

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by The Anne Sullivan Centre Limited
Centre ID:	OSV-0001388
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Anne Sullivan Centre Limited
Provider Nominee:	James O'Loughlin
Lead inspector:	Helen Lindsey
Support inspector(s):	Linda Moore
Type of inspection	Announced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 February 2015 09:00	10 February 2015 17:30
11 February 2015 08:30	11 February 2015 15:30

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

This was the second inspection of this centre by the Health Information and Quality Authority (HIQA). As part of the inspection, the inspectors visited the units that made up the designated centre and met the residents and staff members. The inspectors observed practice and reviewed documentation such as personal plans, medical records, policies and procedures, and staff files.

The centre is run specifically to meet the needs of people who are deafblind. Some residents also have secondary needs, for example responsive or challenging behaviour. The aim of the provider is to facilitate deafblind people to pursue meaningful, active and fruitful lives.

A board was in place that oversaw the governance of the centre. It was made up of a group of volunteers with a range of professional experience in relation to the provision of care services. They met on a regular basis, and included the person in charge to ensure they were kept up to date with the main issues affecting the centre.

Inspectors were limited in their ability to communicate with most of the residents, and so relied on the staff and family members to share their views of the resident experiences. Records of other professional's assessments and judgements were also used to give a view on the experience of the residents.

The centre was made up of four houses and the main building, all within a cul-de-sac in a residential area. It was close to amenities such as shops, restaurants, banks and bus stops. The provider can support 11 residents on a full time or respite basis.

The main building had a flat for one resident, a main kitchen, a kitchen for residents, and a range of offices and recreation rooms. There was a garden and a guided walkway around the building.

One house had a bedroom with en-suite, 2 living rooms and a kitchen diner on the ground floor. There were four bedrooms upstairs, one en-suite. One bedroom was used as the office. Two for residents and one spare room that could be used for staff if needed. There was a garden to the back of the house. Three residents lived in this house.

Three of the houses had been knocked through, so there was access between them. In the whole building there were two kitchen diners, two lounge areas, a separate flat for one resident, and six bedrooms. One of the bedrooms was en-suite. There was a garden area at the back of each house. There were also two bathrooms, and a downstairs toilet. Six residents lived in these houses.

Residents were seen to be engaging positively with staff who knew their communication style well. On the day of the inspection, they were engaged in a range of activities to suit their individual interests.

Overall the inspectors found that there had been improvements made since the last inspection. Some residents' needs were being met by staff who knew them well. Personal support plans were in place for all of the residents, and the information was easier to access. There was clear information on social and health care provided. There had been a significant clean up of the grounds and the units had been de-cluttered. Some residents rooms had been redecorated and had new furniture. Staff and relatives commented that they thought the opportunities for residents were increasing. Most residents were enjoying a range of activities that were of interest to them.

Evidence was seen that there was access to external professionals such as speech and language therapy, occupational therapy, dietician and psychiatry. Also a psychology team had started to work in the centre a for a set number of hours per

week. A review of all the premises had been completed, and the management board was prioritising the actions needed. Staff and volunteer recruitment followed clear guidelines. Residents were supported to communicate, and new options were being explored to maximise their skills.

Some residents had significant behaviour support needs, and the process of working to identify and support residents to manage those behaviours was beginning, focusing on assessing residents needs and training staff.

However, there were significant issues in relation to the processes and procedures around the use of restrictions in the centre. Restrictive practice such as locking doors and limiting peoples freedom of movement did not have the expected safeguards in place to protect the residents rights, and ensure national policy and evidence based practice was being followed. A gap was seen in the service in relation to the skills, experience and training in this area.

Other areas of non compliance related to the policy and procedure around risk identification, lack of annual assessments of some areas of need, recommendations of professionals not being implemented, general repair and decoration of some areas of the premises, the policy for protection of vulnerable adults, recording and instruction for 'as required' (PRN) medication, and two policies that were not available on the day of the inspection.

All of these are discussed further in the report and 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 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):

No actions were required from the previous inspection.

Findings:

There were processes in place to consult with residents about their care and the organisation of the centre as much as possible. They also had access to advocacy and information was available about their rights.

