

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Liskennett Centre
Centre ID:	OSV-0004263
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Joseph's Foundation
Provider Nominee:	David Doyle
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 March 2017 09:15	07 March 2017 20:00
08 March 2017 09:00	08 March 2017 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA). This inspection was undertaken to inform a decision in relation to an application to vary the conditions of registration of the centre lodged by the provider; the provider wished to increase the capacity of the centre to allow for the accommodation of 16 residents as opposed to 14.

The inspection was facilitated by the person in charge, the residential coordinator who was one of the nominated persons participating in the management of the

centre (PPIM) and front-line staff on duty. The nominated provider was also on-site and available to the inspectors as required during the two days of inspection.

How we gathered our evidence:

Prior to the inspection the inspector reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the application to vary the conditions of registration of the centre, notice received of any incidents that had occurred in the centre and records and correspondence in relation to such notice. On site the inspectors reviewed records including policies and procedures, fire and health and safety related records, and records pertaining to staff and residents.

The interaction and engagement with residents was led and guided by each resident and their individual choices and needs. Three residents choose not to meet with the inspectors and this was respected. The majority of the residents did not communicate by spoken word and indicated their comfort with the presence of the inspectors and their preference whether to engage or not by gesture, general demeanour or facial expression. Some residents welcomed inspectors into their personal apartment and shared their personal space and personal items with inspectors; other residents simply indicated their comfort with the presence of the inspectors in their home by gesture such as a "thumbs-up" or a gentle hand-hold.

The inspectors as unobtrusively as possible, observed staff and resident interactions and saw that residents and staff mixed easily with each other. Staff were seen to respect residents' personal space while at the same time ensuring their safety; staff were mindful of and took discreet action to protect resident privacy and dignity while inspectors were on site.

Description of the service:

The centre was purpose built and comprised 16 individual apartments divided into three sections with an affiliated therapeutic equestrian centre. The centre was built on the site of what was at one-time an agricultural farm and was located approximately 20 minutes from the local busy town.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The document was clear on the stated purpose and function of the centre and there were specific admission criteria. Residential and respite support was provided to male and female residents with a diagnosis of Autism and behaviours of concern with medium to high dependency needs. A transition period from 17 years of age was also offered subject to suitability of placement.

Inspectors found that the service to be provided was as described in that document.

Overall findings:

In the months prior to this inspection the provider had as legally required, notified the Chief Inspector of alleged failings in the quality and safety of the services and supports provided to residents. The investigation of these matters on behalf of the provider by external persons had identified failings in the systems to protect

residents, in the systems to ensure that residents were at all times in receipt of safe, quality supports and in the systems for monitoring this. The provider transparently shared this information with HIQA and clarified for HIQA how it intended to address these serious breaches and prevent reoccurrence.

While failings were identified, this HIQA inspection did not identify any new safeguarding concerns; the actions that had been taken and were being taken by the provider in response to failings were evidenced and are reflected in these HIQA inspection findings.

It was however reiterated to, and the provider accepted that the failings identified were indicators of governance arrangements that had not ensured that residents were at all times protected from harm and abuse and that systems were not in-place that ensured the effective and consistent monitoring of the quality and safety of the care and supports provided.

The provider had undertaken a comprehensive annual review of the service In December 2016; good practice was acknowledged but 25 separate improvement plans were issued. A further review of elements of practice in the centre was also commissioned by the provider and was on-going at the time of this inspection.

Training had and was being provided to staff with a supervision role; key-worker training was provided to frontline staff. A behaviour analyst had been employed to provide support to both staff and residents and a full multi-disciplinary review had been completed of supports provided to residents.

The emerging positive impact of these actions was evidenced by inspectors and inspectors' observations of staff and resident interactions during this inspection were positive.

Inspectors were satisfied that resident's physical health was monitored and generally residents did have access to the services required; action was required however in the area of diet and nutrition.

Residents had access to a range of activities and opportunities both in and outside of the centre; however improvement was required to ensure that all residents had consistent access to meaningful opportunities for activity and engagement and community participation in line with their assessed needs.

There was evidence of good communication practice supported by input from the speech and language therapist.

There was evidence of the maintenance and promotion of positive family links.

