently, the inspectors met with the resident's family who highlighted their satisfaction with the GP service and the healthcare supports provided to their sibling.

The inspectors observed that residents' nutritional needs were assessed and documented in their care plans in the nutrition, eating and drinking section. The inspectors found that residents' choice and preferences were acknowledged and supported. Staff demonstrated the process for supporting residents' choice to the inspectors and additionally highlighted that residents had the option of going to the campus canteen. A mealtime experience was observed and found to be a relaxed and social experience. Residents informed the inspectors that the food was good.

A dietician was available to support and review residents needs as required. Residents' weights and nutritional status were noted to be monitored. Specialised diets were facilitated. Drinks and snacks were available outside of residents' mealtimes and the inspectors observed that residents freely accessed and utilised the kitchen. Also, staff were noted to have attended food safety training.

**Judgment:**  
Compliant

## Outcome 12. Medication Management

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

In general, the inspectors found that residents were protected by the centre's policies and procedures for medication management. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, improvement was required with some of the centre's medication practices as the inspector observed that a resident received their medication outside of the stipulated timeframe. Medicines in the centre were stored as required and residents' medication records were kept in a safe and accessible place.

During the inspection, a resident reported to the inspector that they were late in receiving their medication on that actual morning. The resident stated that she didn't like when this happened, noting that it had occurred previously and that she had reported it to the person in charge that day. Additionally, this practice related finding was contrary to the medication administration procedure as outlined in the service's medication management policy of 26 January 2015.

In the opening meeting the person in charge had highlighted that since taking up the post in June 2016 he had reviewed, risk assessed and introduced changes to medication administration practice to address timeframe issues that he had observed. Subsequently, two staff were now involved in medication administration. The inspector also noted this matter was discussed at a recent management meeting where it was noted that this issue mainly occurred in the morning. Medication in this centre was only administered by staff nurses. Also, six of the ten staff nurses had recently completed the HSEland medication training.

This finding was highlighted and discussed at the inspection feedback meeting especially as the inspectors observed that the medical needs of residents were assessed as high. The provider noted that the resident's issue will additionally be responded to through the centre's complaints process.

In general, there was a system in place for reviewing and monitoring safe medication management practices.

Residents were facilitated by the services of a pharmacist as required. The inspectors observed evidence of review of the residents' medical status and their medication.

The inspectors observed that medicines in the centre, which included MDA drugs, were stored as required in the drug trolley, press and fridge. The inspectors noted that the fridge temperature was regularly checked and there was a cleaning checklist in operation. Residents' medication records were kept in a safe and accessible place

The inspector noted that no resident was responsible for their own medication administration.

**Judgment:**

Non Compliant - Moderate

**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:**

Overall, the inspectors observed that the management systems in place in the centre ensured the delivery of safe and quality services. However, improvements were required to ensure that the service provided is effectively monitored and reviewed with residents and their representatives systematically consulted as part of this process. Also, the identified gap in ensuring that the person in charge had governance over all staff members needed to be addressed.

No annual review of the quality and safety of care and support in the centre had been completed by the registered provider for 2016. The inspectors also noted that the previously completed review in June 2015 had not facilitated consultation with the resident and their representatives. This review had assessed the centre's compliance with the standards and regulations for residents' social care needs, safeguarding requirements, complaints and notification requirements. The inspectors observed evidence that an identified action from this review was followed up and implemented. At the feedback meeting the provider nominee informed the inspectors that the service's quality and risk manager has plans to undertake a satisfaction survey.

The required six monthly unannounced visits by the registered provider had not been completed within the required timeframe. The most recently recorded visits were completed in September and March 2015. The inspectors noted that the timing of the visits varied with one completed at 14:00 hours and the other at 22:15.

The inspectors observed that the person in charge did not have systems in place to ensure oversight and accountability over all the staff members that provided support to

residents. There was no process for supervising and meeting with permanent night staff. However, the person in charge was aware of his responsibility in this regard and there was evidence that this matter had been raised at a recent management meeting with discussion and plans to address this deficit explored.