During the inspection, it was observed that residents were consulted about different activities, including personal care routines and choosing clothing.

Inspectors saw systems for residents to choose activities by making a selection of objects of reference or cards with raised images. Records showed that relatives were also involved in supporting staff to identify activities and pastimes the residents enjoyed.

Staff reported that residents were also being supported to develop their use of signs to support them in expressing more choice. Speech and Language therapy assessments had recommended this for a number of residents.

The person in charge had made contact with a local advocacy service. The centre had recruited a volunteer befriender who was going to receive some training from the advocacy service. If this was successful they planned to expand their recruitment further.

There was a complaints policy available in the centre, which was also displayed on the wall. It contained details of who to contact. It also included the process for appeal if the person raising the issue was not satisfied with the outcome. Relatives who responded to the HIQA questionnaire said they knew who to make a complaint to, and that there was a brochure setting out the process.

Where residents were able to verbally communicate they knew the process for making complaints. Other residents may show their dissatisfaction or discomfort in other ways, and staff spoken with during the inspection felt they knew the residents well, and would pick up if there was a change in their communication style.

Staff members were seen to treat residents with respect on both days of the inspection. Family also fed back that staff were very positive and had good relationships with the residents. One said the centre was 'always trying to improve and make life better for the residents'. Another said 'care was excellent, always putting their relatives needs first'.

Residents all had their own individual routine which included meaningful daytime activity, and social events. For example residents enjoyed going swimming, to local pubs and restaurants and local parks.

All bedrooms were single, and staff were seen to promote privacy and dignity by knocking on doors before entering, and ensuring doors were closed when personal care and support was being provided.

Staff confirmed there were arrangements for residents to see relatives, friends and other visitors in private if they wanted to. Where residents wanted to meet in places other than their home, this was arranged. There was evidence in the personal support plans, and daily records of regular contact with relatives and friends.

The visitor policy stated visitors were welcome at all times but requested that visits were prearranged to support the residents and respect others privacy.

Since the last inspection, key workers had worked with some of the residents to further personalise their bedrooms. This included coloured walls, new furniture and personal objects such as sensory objects.

Resident's personal money was stored securely, and they were able to access it via staff when they needed to. Records of individual finances and fees were clearly recorded, with a full record of incoming and outgoing funds. These records were reviewed by an independent auditor annually.

There was a policy in place that covered resident's personal possessions and basic records of their belongings were seen.

There were examples on seen during the inspection where residents rights were being respected, for example about who could access their accommodation. However there were some examples seen where residents rights had not been upheld, and the systems around restricting peoples rights were not effective. These issues are covered in detail under outcome 8.

Judgment:
Compliant

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:

Residents were assisted and supported to communicate, appropriate to their identified needs, and had any aids needed to support them.

The centre was a service specifically for people who were deafblind. Each resident was seen to have a communication system in place. Some residents were able to sign or understand sign either visually, or done on to their hand. All staff had completed sign language training to grade one, and some were progressing to stage two.

Some residents used objects of reference, or pictures to communicate their choices and wishes. The staff supporting residents were seen to understand these systems well, and were seen to use them effectively. For example one resident was preparing a drink in the kitchen and being supported by a staff member, via sign, to complete that task and then move to a different area of the house.

Personal support plans were seen to set out what each individual's communication style was. The information covered their ability to understand and any support needed to express themselves. There was also a communication assessment tool being used by the staff in the service.

There was evidence seen of speech and language therapy being involved with the residents, and some had a plan to work to improve their range of communication, or to try different systems to test if they were easier to use.

Residents had access to TV, radio, DVDs. There was also a music therapy room for those that enjoyed that experience.

The communication policy in place covered the need to assess and identify communication skills, and any support needed by the resident to express themselves.

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:

Residents were supported to develop and maintain personal relationships and links with the wider community.

Personal support plans had a section on maintaining family and friend relationships, and this included the methods each resident used to maintain their links. For some residents this was regular visits home, and phone contact/ tablet access for others.

There were meetings at least annually that involved the resident's families, and relatives confirmed they were kept up to date with pertinent information for their relatives.