There was evidence of recent investment in the supports provided to each resident in the management of behaviours of concern and risk. Given the communal model of living however, particularly in one area of the complex, it was clear that this model was not suited to all residents' needs; this was confirmed by clinical records seen and acknowledged by the provider. This had contributed however to a high level of

environmental restrictive practices including the introduction of a high level of visual surveillance.

Of the eighteen Outcomes inspected, the provider was judged to be compliant in nine outcomes, substantially compliant in one outcome and in moderate non-compliance in eight outcomes. The findings to support these judgments are discussed in the body of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Staff took action to respect residents' right and provide for consultation. However some improvement was required in relation to ensuring residents' privacy and dignity, in the provision of activities and the recording of complaints.

Over the course of the two day inspection staff members were seen engaging with residents in a warm, caring and respectful manner. From talking to staff and reviewing documentation there was evidence that staff offered residents choice and respected their decision where appropriate. Residents' meetings were also held though all residents did not engage with this format of consultation; staff respected residents' wishes if they did not wish to participate.

While visiting some of the individual apartments of residents it was noted by inspectors that some residents' bedroom doors had clear glass viewing panels. Although staff were observed preserving resident privacy where possible, for example advising inspectors of personal care in progress, the unobstructed nature of the viewing panels did not assure some residents' right to privacy and dignity was adequately maintained while in their bedrooms.

In addition visual surveillance equipment had been installed within the circulation and a shared communal area of one of the buildings which made up the designated centre. There was a policy advising that the CCTV had been put in place with an emphasis on security. However inspectors were not satisfied that appropriate consideration of the residents' right to privacy had been given sufficient consideration before the installation of the high level of visual surveillance.

The designated centre was located in the grounds a large farm and parkland area which allowed residents the opportunities to engage in various outdoor activities including nature walks, equestrian therapy and the use of recreational facilities. Some residents regularly engaged in such activities. From speaking to staff and reviewing activity records it was clear that some residents engaged in a wide variety of activities away from the centre such as swimming, dance, and attending concerts and sporting events.

However while reviewing some residents' personal plans it was noted that residents had clinical recommendations to be engaged in stimulating and meaningful activities that promoted skill development and community participation. The activity records of these residents were reviewed and discussed with staff. It was clear that such activities were not being consistently provided. For example the activity record for one resident indicated that they were spending a lot of time in the designated centre or going for drives on the bus allocated to the centre. This did not assure inspectors that all residents were being afforded the opportunity to participate in the activities recommended for them.

A complaints policy was in place which included the processes to be followed for responding to verbal and written complaints. A complaints officer was clearly identified and since the previous inspection of this centre an identified person had been put in place to review the management of complaints by the complaints officer as required by the regulations. A record of complaints was maintained which was reviewed by inspectors who noted that the satisfaction of complainants following complaints was not always recorded.

Facilities were in place for residents to retain control and manage their clothes if they so wished. Residents were also provided with adequate space to store their personal belongings and clothes in bedside lockers and wardrobes. Lists were also maintained of residents' personal property. The provider had completed an audit of the management of residents personal finances in 2016.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The majority of the residents did not communicate by using spoken language. An assessment has been completed of each resident's communication skills and these were augmented by assessments completed by the speech and language therapist in December 2016. Based on the findings of these assessments there were clear explicit strategies to guide good and effective communication. These strategies included recognition of receptive ability and understanding, manual signing, gestures, visual supports, objects of references (the use of an item or object to communicate perhaps an activity) and picture exchange communication strategies (PECS). Staff spoken with were familiar with the strategies outlined in the communication plans and there was evidence of their implementation in practice.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

A visiting policy was in place which encouraged residents to receive visitors in the centre. Residents were facilitated to receive visits from family and friends and were also supported to leave the centre to visit their family and home. Facilities were available for residents to receive visitors in private.

Staff maintained a log of communication with responsible family members.

The designated centre had access to three vehicles which enabled residents to leave the centre and engage in community based activities. However as mentioned previously some residents were not consistently engaging in stimulating activities that promoted community participation. This has been addressed under Outcome 1.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

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

Findings:

An admission policy was in place which clearly set out the criteria for admission to the centre and the procedures to be followed. Residents' relatives indicated, in questionnaires submitted prior to inspection and during interviews, that they were given the opportunity to visit the centre before coming to live there. Staff members also described how they were informed of any new residents who came to live in the centre.

