Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Shandra
Centre ID:	OSV-0003382
Centre county:	Laois
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services
Provider Nominee:	Noel Dunne
Lead inspector:	Louise Renwick
Support inspector(s):	Noelene Dowling
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 July 2016 09:50	12 July 2016 19:25

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 17: Workforce

Summary of findings from this inspection

Background for the inspection:
This centre had been registered in June 2015 by the Health Information and Quality Authority (HIQA). This inspection was carried out in response to a pattern of notifications received by HIQA. Unsolicited information had also been received in relation to the safeguarding of residents, the use of restraint, medication management and fire safety.

How we gathered our evidence:
Inspectors met with the team leader, the person in charge and spoke with some staff members and residents. Inspectors reviewed all notifications submitted to HIQA prior to the inspection, and discussed these in depth with the person in charge and team leader. Inspectors observed practices and reviewed documentation such as personal plans, medical records, accident and incident logs, policies and procedures and investigation records.

Description of the service:
This centre caters for children and adults between the ages of 16 – 30 years and can accommodate six female residents. The statement of purpose described the centre as catering for mental health, high support and challenging behaviour.

Overall judgment of our findings:
Overall, inspectors were not satisfied that the provider had put system in place to ensure that the quality of care and safety of residents was being effectively monitored and promoted. Inspectors were concerned that appropriate measures were not in place to adequately safeguard residents.

Some positive findings:
• staffing ratios and rosters were responsive to changing needs of residents
• residents had timely access to a wide range of allied health care professionals
• residents health care needs were met.

Inspectors found that the lack of effective governance and monitoring of the centre had resulted in:
• risks not being appropriately managed (outcome 7)
• inconsistencies in the management of allegations or suspicions of abuse and safeguarding measures (outcome 8)
• physical restrictions not being monitored, managed and used in line with best practice (outcome 8).

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

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

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

Theme:
Effective Services

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

Findings:
This outcome was not reviewed in its entirety during this inspection. From the evidence that was reviewed, inspectors determined that residents were afforded opportunities to be social and interact with the community. Inspectors determined that residents could access day services if they so wished, or further education and training outside of the organisation. Residents were supported to work on goals as set out in their plans. Staffing ratios and rosters appeared to support this. For example, residents who required 2:1 support in the community had this available to them.

As will be mentioned under outcome 7 and outcome 11, inspectors determined that assessment and planning documentation was not actively updated or reviewed following changes in need, risk or circumstance for all residents. For example, a resident who was working towards moving home in a number of weeks had no updated risk assessments or personal plan outlining changes to risks and supports.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors found that improvements were required to ensure the ongoing promotion and protection of the health and safety of residents, staff and visitors in the centre.

Risk:
Inspectors noted that there was a risk management policy in place along with a centre specific safety statement dated January 2016. However, inspectors found that the systems for assessing and responding to risk required improvements given the nature of the centre, residents' profile and the security of the premises.

Inspectors determined that there was no satisfactory and ongoing review of the premises or practices to reduce and manage risks. In the absence of this, inspectors found that safe practice and the use of control measures was inconsistent. For example, cutlery was securely locked away but numerous other items were not accounted for in any systematic manner. Likewise, residents were given access to a bathroom which contained a broken mirror and a bottle of cleaning chemicals despite self harm risk assessments outlining the need for these to be locked away.

Inspectors discussed a number of individual risk assessments with the person in charge and found that documentation was not being appropriately updated to reflect change or progress. For example, a resident had a risk assessment outlining 2:1 support in the community to alleviate a risk of physical aggression to others. However, inspectors found that in recent weeks the resident was engaging in the community for large parts of the day unsupervised.

Inspectors were concerned that there had been no risk assessment as to the suitability or safety of the combined age range of residents living in the centre. At the time of the inspection this centre catered for both children and adults living together in the designated centre. This had not been risk assessed to determine and identify any impacts this may have on residents. For example, younger residents copying the negative or inappropriate behaviours of older residents.