Residents had many links in the wider community, and within the services provided by the organisation.

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):

No actions were required from the previous inspection.

Findings:

Residents moving in to and out of the service were supported by appropriate planning and processes, and had contracts that set out the service they received and the fees.

There was a policy and process in place for admissions, transfer, temporary absence and discharge of residents. Evidence was seen of detailed transition planning for the recent admissions. The policy would be improved by having clear information on the specific

service provided. See outcome 13 on the statement of purpose.

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):

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

Findings:

Each resident has a personal care plan in place that identified their abilities. However, some examples of care plans that were not detailed enough to guide staff practice were seen. Re-assessments of residents' needs were being carried out, but there were some gaps identified.

Inspectors read a sample of the personal support plans. They were based on the individual residents, and covered areas such as 'what can I do', 'how can you help me', 'what do I find difficult'? Inspectors noted that a lot of work had been done on these since the last inspection to make sure they were up to date and were specific to the residents.

As the residents were deafblind, the communication section was detailed and set out how the resident communicated, and what support they needed from the staff. There was also a detailed assessment that identified resident's abilities in relation to a range of communication skills and functional vision assessments were available. These had been completed by the staff in the centre and a deafblind consultant. Recommendations in the assessments were seen to be used by the staff in the centre to support the residents.

Staff had developed the plans using their knowledge of the residents to complete the information. A number of staff had worked at the centre for a long time and therefore knew the needs of the residents well. However, it was noted that the personal support plans and the care plan documents included the exactly the same information, and for a number of areas did not set out clear instructions about how resident's needs were to be

met. This is discussed further under outcome 8 and 11.

There was evidence of referrals made to a range of allied health professionals, and assessments in place where it had been requested. For example, speech and language therapy assessments recommending increasing the range of Irish sign language signs residents used, or introducing other systems such as pictures or photographs. In some cases these had been followed, others records showed they had been tried but may not have been effective for a range of reasons.

Other professionals involved with residents at the centre included physiotherapy, dietician, psychiatry, and for some residents psychology. Assessments and recommendations were seen from these professionals. In some cases they had been implemented, however in some examples seen by inspectors they had not.

There was a system in place to keep residents needs under review. This included setting up person centred plans, multidisciplinary reviews, family meetings, spread throughout the year.

Although a range of assessment and review of needs were seen to be in place, carried out by the professionals listed above, there were some gaps in relation to healthcare. Staff reported that all residents were seen regularly by a general practitioner, however during the inspection these assessments were not seen by inspectors. Historic versions from 2013 were in place. To fully meet the regulation, residents health, personal and social care needs needed to be reviewed no less than on an annual basis.

Most residents were seen to be involved in range of meaningful activities, which included trips out in to the community, and using local amenities. Social activities included cycling, swimming, going for walks and trips out on the bus. Some residents also enjoyed eating out, which was supported. Some residents were also involved in learning new skills such as knitting.

Some goals had been identified for residents, and updates on progress against them had been recorded. The goals could be improved by being more specific and so able to identify when they had been achieved.

Residents daily routines were set out in the individual communication system of the residents, and staff explained to the inspectors how they chose the different activities they took part in. Some residents had a routine they were familiar with, and others chose from activities by picking out the symbol of that option. All staff were seen to be familiar with these systems and used them effectively to communicate with the residents and support them to make a range of choices. Some relatives commented in questionnaires returned to HIQA that residents skills had increased in this area.

Since the last inspection, access to information had improved. There were full paper copies of personal support plans in the different units, and care plan information on the computerised system, along with other information for the residents such as medical appointments, incident reports and basic information such as next of kin.

Evidence was seen that annual meetings were taking place with families of the

residents, and this was confirmed in the questionnaires sent in to HIQA and completed by relatives.

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):

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

Findings:

The design and layout of the units that made up the designated centre were suitable in their layout and design. However, some decoration and maintenance issues remained outstanding and needed to be addressed.

Since the last inspection, there had been an improvement in the storage arrangements in the centre. Many rooms had been cleared and now held furniture and equipment for their purpose. The paths and outside areas had been cleared and the grounds were now clear of debris and were well presented. The trailing path was seen to be free of trip hazards.