Inspectors reviewed a sample of contracts for the provision of services and noted that they contained all of the information required by the regulations such as the services to be provided as well as the fees to be charged. It was noted that the sample of contracts reviewed had been signed by either residents or their representatives.

Judgment:

Compliant

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:

Based on the findings of the provider's own annual review of the service, there was evidence of work completed on resident's personal plans to address some of the deficits identified by that review.

Inspectors saw that an assessment of residents' holistic needs had been completed and based on these assessments, plans of support were devised; the plans were well presented. Based on the sample of plans reviewed by inspectors these assessments and

plans were current (December 2016). The plan was available to some residents in a meaningful and accessible format. Key-workers had been identified and key-working training was ongoing and reported to be almost complete.

However, what was not clearly evidenced was how the resident or their representative with consulted with and participated in the development and the review of the plan.

There was clear evidence from records of referrals and reviews that the plan of support and care was supported and informed by input from the members of the multidisciplinary team (MDT) as appropriate to each resident's needs. However, with the exception of behaviour support plans, the MDT review of the complete plan of support was not evidenced.

The process for recording the progression of resident's personal goals and objectives was poor. There were records of identified goals, however there was no evidence of timely actions taken to progress them, who was responsible for this and the date by which they were to be achieved. It was not clear how or by whom goals were identified. For example there was one clearly recorded goal seen in a support plan that was not included in the records specific to personal goals and objectives.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The designated centre was a purpose built facility comprised individual apartments in three separate complexes which at the time of inspection provided a home to 14 residents. As part of the application to vary the centre's conditions of registration, the provider was applying to increase the capacity of the centre to 16 by opening up a fourth apartment complex containing two individual apartments.

This new complex was visited by inspectors. It consisted of a shared kitchen and dining area which connected the two apartments. This kitchen and dining area had a cooker, fridge, washing machine, microwave and dining table and chairs in place. Each apartment consisted of a living room area, each with a television and couches, a

bedroom and bathroom. The complex satisfied regulatory requirements in terms of space, privacy and the facilities provided.

The various other apartments that made up the rest of the designated were of a similar design and inspectors were satisfied that the premises was suited to the needs of residents. The designated centre was visible clean, well maintained internally and externally and in a good state of repair.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

While there were measures in place to protect the health and safety of residents and evidence of pro-active measures taken by the provider, failings were identified in systems to ensure fire safety and in the provision of fire safety training.

A fire detection system and emergency lighting were present in the designated centre and had been serviced at regular intervals. Fire doors were also present in the designated centre. However the provider had engaged an external fire consultant to conduct a review of the fire safety arrangements in the centre in January 2017. The resulting report recommended that remedial works be conducted in relation to the fire alarm, emergency lighting and fire containment provision in order to comply with the necessary fire regulations.

Although the representative of the provider confirmed that remedial works to address the issues raised by the external fire consultant had taken place in the days before this inspection, at the time of inspection there was no confirmation available from a suitably qualified person that the works carried out met the requirements of the fire safety consultant and that they had been completed to the required standard.

Fire fighting equipment had been serviced on an annual basis as required. Internal staff checks on fire safety measures were being carried out on a regular basis. However during the course of inspection it was noted that one fire door was being purposefully held open. This was highlighted to the PPIM who took immediate action and to the provider who undertook to address it. It was also observed that there was a build of items under the stairway of an escape route. This and the fire door being held open did not demonstrate to inspectors that there were fully effective systems in place to monitor

fire safety measures.

Fire drills had been carried out at regular intervals and staff members spoken to confirm that they had participated in such drills. It was noted that during one drill carried out in 2016, two residents had refused to leave the centre. Despite this, an evacuation time of the centre was recorded. However, both residents involved had personal evacuation plans in place which were reviewed to reflect the outcome of this drill. Subsequent drills had been carried out without issue.

Inspectors reviewed staff training records and noted that the majority of staff had undergone fire safety training within the last 12 months. However for some staff members it was noted that they had undergone an online fire training course while it was not clear if other staff had undergone training. This did not provide adequate assurance that all staff had received suitable fire safety training particularly in the use of fire fighting equipment. Inspectors were informed that some onsite training was scheduled at the designated centre in the weeks following inspection.