Inspectors found that there was a clearly defined management structure in place with clear lines of authority and accountability. The person in charge was supervised by a clinical nurse manager 3/service manager and involved in the operational management of the centre. There was evidence of communication and regular meetings with the provider nominee. Additionally, the person in charge attended campus service manager meetings where quality and safety issues were discussed and reviewed with learning shared. There was evidence of auditing being used, for example with incidents and accidents that occurred.

The person in charge who had recently taken up the post was found to be very knowledgeable regarding residents' needs and was clearly identifiable to them. He was responsible for this centre only, worked full time with a significant amount of this time alongside the day staff team, providing direct care and support to residents. The person in charge was committed to his professional development and had recently attended a course in the facilitation of effective staff supervision.

**Judgment:**

Non Compliant - Moderate

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

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

**Findings:**

Overall, inspectors found that the action from the previous inspection regarding the staff complement was not addressed. Also, there was insufficient access to transport to facilitate residents in implementing their social goals.

The person in charge identified the need for six staff on duty to support the needs of residents and informed inspectors that there were six staff on from 10.00 - 17.00, three from 18.00 to 23.00 and then reduced to two during the night when residents were in bed. The inspectors also found that dependency assessments scales were completed with residents which outlined their support requirements. Inspectors reviewed a random sample of the rota and found that there was a lack of clarity in

relation to the deployment of the staffing numbers. For example, inspectors identified occasions on some weeks when staffing was lower than the identified staffing requirement, predominantly in the evening period when it reduced to two rather than the identified three. The inspectors observed that this confined the supports provided to residents to care and functional needs with limited options for social goals.

Inspectors reviewed activities and found that access to suitable transport was impacting on some residents engaging in activities and accessing the community. This was also discussed at the feedback meeting and inspectors were informed that the centre was in the process of looking at an alternative wheelchair friendly vehicle.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Overall, the inspectors observed that the staff complement during the daytime period was appropriate to meet the assessed needs of residents. However, the number of staff was not found to be consistently maintained in the evenings. Gaps in staff training were also identified. Inspectors observed that staff were very familiar with the needs of the residents and the residents displayed comfort and familiarity with staff.

Inspectors found at the time of inspection that staffing levels were not consistently appropriate to meet the needs of residents in the evening period of 18:00 to 20:00. This is discussed further under Outcome 16.

Inspectors reviewed staff mandatory training records and found that not all staff had up to date training in safeguarding and behaviour management. This was also an action identified in the previous inspection. The centre was in the process of addressing this. The centre also provided additional, as needed, training to staff in particular areas, for example dementia, end of life and palliative care.

Inspectors found that staff were supervised through regular team meetings, an annual

appraisal system and the person in charge worked on the floor. The centre was in the process of rolling out a formal supervision system.

There was one clinical nurse manager vacancy in the staff complement and inspectors were informed that this position was in the final stages of recruitment.

Inspectors did not review staff files as they were reviewed at the last inspection and found to have all the information required under Schedule 2 of the regulations.

There were no volunteers active within the centre.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Helen Thompson  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0003728
<b>Date of Inspection:</b>	06 October 2016
<b>Date of response:</b>	22 November 2016

### Requirements

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

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

### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Plans were not available in an accessible format to the residents or their representatives.

#### 1. Action Required:

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

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

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

The accessible format of the care plan is now in progress and will be made available to service users and family by 15 December.

**Proposed Timescale:** 15/12/2016

**Theme:** Effective Services

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

Some residents' plans were not reviewed for the effectiveness of their implementation or outcomes for residents.

**2. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan 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 PIC had addressed this issue with the team, some care plan was not reviewed within the scheduled time frame including the advance care plan. The PIC is in progress of completing a care plan audit at this point to identify the areas to work on. The PIC/PPIM will be discussing the result of the review with the keyworker. Together, the PIC/PPIM and keyworker will work together to ensure that future reviews are done within the scheduled time frame. The keyworkers are now in progress of completing the care plan review.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Some residents' assessed social needs were not being met.

**3. Action Required:**

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

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

The PIC and his team meet on 21 October 2016. The keyworkers will increase their focus on the social care plans of the service users as well as ensuring that their wishes and aspirations are met and evaluated.

The PIC scheduled staff members to attend the Person centred planning training. Two staff has now completed the training and other staffs are scheduled to attend the next training scheduled 15 November 2016. Furthermore, the PIC and PPIM plans to meet with the service user and their key worker/s once a month to discuss their wishes and aspirations and to evaluate the progress of their social plans.