Incidents / accidents:
A record was maintained of all accidents, incidents and adverse events in the centre. While there was evidence that some individual incidents had been reviewed this was not consistent. There was a lack of evidence of learning gained from patterns or repetition of incidents to provide an overview of casual factors. For example, it was known from incidents reviewed that a resident would attempt to set off the fire alarm button during times of challenging behaviour. No environmental changes had been implemented in response to this issue. This resulted in physical restraint being used not in line with best practice or the resident's personal plan which outlined its use only to alleviate a high risk of self harm.

Fire Safety:
Inspectors saw evidence that the fire alarm had been serviced quarterly as required and the extinguishers annually. The building was fitted with fire doors, and had two designated assembly points. However, there was no evidence available on the day that the emergency lighting had been serviced.

A number of concerns in relation to fire safety systems were also noted. These included:
• lack of adequate fire drills. For example, only one recorded date of a planned day time drill for 2016 which did not detail who took part, the outcome or time frames involved
• a relatively new member of staff had not been afforded the opportunity to participate in a fire drill since taking up position
• lack of clear egress from the building: One room off the kitchen was used as a staff sleepover room and this was the fire exit from this section of the building
• not all break glass key units had a key in them or alternative
• there was no written procedure to follow available or on display in the centre in the event of a fire
• staff were not aware of the different zones in the building as identifiable on the fire alarm panel, this could pose a risk to identifying the location of a possible fire and planned escape route.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Inspectors were not satisfied that measures in place for the protection and safeguarding of children and vulnerable adults were sufficiently robust.

There was a policy in place entitled "Policy and Procedure on Vulnerable person" .This encompassed one process path for allegations or suspicions made regarding a child or a vulnerable adult, with no definitive guidelines for the protection of children. The Children First guidelines were not available in the designated centre. The training matrix demonstrated that training had been undertaken for staff in "protection and welfare of

vulnerable adults and child". However, inspectors were informed that this was in an e-learning format, and the person in charge and team leader could not confirm if this training was inclusive of Children First training. Inspectors also noted that a high volume of training on different topics was delivered over a one day period. This is further discussed under outcome 17 Workforce.

Where children were the subject of assaults from older residents' or external risks no safeguarding plans had been implemented. As mentioned in outcome 7, documentation did not show evidence that the possible risks of the mix of residents not only in age but in complexity of need was considered. The person in charge concurred with this finding and stated they were now considering the implementation of safeguarding plans.

Inspectors determined that the investigation process into allegations of abuse was not sufficient. Inspectors reviewed all notifications of alleged abuse or misconduct which had been forwarded to HIQA. There was a lack of cohesion and completeness to the records maintained and made available to the inspectors. From the documentation available and from discussion with the person in charge and the team leader the process used to screen or investigate allegations made was not satisfactory.

While there was evidence that allegations were reported to the Health Service Executive (HSE) and screened internally in line with the policy, in two instances the resident who had made the allegations was not spoken with as part of the of the investigation process. There was no evidence that the outcome, when unfounded, was discussed with and reported to the resident. On an occasion where a resident had named another resident as a witness to their allegation of sexual assault, this resident was also not considered as part of the provider's formal investigation process.

In another instance the outcome of an investigation was decided upon based on an inadvertent conversation which staff had with the resident making the allegation. This was not part of the screening or terms of reference for the investigation. The resident's subsequent retraction of the allegation was typed by staff and the resident asked to sign it.

From reading the record of the conversation inspectors found that staff required significant further training in engaging with residents in this manner and in how to conduct such conversations so as not to influence the outcome. This finding was discussed at length with the person in charge who concurred. The provider's decision on this incident as unfounded was not accepted by the HSE safeguarding team who were conducting their own investigation at the time of report writing.