A centre specific safety statement was in place along with a risk management policy. Inspectors reviewed the risk register in place and found that risk assessments were maintained for general risks such as slips, trips and falls along with resident specific risks. All risk assessments seen were noted to have been recently reviewed. The person in charge informed inspectors that a new digital system to record the risk register and accidents and incidents was soon to be trialled in this centre.

Hand gels and personal protective equipments such as gloves and aprons were available throughout the designated centre.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

There were measures in place to protect residents from harm and abuse; these

measures included clear policy and procedure that was referenced to national policy; staff training and a designated safeguarding officer. However, the provider had notified the Chief Inspector of alleged breaches in the safeguarding of residents and of the actions taken by the provider to investigate these alleged breaches and to safeguard residents.

There was alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to behaviours of concern; this alleged normalisation resulted in both alleged implementation and the failure of all staff to see them as and report them as a breach of good practice and approved supports, acts that breached residents' rights to dignified and safe support at all times. A further investigation into these alleged practices was ongoing at the time of this inspection.

Inspectors met and spoke with a broad sample of staff working in the centre over the two days of inspection. Staff spoken with said that they had attended safeguarding training; that they had never heard or seen any practice that caused them concern and that they would report concerns if they had them; staff had knowledge of the reporting procedure. Staff spoken with also confirmed that there was no requirement for physical intervention in some described scenarios.

However, it was of concern to inspectors that based on the information made available to them by the provider that these practices had developed and were not recognised and reported by all staff as abuse as defined by national safeguarding policy.

There was one identified possible but un-verified barrier to reporting brought to the attention of inspectors. There was a possible perception on behalf of staff (as reported to inspectors) that the seniority and role of some persons who participated in the on-call rota may impact of staff readiness to contact those persons. There was no suggestion that staff would not receive or had not received requested support or guidance but there may be reluctance amongst some staff to contact them.

Residents did by virtue of their diagnosis present with behaviours of concern and risk; clinical records seen indicated that some residents did not have the capacity to understand the consequences of their behaviours. The provider had commissioned an MDT review in December 2016 of each resident, their needs and the plans in place to support them in the context of their behaviours. The plans were detailed and offered sufficient guidance to staff; additional support had been provided from speech and language and occupational therapy in relation to the communication and sensory dimension of behaviours. A behaviour analyst had been employed to provide support to both staff and residents. There was clarity on areas that required investment and improvement including:

- monitoring and analysis of daily schedules
- monitoring of the implementation of interventions designed to support resident progression and learning, coping and tolerance barriers. Staff spoken with were aware of and described the implementation of strategies as outlined in the positive behaviour support plans.

However, some but not all support plans included the requirement for reactive strategies including physical intervention and what the approved interventions were.

Training records indicated that a significant number of staff employed (approximately 30%) required either baseline or refresher training in de-escalation and physical interventions in response to behaviour of concern and risk.

It was evidenced that the individual but ultimately communal model of living was not suited to all residents' assessed needs; based on records seen it was "too busy" and too stimulating for some; the environment also presented ongoing challenges to and did not support all resident' and staff to therapeutically manage behaviours. This had contributed to a high level of environmental restrictions predominantly to protect and promote personal space, safety and privacy. What inspectors would describe as a high level of visual surveillance had also been installed in the circulation areas and a shared communal area. The person in charge confirmed that a restrictive practice committee had been established and that interventions identified as potential restrictions had been identified and submitted to the committee; the listed interventions included keypad locks on doors, manual locks on doors and restricted access to toiletries and recreational materials. The installation of the visual surveillance and the use of physical interventions in response to behaviours of concern were not included.

Each restrictive practice required full review in the context of the individual and collective needs and rights of each resident to ensure that a reasonable and proportionate balance was achieved between safety, security, privacy and freedom of movement and access without unreasonable restriction and surveillance.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed records of accidents and incidents and did not find evidence of an adverse incident which had not been submitted to the Chief Inspector as required. However in the months before this inspection a number of notifications had not been submitted within the three working day timeframe as required. In addition there were also some restrictive practices that had not been notified at quarterly intervals.

Judgment:

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There was evidence based on staff spoken with, records seen and inspectors' own observations that residents did have opportunities for activation, occupation, social and community engagement. However, there was also evidence that supports in this area were inconsistent and some residents did not always experience meaningful activity and engagement on a daily basis; it was described to inspectors as of being somewhat "less quality" for some residents. This failing is discussed here but the relevant action required is issued under Outcome 1.