Records reviewed and a tour of the premises showed some maintenance had been carried out, but other items that needed attention had not been addressed. For example in a kitchen some of the doors remained missing off the cabinets.

A number of the resident's bedrooms had been redecorated to make them more homely. However the decor in other areas such as stairs and landings still needed to be addressed.

Some residents had new furniture, and staff explained some had been involved in the process of putting it together. The furniture in the communal areas was worn and in need of replacement in some areas. Staff confirmed they had been allocated an budget to replace items such as dining tables and sofas, but had not yet chosen items, and wanted to involve residents in the process.

There were adequate numbers of toilets and bathrooms to meet resident's needs, and the inspectors observed that a number of residents had their own en-suite, which

supported them to be familiar with the space and placement of items, and so more independent. These areas had been deep cleaned since the last inspection.

The inspectors observed that there was equipment available as needed by the residents, for example standing poles and wheelchairs.

A full assessment of the premises had been undertaken by an external organisation commissioned by the provider. They had produced a report of their findings that was seen by the inspectors. The board meeting minutes showed that discussions were being held to decide what action to take, and to prioritise the improvements needed.

On the day of the inspection, the premises were seen to have suitable heating, lighting and ventilation. There was also sufficient private and communal accommodation. At the time of the inspection one area had a gas boiler that was not working, but alternative heating was provided while the process of repair was carried out.

Each area had a kitchen that provided cooking facilities and equipment. There was also a main kitchen that produced the main meals for residents. It was seen to be clean and well presented, with sufficient equipment to provide meals for the service.

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):

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

Findings:

There were systems in place to promote and protect the health and safety of residents, visitors and staff. However, the policy and practice around risk management needed to be improved, and learning from incidents needed to be undertaken.

Inspectors saw a range of policies and procedures relating to health and safety. This included an up to date safety statement. Staff were seen to be implementing good practice around health and safety, such as infection control practice.

A risk management policy was in place that covered some of the measures to identify and assess risk as set out in regulations. However, it did not include the measures that were in place to control risks identified, and the arrangements for learning from serious incidents. It also did not cover the measures and actions in place to cover unexpected

absence of any resident, accidental injury to residents, visitors or staff, aggression and violence, and self harm.

There were system in place to identify risks and documentation on how those risks would be reduced or managed at an organisational level and individual resident level. The areas covered by the risk assessments and registers included financial security, information technology security, staff training and retention and service development. Individual risk assessments covered environment, and actions and behaviours of residents. However, it was noted that there was no link between the two, and the organisational risks did not reflect the impact of the individual's risks on the service provision.

For the risk assessments seen, none were fully completed, as they did not assess the level of the risk and so could not be used to identify appropriate use of resources.

Inspectors reviewed the incidents that had been recorded. They provided detail about the incident, and the action taken, but they did not identify any learning for the organisation, or any changes needed to reduce the risk of the incident happening again.

Most incidents were focused on residents, for example self injury, use of physical intervention to redirect someone from danger. There were also examples of medication errors. There were few falls by resident's in the service, and few accidents relating to the premises.

An infection control policy was in place that covered a range of areas including hand hygiene and personal protective equipment. The policy was seen to be put in to practice. There was a project in place where a member of staff was auditing practice in the centre, and would then produce a report to identify any steps needed to improve practice. Training was also planned for 2015.

Inspectors saw that there was a missing person policy in place, and a format for providing information to those looking for the resident.

Inspectors reviewed the policy on fire prevention and management and looked at the records for servicing and drills. Records showed that the fire alarms were serviced on a quarterly basis in the units and the fire safety equipment was serviced on an annual basis. Regular testing of the alarm system was being carried out and recorded and staff spoken with were familiar with the procedure to follow. The records of fire drills included who had taken part, what happened, and any actions needed to improve the response. Fire safety training had been carried out, and for the few staff who had not completed it, the dates were booked for that month.

There was an emergency plan in place, and staff knew where to go if they were unable to remain at the building. Staff reported that residents knew if staff signed a cross to them, that they needed to leave the premises.