The residents living in this centre had complex and multifaceted needs and the service was described as high support. To this end the environment was highly restrictive in nature. A number of practices were found including locked exit doors, restricted windows, the use of plastic crockery and cutlery and significant use of physical restraint. However, the model of care and subsequent systems for care provision required review and oversight.

While the policy on the use of restrictive practices was in accordance with national guidelines it was not adhered to. For example, it was not clear to see that at times of

physical intervention; the risk of not intervening was greater than the risk of the behaviour being displayed. This can again be linked to the lack of oversight of practice and appropriate incident review.

There were 45 incidents' of physical restraint noted in the quarter prior to the inspection. This was an increase of 21 on the previous quarter. Inspectors were not satisfied that the rational for such interventions were satisfactory or that the incidents had been adequately and consistently reviewed. As confirmed by the team leader there was no evidence that the physical intervention piece was routinely reviewed as part of the behaviour support plan review process. For example, in some incident records it was apparent that the physical intervention being used was not successful, resulting in staff injury and prolonged trauma for the resident. Inspectors were informed that the type of intervention used is minimal and staff do not have training in the advanced level of restraint. A piece of protective personal equipment had been purchased to protect staff from being bitten while engaging a resident in a physical hold. There was no evidence that this had been clinically reviewed as to the effectiveness of the intervention, or that other levels or types of interventions had been considered.

While self harm was identified as a considerable risk the systems for minimising risks were not robust, as previously mentioned under outcome 7.

Inspectors found that sedative medicine was used to manage episodes of behaviour and was documented on records as such. While the medicines were correctly prescribed and reviewed by the prescribing clinician, the records did not demonstrate that the protocol was consistently being followed in practice. For example, they did not detail the precipitating factors, alternative actions tried prior to the decision to administer the medicine and they did not note the affect of the medicine had on the resident.

There was considerable access to specialist clinicians including psychiatry , psychology and behaviour specialists. Multi-elemental behaviour support plans were in place for residents which contained details on how to proactively engage with residents, and how to respond should things escalate. However, there was no evidence available to the inspectors that the implementation of the plans was overseen, that incidents and actions taken were reviewed for causal factors or deviations from the plans and responses redefined. For example, on review of a sample of incidents it was evident that the some of the positive information on how to engage with residents to prevent problematic behaviour was not followed.

There was a policy on the provision of intimate care and support to residents but no individual plans for the residents outlining their preferences, needs or vulnerabilities in relation to this. On reviewing incident records and a residents' file it was apparent that some resident did require a level of support in relation to their personal and intimate care, and this had not been adequately included into an intimate care plan.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
The provider was compliant with this regulation in terms of residents' overall healthcare needs and residents had access to appropriate general medical and allied healthcare services. Residents healthcare needs were reviewed at a minimum annually and as required. For example, there was good access to GP services and regular monitoring bloods where this was indicated. Reviews of resident's health were undertaken and from a review of daily records inspectors found that there was a prompt response by staff to changes in resident's health.

Where a specific care plan for health care needs was required it was available and staff were familiar with the protocols required. In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including dentists and chiropodists or neurology where required. Records of referrals and reports of these interventions were maintained in residents' files.

There was evidence that where treatment was recommended and agreed by residents this treatment was facilitated.

There was evidence on documentation that residents and their representatives were consulted about their health and medical needs. A protocol was in place for the management of epilepsy and the use of emergency medication and training has been provided to staff in its use. As observed by inspectors and confirmed by the residents the food was nutritious, fresh and choices were accommodated. Residents helped to prepare the food with staff assistance where this was necessary although some access to the kitchens was restricted. Where specific dietary needs were identified by dieticians these were seen to be adhered to with a residents' on a dieter plan. Where necessary weights were monitored.

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:
This outcome was not reviewed in its entirety but inspectors found that there were systems in place for the safe receipt of storage administration and return of medication. Staff had received training in medicines management.