There was an equestrian centre on site that residents accessed and where they could benefit from therapeutic horseback riding. There was a sensory trail and a mountain trail that residents walked in the company of staff. Equipment including swings and a trampoline were provided and used by residents. A music therapist attended during the inspection and met individually with residents; residents were seen to engage in table-top activities with staff. Some residents went to the provider's day service in the local town. There was evidence of further recent developments on site such as a "men's-shed".

Over the course of the inspection, inspectors saw that residents came and went from the centre with staff. The local community was accessed for swimming, dining out, social occasions such as birthdays, or personal care such as the hairdresser.

Residents' needs were highly individualised and it was clinically acknowledged in records seen that it was a challenge at times for staff to identify activity and interests that residents proactively engaged with. It was also clinically requested however that residents be provided with opportunities for engagement that were meaningful and motivating to residents, activities that developed skills, social and community participation. This was not evidenced on a daily basis for all residents. One set of records of daily activity in particular demonstrated an overreliance on social drives; some blank records were also seen. While new experiences and social and community participation were themes reflected in personal goals and objectives, as discussed in Outcome 5 it was not evidenced that this was progressed.

Judgment:

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 based on records seen and staff spoken, with inspectors were satisfied that staff supported residents to achieve and maintain good health and well-being; there was scope for improvement in relation to diet and nutrition.

Records indicated that staff monitored residents and sought medical advice and care from the General Practitioner (GP) as required; based on expressed choices and preferences three different GP practices attended to the needs of the residents. Inspectors also saw that as appropriate to their needs residents had access to psychiatry, psychology, neurology, speech and language, dental care, occupational therapy and physiotherapy. Nursing input was available in the centre and from the wider organisational structure. For example the PPIM was a registered general nurse and had completed the assessment of residents' physical and healthcare needs.

Where there was an identified health-care need, plans of support were in place, for example, for the management of seizure activity. Staff implemented measures to monitor well-being that included monthly monitoring of body weight and blood pressure. There was evidence of recent blood-profiling completed by the GP's.

There was some evidence that residents did not always consent to healthcare related interventions and this was respected. The person in charge explained how with planning, flexibility and support staff sought to ensure that residents received all required care.

Staff cooked on an individual basis for residents or sourced main meals for the canteen on the main campus. Staff spoken with had an awareness of the importance of healthy eating. This was reflected in the plans of support seen and daily food intake records had been introduced. However, some of these records indicated that balanced, healthy eating choices were not always made; a risk assessment and plan seen for healthy eating had identified the requirement for dietetic referral and review; this had not been facilitated.

Judgment:

Non Compliant - Moderate

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:

Medicines were supplied to residents by community based pharmacies in a compliance aid or in their original containers. Inspectors saw that medicines were securely stored, supplied on an individual resident basis and had legible labels from the pharmacy affixed.

The sample of medicines prescriptions seen was current and legible; each prescription was signed and dated by the prescriber, discontinued medicines were signed and dated as such. There was medical authorisation on the prescription for the administration of medicines in an altered format (crushed) and an appropriate format had been supplied by the pharmacist. The maximum daily dosage of medicines prescribed on a p.r.n basis (as required) was stated.

Staff maintained a record of all medicines administered to residents and the sample reviewed by inspectors reflected the instructions of the prescription.

Other systems implemented to promote the safety of medicines management practice included the checking by nursing staff of all medicines supplied and the monitoring of the usage of p.r.n. medicines.

All staff were not trained and did not administer medicines on a routine basis; staff were however trained to administer rescue medicines. The person in charge confirmed that there was always staff available to residents with rescue medicines training, for example on social outings. Explicit protocols for the administration of these rescue medicines were in place.

Medicines management practice was the subject of audit most recently in March 2017. Systems were in place for the identification, reporting and management of medicines management incidents.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors reviewed a copy of the statement of purpose during the course of inspection. While it contained most of the information required by the regulations it did not list the sizes of all rooms within the designated centre or the organisational structure.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There was a clear management structure and clarity on roles and responsibilities. Care staff reported to the social care worker, one of whom was the person in charge; the person in charge reported to the PPIM who in turn reported to the person representing the provider. The person in charge worked full-time and was a registered nurse in intellectual disability. This centre was the only centre that the person in charge was responsible for.