On the day of the inspection, the fire exits were clearly marked and not obstructed. A new system had been introduced to do daily and weekly checks, to check on issues such as exit routes, equipment and lighting.

Inspectors also observed there was a system in place for checking the vehicles used by the centre were roadworthy.

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):

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

Findings:

Some measures were in place to safeguard residents from abuse, however policies, procedures and systems required to be improved to meet the regulations and provide a safe and effective service to the residents.

Inspectors observed that there was a policy and procedure on the prevention, detection and response to abuse. However it was not clear enough to guide staff practice. Due to the lack of clarity in the policies available it was not clear what issues could be raised as a concern or as a safeguarding issue. The roles in the policy also lead to confusion in those staff asked about it. For example, staff spoken with were clear about what constituted abuse, and what action they would take, however they gave a variety of responses about who they would report it to.

Inspectors observed that staff interacted with residents in a calm and respectful way and the residents appeared to have a good relationship with staff on duty. The inspectors asked staff what signs they would look for as residents may not be able to communicate if something had happened to them they were unhappy about. They described they would look for physical signs and also changes in mood and behaviours.

Since the previous inspection, all staff working directly with residents had received training in recognising and responding to abuse. Staff knowledge was seen to be good in understanding the signs of abuse.

There was a behaviour support policy in place that included the guidance on restrictive

practice. However it was not sufficiently detailed to guide staff practice. It did not cover resident's rights, people to be involved in assessment and review of need, and legal implications relating to restrictive practice.

Some residents had behaviour support plans in place that provided details for staff in meeting their needs, and evidence was seen that residents quality of life had improved and they were expressing less anxiety since the plans had been implemented. One member of staff was taking a lead around this area, and was completing a training course. However, some behaviour support plans did not consistently provide clear instructions about what behaviours a resident may engage in, including any restrictive practice that may be approved.

Since the last inspection, the provider had commissioned a clinical psychologist consultant team to support the staff in indentifying the cause of resident's actions and behaviour. For the two residents they had worked with, evidence was seen of improvement in the effectiveness of the support provided by the staff, and the quality of life of the resident. They were starting to work with two more residents, and had given staff instruction in observing and recording any responses to set a clear picture of their needs. This would support the development of a behaviour support plan. However, in one case, inspectors found that recommendations had been made that were not being followed.

Although there had been improvements for some residents, the amount of time the psychology team was spending in the service impacted the level of support they could provide to the other residents. It was made clear by the provider that all resident would receive this support over time.

The psychologists were also conducting training for the staff around positive behaviour support following an evidence based practice approach. At the time of the inspection an introduction had been provided for two and half hours.

The service manager was the trainer for the protocol for using physical restraint in the service. Where it was identified that residents may require some form of physical intervention to support their safety, the approved methods were recorded clearly. He reported that staff were trained specifically for how to work with each resident and examples were seen where the approved responses to residents behaviour were clearly set out.

Since the last inspection, steps had been taken to complete a register of restrictive practice being used in the centre, and to set up a committee to approve and review any restrictions to ensure they were appropriate. However, the register did not reflect all of the restrictions being used in the centre, or a clear and approved rational for using them. For examples locked door in more than one location.

The committee was made up of a range of staff and board members. It was noted that there were gaps in expected practice in relation to the use of restrictions. For example the review the use of the restrictions in relation to them being the least restrictive method, and their use being for the shortest duration necessary, also a record of each occasion a restriction was used. Restrictions were also not reviewed in line with national

policy and evidence based practice.

Inspectors observed an example of restrictions that were in place that did not respect the rights of the resident, with no evidence based rationale for them being used, nor were they in line with national policies. This matter remained outstanding since the last inspection.

The residents had a range of complex needs, for some residents this included behaviour that was challenging. Inspectors observed that some residents had not been assessed by health professionals in relation to these needs, however, the staff in the centre trained in positive behaviour support were in the process of assessing their needs, and developing positive support plans where they were not already in place.

It was discussed with the provider and person in charge that they needed to ensure systems and procedures need to be put in place to address this breach of the regulation. Also that they should ensure safe and effective services were being provided, in line with residents human rights.