There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Most mediation was dispensed in blister packs to support the non nursing staff. There was identification of medication on each of the medication dispensing pack. Inspectors were informed that no residents were assessed as being able or wished to manage their own medication at the time of the inspection.

Inspectors were informed that a number of medication audits had taken place and deficits noted were not significant but had been addressed.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that while there were governance structures in place improvements were required.

The person in charge was experienced in working with people with disabilities and had been in involved in the centre for a significant period of time. At the time of this inspection she was in the process of moving to another position. There was a team leader who was new to the centre and was identified to inspectors as the incoming person in charge. Staff identified the team leader as the person they would report to directly.

Inspectors were not satisfied that the current structure in place allowed for clearly defined responsibility and accountability. While there was an extensive multidisciplinary team and additional administrative support, there was a lack of clarity around who held responsible and accountable for the overall review and monitoring of the day to day practices of the centre. For example, behavioural incidents were reviewed by a behaviour therapist, but the review of staff approach or practices outside of this was missing. Likewise not all notifiable events had been submitted to HIQA. The administrative process in place for dealing with notifiable events allowed for gaps which had not been identified through review.

The person in charge did not have clear accountability for investigations of allegations or suspicions of abuse. While the process was being followed, there were gaps in the local management's awareness of the status of investigations and steps to be taken. On review of an allegation of misconduct against a staff member it was apparent that management were present at a time when a staff member failed to do their duties. The local management on site did not address this at the time and it was later reported formally by residents.

Inspectors acknowledge the significant commitment on behalf of the management team and the complexity of the service which is provided. However, the findings on safeguarding, risk management and workforce indicate that improvements were required in the management systems to ensure effective monitoring of the quality and safety of care delivered to residents in line with their needs.

The annual report seen by inspectors did not address significant issues such as the management of incidents, allegations, staff training, complaints or quality improvements for residents. It also did not include the views of resident and or relatives.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that there were sufficient staff available and the ratio had been increased significantly as resident's behaviour support needs had changed. There was evidence that one to one or two to one supports were available to the residents which ensured that their activities and day-to-day schedules could be maintained. Staff spoke respectfully about residents and their support needs.

It was not apparent that training provided was in accordance with the statement of purpose and the residents' assessed needs. While unable to access the personal files on this inspection the team leader stated that most of the staff team had social care qualifications.

Training records available indicated that mandatory training was provided, and refreshed where necessary. For example, training in Fire Safety, MAPA and the Safe Administration of Medicine (SAM). Additional training also available in an e-learning format in basic first aid, Aspergers syndrome and Autism pertinent to residents with intellectual disability. While this training is assistive, this centre was not catering for residents who were on the Autistic spectrum. Inspectors spoke with staff who outlined that they had not received training in mental health needs or how to support residents who self harm.

On review of records inspectors found that a number of staff members had completed 8 different training modules in a one day period inclusive of training in the protection of vulnerable adults and children. This raised concerns to inspectors as to the quality of the content of the training provided. The findings under outcome 8 safeguarding and safety indicate that training was not sufficient to ensure staff responded appropriately to allegations made. The findings in relation to restrictive practices, responses to behaviours and incidents occurring also demonstrates that the skill mix of staff and training requires review in order to support the staff to carry out their duties.

As stated inspectors did not have access to the personal files on this occasion. A number of staff supervision records were seen. These did not demonstrate sufficient review of professional practice, residents care and progress or training needs. This was acknowledged by the local team. The team leader will assume responsibility for the formal supervision of staff going forward.

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:

Louise Renwick
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Shandra
Centre ID:	OSV-0003382
Date of Inspection:	12 July 2016
Date of response:	16 August 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:
Residents' assessments and plans were not all amended following change in circumstance.

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

1. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
Person In Charge will ensure that all Residents plans are updated and reflective of residents current presentation.

Proposed Timescale: 06/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an inadequate system for identifying, assessing, managing and reviewing all risks in the centre.

2. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
Environmental Risk checks are completed by the lead staff at handover which takes place twice a day in the centre. All Risks identified which require actions will be escalated to the Team Leader and PIC to ensure formal corrective action. Weekly Health and Safety checks are also completed by the Health and Safety Representative to ensure all risks are identified and managed.

Proposed Timescale: 20/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the emergency lighting system had been tested or serviced.

3. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
The Person In Charge will ensure that all serving history of emergency lighting is held in the centre

Proposed Timescale: 20/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had been given the opportunity to take part in a fire drill.

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

Please state the actions you have taken or are planning to take:
Fire Drills will be completed in line with the Regulation and the record of the drill will include all details required.

Proposed Timescale: 20/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no written procedure to be followed in the event of a fire.

5. Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
A review of the Centre's Fire evacuation plan will be completed by the PIC and the Health and Safety Representative to ensure that all responsibilities and roles are clearly outlined in the event of an emergency.

Proposed Timescale: 06/09/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Physical interventions were not reviewed as part of the personal planning process. **6. Action Required:** Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process. **Please state the actions you have taken or are planning to take:** Person in Charge will ensure that the evidence of reviewing of physical intervention is available in the centre following Clinical and team meetings.
Proposed Timescale: 20/09/2016
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The use of restrictive interventions were not consistently carried out in line with best practice or the centre's own policy. **7. 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:** A review of the all restrictive practice will be completed to ensure that it takes place in line with each individuals Multi-Element Behavioural Support plan, Individual Risk Assessments and SOP's and the Centre's Policy by the Behavioural Specialist and the Team leader. All incidents of Restrictive practice are reviewed at Clinical meeting and corrective actions will be completed by the PIC.
Proposed Timescale: 20/09/2016
Theme: Safe Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There was no evidence that staff had received training in Children First.

8. Action Required:
Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

Please state the actions you have taken or are planning to take:
A review of the Vulnerable Person's training will be completed to ensure that it clearly outlined Children's First training within this training module. Further Training will be completed on safeguarding of Children & Adults with this team.

Proposed Timescale: 20/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review and monitoring systems in place were insufficient in ensuring all residents were protected from all forms of abuse.

9. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A full review of the Policy and the Implementation of the practice within the policy will be monitored by all management and Designated Officer to ensure all safeguarding measures required are in place.

Proposed Timescale: 20/09/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The investigation process did not consistently include interviewing residents who had made allegations or had been named as a witness to an allegation.

The recording of statements taken from residents who had made allegations were not carried out in line with the centre's policy.

10. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The Policy on Protection of Vulnerable Person's and the implementation of this policy within this centre is been reviewed to ensure that all investigations are completed in

line with the Safeguarding of vulnerable person's at risk policy and the Children's first policy. Training will be completed with the staff team to ensure the implementation of Policy is in line with regulation.

Proposed Timescale: 20/09/2016

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:
Systems were inadequate to monitor the quality and safety of care.

11. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Annual Review report has been updated in line with the guidance which has been provided by HIQA. The Measures in place to review all risk factors within the centre will be reviewed to ensure that they measure the quality of care been provided.

Proposed Timescale: 20/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Lines of accountability and responsibility were unclear.

12. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The lines of accountability and responsibility will be outlined in writing within the centre to ensure that all staff members are clear on the roles and responsibility of each management role.

Proposed Timescale: 20/09/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Staff had not received training to assist them to support residents assessed needs. For example, self harm, mental health conditions. **13. Action Required:** Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. **Please state the actions you have taken or are planning to take:** Training needs within this centre will be completed and further training will be arranged to assist staff to support the residents in all areas of need.
Proposed Timescale: 20/10/2016
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Records reviewed did not demonstrate sufficient supervision appropriate to staff roles. **14. 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:** Training will be provided to ensure that team leader provides comprehensive professional supervision.
Proposed Timescale: 20/09/2016