However, investigations recently commissioned by the provider into matters in this centre had identified failings that included; staff failure to adhere to the guidance prescribed in residents' support plans, physical interventions that were not consistent

with support plans or good practice, systems of staff allocation that did not ensure responsibility and accountability for care and supports provided, poor recordkeeping and limited opportunity for the supervision of staff. These failings were indicative of governance systems that did not ensure that the care, supports and services provided to residents was at all times safe, reflective of good practice, appropriate to residents' needs, consistent and effectively monitored. Inspectors also noted that an unannounced internal review undertaken on behalf of the provider in August 2016 had reported "concerns regarding the culture that had developed".

There was evidence of proactive measures taken by the provider to address these failings. The PPIM told inspectors that she was now on site in the centre on a regular and consistent basis to provide practical support to the person in charge; the person in charge confirmed this. The person in charge confirmed that changes had been made to the social care rota and that these changes should better support the person in charge in exercising their regulatory responsibilities. A formal system of staff allocation had been implemented and there was improved consistency of staffing. Training on staff supervision and training specific to the role of person in charge had been provided. A full MDT review of resident's behaviour support plans had been undertaken and an additional resource was based on site to support staff to support residents in the management of behaviours of concern.

Two senior PPIM had completed a comprehensive annual review in December 2016; the report was available for inspection. Inspectors saw that the review was completed to a high standard and while good practice was acknowledged substantial non-compliance was also evidenced in most areas reviewed. Twenty-five separate improvement plans were issued, responsible persons and timescales were identified; responsibilities were seen to be allocated as appropriate to each person's role and scope of authority.

While acknowledging the transparency of the reviews and the actions taken and planned by the provider, the provider was advised by inspectors of the requirement to ensure and provide assurance to HIQA that all recommendations and action plans were implemented, that there was evidence of improvement and that this improvement was maintained and monitored so as to ensure the safety, quality and appropriateness of the services, care and support provided to residents.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Arrangements were in place for the management of the centre in the absence of the person in charge. The provider had nominated suitably qualified and experienced PPIM to support the person in charge and designated social care staff. The person in charge confirmed that he had not been absent for any period of time (greater than 28 days) that required notification to HIQA.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Based on the findings of this inspection inspectors were satisfied that the centre was adequately resourced. While deficits were identified in the processes for supporting residents to achieve their personal goals and objectives, there was no evidence to indicate that this was a resource issue.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

Based on what inspectors observed and feedback from staff and family members spoken with, there were appropriate numbers of staff to meet the assessed needs of residents. However, staff training gaps were identified and improvement was required in relation to staff supervision and equipping staff with the skills for supervision.

Inspectors reviewed staff rosters and were satisfied that the numbers and arrangements of staff were as described; there was no evidence available to inspectors that staff numbers and staffing arrangements were not adequate to meet the assessed needs of the residents on an ongoing basis. There was evidence that continuity of staff within the designated centre had improved in the months prior to inspection.

Inspectors reviewed a sample of staff files and found that all of the required information such as proof of identity, Garda vetting and two written references were maintained in the files.

While reviewing the personal plans of residents, it was noted that clinical assessment had recommended that staff receive specific therapeutic training to assist in meeting the needs of this resident. At the time of this inspection this training had yet to commence. It was also noted (given the stated purpose and function of the centre) that the majority of staff had not undergone Autism specific training and some staff members spoken with confirmed that they had not received such training. This had also been identified as an area for improvement in the centre's most recent annual review.

Training records for all staff were reviewed. As mentioned under Outcomes 7 and 8, there were some shortcomings in relation to fire safety and intervention and de-escalation training in response to behaviours of concern and risk.

It was clear from talking to members of staff and management that supervision of staff and equipping responsible staff with the required knowledge and skills for effective supervision was an area for improvement in the designated centre. The provider's annual review had also highlighted the need for additional training to be provided to relevant staff in the area of supervision. From reviewing the training records and talking to staff such training had yet to be provided to all relevant staff.

There were no volunteers involved in the designated centre at the time of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of

retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The required policies were all in place in the designated centre along with supporting procedure documents where necessary. A residents' guide was in place which contained all of the information required by the regulations. This was available in an easy to read format for residents. A directory of residents was also reviewed by inspectors.