Judgment:

Non Compliant - Major

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:

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. They were clear of what incidents needed to be notified and the timescales in which they must be completed. They had also provided three monthly notifications as required.

Judgment:

Compliant

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:

Residents had opportunities for new experiences, social participation, and development of new skills.

Staff fed back to the inspectors that the opportunities for different experiences were expanding for the residents. They explained the impact that improved communication skills was having on resident's ability to make choices about their leisure time. Some residents really enjoyed going out for meals, others enjoyed going for a bike ride, or going swimming.

Staffing was seen to be available to support residents, with some forward planning needed if a resident needed support of more than one member of staff in the community.

Residents were also involved in learning and developing daily living skills, for example preparing meals, drinks and snacks. Also taking part in tasks such as laundry.

Each resident had goals identified of things they wanted to achieve, and although some of these were not specific, it was clear steps were being made it reach the goal. For example increasing community involvement.

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:

The inspectors found that there were arrangements in place to provide health care for each resident, and they had access to medical and allied healthcare professionals as needed. However, some recommendations made by health professionals had not been followed up.

There was evidence seen in the residents records that they had good access to general practitioners (GP's). There was evidence that residents accessed other health professionals such as occupational therapy, speech and language therapy, and specialists for specific medical conditions such as epilepsy. Letters, assessments and medical reports were available as part of the residents records. However, some examples were seen of recommendations being made that were not followed through, for example occupational therapy assessments on expanding the opportunities for sensory input and sensory seeking.

Records also showed that residents had regular dental checkups, sight tests, and tests in relation to national screening programmes. There was also information available that residents had access to psychiatry services if needed, and reviews of their medication were carried out regularly.

On the day of the inspection, there were no up to date annual assessments of residents' healthcare needs. Copies from previous years were seen on archived files. This meant that needs of the residents, including possible intellectual disabilities, behaviour that challenges and some autistic type behaviours were not being reviewed by a multidisciplinary team to identify any changes in their health needs. The action for this is made under outcome 5.

Meals were sent over from the main kitchen, and staff reported that residents had a good appetite and seemed to enjoy the meals served. For some meals, staff were seen to support residents to prepare meals in their own kitchens or the kitchen in the centre, and were supporting some residents to develop their food preparation skills.

For those with specialist and modified diets, detail was available in the centre to ensure those needs were met. Snacks and drinks were available to the residents at all times. Residents were seen accessing the kitchen diner in the main building as a social activity to meet up with other residents and staff, and for a change of environment.

Residents were seen to be eating the meals served during the inspection, and enjoying the fresh baking carried out by the chef.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

The inspectors found there were policies and procedures around the safe administration of medication. However, written protocols needed to be reviewed to ensure they matched residents prescriptions and 'as required' (PRN) medication needed to have clear advice as to when it should be used, and the maximum dose in 24hours.

There was a policy in place for the administration of medication which covered key areas such as safe administration, storage, audit and disposal of medication. The processes in place for the handling of medication were well known by staff, who were able to describe the process competently including administration and disposal.

Staff had completed medication training, which was provided by the pharmacist who provided the medication administration system. Some staff described the process of staff shadowing experienced staff until they were competent to administer the medication.

Inspectors reviewed the prescription record and medication administration records for residents and found that the documentation was generally complete. However it was noted in some cases the maximum dose that could be administered in 24 hours was not included.

Protocols around when to give 'as required' (PRN) medication had been developed, however they needed to be reviewed to ensure the doses of medication referred to matched the prescription. Staff spoken to were very clear of the procedures for administering, and described what was set out in the written protocol.

The inspectors observed that the medication storage was in the office in each house. It was a medication trolley that locked securely, and a staff member kept the keys at all times. No fridge was available for the storage of medications that needed to be refrigerated, but no residents had a need for this at the time of the inspection, and the person in charge confirmed one would be purchased if the need arose.

Records showed that some residents go home on a regular basis. There was evidence that there were arrangements in place for sending the correct medication with the resident. For example sign out sheets for the medication.

Staff reported that the pharmacist was available to provide support if they needed it. They also undertook a review of how the system was operating. The residential services

manager explained that external audits were to commence on the medication systems in the service, to identify any areas for improvement.