**Proposed Timescale:** 15/12/2016

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

The usage of a restrictive procedure for a resident was not observed to be reviewed in line with best practice requirements.

**4. Action Required:**

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

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

The PIC has nominated a key staff member in charge of ensuring that the reviews of the restrictive practice by the multi-disciplinary team / MDT are completed within the specified time frame.

**Proposed Timescale:** 30/10/2016

### **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:**

The time of administration of medication to a resident was outside of the stipulated timeframe.

**5. 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:**

Two Nurses are now completing the drug rounds in the morning where the volume of

medications to be administered to service users is high. The PIC and PPIMs had met with the attending GP/Doctor and discussed the nursing concern with regards to the high volume of medications at 0800 hours. The Doctor is now reviewing the medications prescribed to all the service users in the morning and is now in progress of making changes to some of the once a day drugs.

**Proposed Timescale:** 15/12/2016

#### **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

No annual review of the quality and safety of care and support in the centre had been completed by the registered provider for 2016.

**6. Action Required:**

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

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

The quality and risk officer is scheduled to conduct the annual quality and safety inspection on this centre by 13th December.

**Proposed Timescale:** 15/12/2016

**Theme:** Leadership, Governance and Management

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

The completed annual review for 2015 did not have evidence that consultation with residents and their representatives had been facilitated.

**7. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

The PIC acknowledged that the annual review for 2015 did not mention any consultation with the service users and representatives as part of the process. The PIC will ensure in the succeeding quality care reviews that the service users and their representatives are informed. Service users will be informed and consulted through the service users meeting and representatives through their visit in the unit, by phone or by letter.

**Proposed Timescale:** 30/12/2016

**Theme:** Leadership, Governance and Management

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

The required six monthly unannounced visits by the registered provider had not been completed within the required timeframe.

**8. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The service manager has confirmed on the managers meeting 4th October 2016 that this will be carried out in due course. The visit is scheduled in the middle of November.

**Proposed Timescale:** 30/11/2016

**Theme:** Leadership, Governance and Management

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

The person in charge did not have systems in place to ensure oversight and accountability over all the staff members.

**9. Action Required:**

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

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

The PIC has now put in place a system for ensuring oversight of all the staff members working in this centre. A total of 2 duties were completed to this time with night staff. The PIC also discussed this with the new CNM1/PPIM and will be carrying out rotation duty in the future.

**Proposed Timescale:** 30/10/2016

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

There was insufficient clarity in relation to the deployment of staffing resources in the centre.

There was limited access to suitable transport for some residents.

**10. Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

The PIC has looked on to the staffing deployment in this centre. One staff nurse to come in at 0740hours to receive the handover from the night staff. The rest of the staff starts at 0800hours with the aim to maintain six staff for the day. The number of staff working on the day is dropped to three between 1800hours to 2000hours and three night shift staff between 2000hours to 2300hours. Two will remain to complete the full night shift as this is deemed suitable to support requirements during the night where all the service users are resting in bed.

The PIC has creatively used his current resources to ensure the centre is covered at peak hours where the needs of the service users are most required and enough handover time is allocated. There is a staff nurse vacancy post at present in this centre and the request to fill a vacant post for one staff nurse has been sent to the service manager.

The management is now in progress in looking to change the current transport to a wheelchair- accessible transport/car.

**Proposed Timescale:** 30/11/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Not all staff had up to date training in safeguarding vulnerable adults and managing behaviour.

**11. Action Required:**

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

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

The PIC has addressed this issue with the senior management. Refresher training with regards to "Service user's protection and welfare" (SUPW) is now completed for all the staff working at this centre. Further request for refresher training in early 2017 training calendar has also been forwarded.

Training requirements for the staffs on managing behaviour that challenge has also been highlighted to the senior management for those relevant staff directly involved in the care of service users.

**Proposed Timescale:** 30/11/2016

**Theme:** Responsive Workforce

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

Staff on the night shift were not appropriately supervised.

**12. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

The PIC has addressed this supervision about staff on the night shift in outcome 14 action plan 7. A system is now in placed.

**Proposed Timescale:** 30/10/2016