All other documents requested by inspectors were made available to review.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Moore
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 report¹

Centre name:	A designated centre for people with disabilities operated by St Joseph's Foundation
Centre ID:	OSV-0004263
Date of Inspection:	07 & 08 March 2017
Date of response:	27 April 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The presence of clear glass viewing panels in some residents' bedrooms and the use of CCTV in circulation and communal areas of one building in the centre did not ensure that residents' right to privacy and dignity was maintained.

1. Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Under Regulation 09 (3) the Registered Provider will ensure the dignity and privacy of the residents by obscuring the glass panels on the doors of individuals apartments, by reviewing the use of CCTV cameras and reducing the number of cameras in use where possible and removing the CCTV camera from the communal area.

Proposed Timescale: 05/05/2017

Theme: Individualised Supports and Care

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

Not all residents were engaged in the stimulating and meaningful activities recommended for the general welfare and development.

2. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

Under Regulation 13 (2) (b) the Registered Provider will ensure that opportunities are provided to residents to participate in activities in accordance with their interests, capacities and developmental needs. This will be facilitated by having an ongoing review of the activities offered and available to residents, following the New Directions programme as per HSE and by having staffing arrangements in place to support the residents. A schedule of reviews has been organised as follows:

May X 4 plans, June X 4 plans, July X 4 plans , August x4 plans. All plans to be completed by 5th September 2017

Proposed Timescale: 05/09/2017

Theme: Individualised Supports and Care

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

The level of satisfaction was not always clear from the compliants' log.

3. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and

whether or not the resident was satisfied.

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

Under Regulation 34 (2) (f) the Registered Provider will ensure that the levels of satisfaction relating to all complaints will be logged in the complaints book

Proposed Timescale: 01/05/2017

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:

The process for recording the progression of resident's personal goals and objectives was poor.

4. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Under Regulation 05 (7) the Person in Charge will ensure that all residents' personal goals will be reviewed and revised and documentation relating to same will be completed appropriately.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

It was not clearly evidenced how the resident or their representative with consulted with and participated in the development and the review of the plan.

5. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Under Regulation 05 (6) (b) the Person in Charge will ensure that all personal plan reviews will have participation by the resident and his/her representative where appropriate. This will be conducted in association with the review by MDT members. A

schedule of reviews has been organised as follows:
May X 4 plans, June X 4 plans, July X 4 plans , August x4 plans. All plans to be completed by 5th September 2017

Proposed Timescale: 05/09/2017

Theme: Effective Services

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

The MDT review of the complete plan of support was not evidenced.

6. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

Under Regulation 05 (6) (a) the Person in Charge will ensure that all personal plan reviews will have multidisciplinary input. A schedule of reviews has been organised as follows:

May X 4 plans, June X 4 plans, July X 4 plans , August x4 plans. All plans to be completed by 5th September 2017

Proposed Timescale: 05/09/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was no confirmation available from a suitably qualified person that remedial fire safety works carried out met the required standard. One fire door was observed to be held open while there there was a build up of items under the stairwell of an escape route.

7. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

Under Regulation 28 (1) the Registered Provider will put in place effective fire safety management systems. The build up under the stairwell has been removed. The remedial works required to meet Regulation 28 has been completed by suitably qualified contractors and confirmed in writing by the project architect.

Proposed Timescale:

Completed 20th March 2017

Proposed Timescale: 18/05/2017

Theme: Effective Services

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

Some staff had only received an online fire safety training course. This did not provide adequate assurance they had received suitable training in the use of fire fighting equipment. In addition it was also not clear if some staff had actually participated in this online training.

8. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Under Regulation 28 (4) (a) the Registered Provider will ensure that all staff have appropriate fire safety training. Training courses are scheduled for May and June 2017

Proposed Timescale: 15/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all support plans included the requirement for reactive strategies including physical intervention and what the approved interventions were.

The installation of visual surveillance equipment and the use of physical interventions in response to behaviours of concern were not included in the list of identified restrictive practices.

Each restrictive practice required full review in the context of the individual and collective needs and rights of each resident to ensure that a reasonable and proportionate balance was achieved between safety, security, privacy and freedom of movement and access without unreasonable restriction and surveillance.