Some audits were seen, for example the audits of the use of PRN medication. Minutes of meetings showed the management team reviewed the audits, and also undertook an audit of the use of any of the medication to ensure use was in line with good practice.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

There was a statement of purpose that reflected the service that was provided.

The statement of purpose covered all the elements required by the regulations, for example the staffing compliment, arrangements for care planning and review, and any therapeutic techniques used in the centre.

The person in charge was aware of the need to keep this document up to date, and to notify the Authority of any changes.

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:

There were systems in place to support and promote the delivery of safe, quality services, however they were not effective in all areas of service provision.

A board was in place that oversaw the governance of the centre. It was made up of a group of volunteers with a range of professional experience in relation to the provision of care services. They met on a regular basis, and covered a standard agenda that included reviewing any risk to the provision of the service, staffing needs, finances and future plans in relation to the service. An annual report had been provided of the service, and it included an audit of the finances of the centre carried out by an external company. It was seen to be very detailed.

The provider confirmed that they had spent time recently debating the service that the centre was to provide in an attempt to support them with future planning.

The role of person in charge was fulfilled by three people. One person covered the role three or four days a week and the two service managers alternated monthly covering the rest of the week. Inspectors found that they had a range of skills and experience between them. For example, the main person in the role had a background in business management, and he was bringing those skills in relation to the operation of the centre. The service managers between them had qualifications in social care, counselling and psychotherapy and occupational health and safety. They were knowledgeable about the regulations and standards.

However, as discussed in outcome 8, there was a gap in knowledge in the service of the relevant legislation, up to date national policies and evidence based practice in relation to restrictive practice.

As part of the organisational structure there was also human resources and administration management. The systems that they operated, for example recruitment were seen to be effective.

In the units there was a supervisor, and then the staff team. Staff spoken with were very clear about their roles and responsibilities, and where decisions needed to be made

by other people.

Reporting systems were seen to be in place for any incidents, for example medication errors. As mentioned in outcome 7, there needed to be a review of the systems for follow up and learning from these events.

The person in charge and the service managers confirmed they met regularly and discussed standard areas of practice, including resident's welfare, medication and the premises. Staff meetings, run by the service managers, covered key areas for the running of the centre, such as rota's and training needs. Records showed these happened monthly.

Although there were a range of systems in place that provided oversight of the running of the centre, the level of non compliance identified would indicate that in some areas they were not effective to ensure that the service provided was safe, appropriate to meet the residents diverse and complex needs, consistent and effectively monitored. For example the system of risk assessments were only in the process of being rolled out, and were not in place for all risks present in the centre.

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:

The provider was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider had appropriate contingency plans in place to manage any such absence. The two service managers were responsible for deputising in the absence of the person in charge. They both demonstrated an understanding of their roles and responsibilities under the Regulations when fulfilling this deputising duty.

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:

Inspectors found that there were sufficient resources to meet the needs of residents, with some areas of improvement being addressed by the provider.

On the day of the inspection there were sufficient staff to meet the needs of the residents, and they were taking part in a range of activities.

There was a volunteer programme in place to provide transport for residents activities, including weekends.

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):

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

Findings:

The inspectors observed that there were sufficient staff to meet the needs of the residents, and they had been recruited through a thorough system. One area of practice in the centre would benefit from staff receiving specific training.

Residents were seen to receive any support they needed in a respectful, timely and safe manner. Residents were seen to respond positively to staff. Some staff had been in the

service for some time and knew the residents really well.

Relief staff were used to cover shifts in the centre, and the system had just changed to allocate the same staff to the same areas of the centre for consistency, and to support the residents in feeling comfortable in their company.

The staff rota matched the staffing in each of the houses.

Staff files reviewed contained all the required documents as outlined in schedule 2, which was evidence of a robust recruitment process. This was also the case for volunteers, who were interviewed and trained before starting to offer their support to the centre.

A process of staff supervision was being rolled out in the organisation. There was an appointed member of staff to complete supervision with the care staff. This was different to their line manager, and had been set up to support staff to raise any subject, and also reflect on their own practice in the centre. An external person had been appointed to supervise the team leaders, and this process was due to commence. Annual appraisals were also carried out.