9. 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:

Under Regulation 07 (4) the Registered Provider will ensure that a MDT review of all restrictive practices will be carried out at the centre, current restrictions will be reduced or removed where appropriate and where restrictions are necessary support plans will be put in place clearly identifying the need for such restraint and ensure that they are applied in line with the national policy.

Proposed Timescale: 30/05/2017

Theme: Safe Services

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

Training records indicated that a significant number of staff employed (approximately 30%) required either baseline or refresher training in de-escalation and physical interventions in response to behaviour of concern and risk.

10. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Under Regulation 07 (2) the Person in Charge will ensure that all staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Proposed Timescale: 25/06/2017

Theme: Safe Services

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

It was of concern to inspectors that based on the information made available to them by the provider that these practices had developed and were not recognised and reported by all staff as abuse as defined by national safeguarding policy.

11. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Under Regulation 08 (7) the Person in Charge will ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Proposed Timescale: 30/05/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Notifications were not being submitted within three working days.

12. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Under Regulation 31 (1) (f) the Person in Charge will ensure that any allegation, suspected or confirmed, abuse of any resident will be reported to the Chief Inspector within 3 working days as required.

Proposed Timescale: 01/05/2017

Theme: Safe Services

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

All uses of restraint were not being notified at the required quarterly intervals.

13. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

Under Regulation 31 (3) (a) the Person in Charge will ensure that restrictive procedure including physical, chemical or environmental restraint if used will be reported to the Chief Inspector at the end of each quarter.

Proposed Timescale: 01/05/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Some records seen indicated that healthy eating choices were not always made; a risk assessment and plan seen for healthy eating had identified the requirement for dietetic referral and review; this had not been facilitated.

14. Action Required:

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

Under Regulation 18 (2) (d) the Person in Charge will ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences. The Registered Provider will engage a dietician to offer guidance and support to residents and staff regarding healthy eating choices and healthy eating options will be encourage within Liskennett Centre.

Proposed Timescale: 30/06/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The sizes of all rooms in the designated centre were not included in the statement of purpose.

15. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Under Regulation 03 (1) the Registered Provider will ensure that the sizes of all rooms in the designated centre will be included in the Statement of Purpose.

Proposed Timescale:
Completed 7th April

Proposed Timescale: 18/05/2017

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:

Failings identified by recent reviews and investigations were indicative of governance systems that did not ensure that the care, supports and services provided to residents was at all times safe, reflective of good practice, appropriate to residents needs, consistent and effectively monitored.

16. 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:

Under Regulation 23 (1) (c) the Registered Provider will 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. The Registered Provider has reviewed the management structure of the Centre and has made changes to the senior management at the centre. The Person in Charge is now working full time in an administration capacity to allow them sufficient time to manage the centre effectively.

Proposed Timescale:

Completed 14th April 2017

Proposed Timescale: 18/05/2017

Theme: Leadership, Governance and Management

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

The provider's annual review of the centre identified substantial non-compliance in most areas reviewed. Twenty-five separate improvement plans were issued.

17. 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:

To comply with Regulation 23 (2) (a) the Registered Provider will ensure that all improvement plans documented in the annual review will be implemented and the areas of non-compliance addressed.

Proposed Timescale: 31/05/2017

Outcome 17: Workforce**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There were training gaps identified in relation to Autism and supervision. A psychologist had also recommended that staff receive therapeutic training.

18. 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:

Under Regulation 16 (1) (a) the Person in Charge will ensure that staff have access to appropriate training in the area of Autism and Supervision. Supervision Training has begun and will be completed by 13th June 2017. Training on Autism will be phased over May – September 2017 due to the number of staff involved. Therapeutic training in mental health is currently being sourced from a suitably qualified instructor and will be made available to staff working with one resident to enable staff to better meet his/her needs.

Proposed Timescale: 30/09/2017**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Improvement was required in relation to the implementation of a system of staff supervision and equipping staff with the required knowledge and skills.

19. 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:

Under Regulation 16 (1) (b) the Person in Charge will ensure staff are appropriately supervised and has ensured that the social care workers are currently receiving supervision training to achieve this. Supervision Training has begun and will be completed by 13th June 2017. Staff supervisions will be scheduled by line managers following the completion of this training.

Proposed Timescale: 13/06/2017