Minutes were seen of staff meetings, covering issues such as training and the regulations and standards.

There was a range of training offered to the staff, and days of training were provided covering different topics so staff could make the most of their time. Upcoming days included sessions on first aid, fire safety, epilepsy awareness, information about Charge Syndrome and infection prevention.

Since the previous inspection, staff had completed fire training and manual handling training. See outcome 7 for information on safeguarding training.

A psychologist had been appointed to present training on a model of care that promoted positive interactions for people with behaviour that challenges. However, this had been a short session of two and a half hours.

The primary needs of the residents were related to them being deafblind, and staff had received a range of training in this area.

For their secondary needs, inspectors saw there was a detailed training programme in place to ensure staff have the right skills to meet the needs of residents, and the impact of this training on staff practice will be followed up on the next inspection.

However, as set out in outcome 8 and 14, there was a gap in knowledge in the centre in relation to restrictive practice, and this needed to be addressed to fully meet this regulation.

Judgment:
Substantially Compliant

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 inspectors found that there were systems in place to maintain complete and accurate records and the required policies were in place. However, at the time of the inspection, a small number were not available.

The inspectors read the residents' guide and found that it provided detail in relation to all of the required areas. This document described the terms and conditions in respect of the accommodation provided and provided a summary of the complaints procedure.

Written operational policies were in place to inform practice and provided guidance to staff. Most of the policies required by schedule 5 were in place with the exception of policies on resident's property, and the retention and destruction of records.

Inspectors found that staff members were sufficiently knowledgeable regarding these operational policies, with the exception of safeguarding and adult protection, which is covered under outcome 7.

Inspectors found that medical records and other records, relating to residents and staff, were maintained in a secure manner. The directory of residents was maintained up-to-date.

Satisfactory evidence of insurance cover was seen to be in place, a copy of which had been submitted to HIQA.

Judgment:

Substantially 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:

Helen Lindsey
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 The Anne Sullivan Centre Limited
Centre ID:	OSV-0001388
Date of Inspection:	10 February 2015
Date of response:	12 May 2015

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:

Some areas of need had not been addressed by the annual comprehensive assessments carried out by healthcare professionals.

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

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

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:

- Existing assessments will be streamlined into a single assessment document, including a health plan.
- Hard and soft copies will be made available.
- Psychological assessments will be carried out for all residents.
- All assessments will be reviewed and integrated the care-plan/IPP and the person-centred plan.

Proposed Timescale: 30/06/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Not all areas of the designated centre were kept in a good state of repair or well decorated.

Action Required:

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

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

- Review the existing plan and to determine whether any additional steps are necessary.
- In line with our actions items from the October report, all bedrooms will be completed by the end of March.
- All other refurbishment items identified in the Building Survey will be implemented, including all communal areas.

Proposed Timescale: 31/07/2015

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:

The risk policy did not clearly state the measures in place to learn from serious incidents, and measures and actions in place to cover:

- unexpected absence of any resident
- accidental injury to residents, visitors and staff

-aggression and violence
-self harm

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

- Amend the policy to ensure it includes all of the above.
- Circulate the updated version to all staff.

Proposed Timescale: 31/05/2015

Theme: Effective Services

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

The system of managing risk, accidents and incidents was in place but did not ensure that there an on-going management of risks, review of risk, and learning from any incidents.

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:

- Update the organisational risk register, to include any significant items from the individual risk register.
- Review all risk assessments currently in place and include them on the epiccare system, together with the risk rating, control and mitigation measures.
- Provide support and training to staff and risk identification and on closing out and learning from incidents.

Proposed Timescale: 30/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The policy on behaviour support and restrictive practice did not give enough information to guide staff practice and restrictive procedures were being applied that were not in line with national policy and evidence based care.

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:

Action Plan:

- Write a new policy on behaviour support and on restrictive practice, including best practice in this area.
- In line with these policies, identify any restrictions in place, and put specific plans in place for each restriction.
- Carry out an external audit of the areas of capacity and restrictive practices and the staff knowledge of and approach to this area.
- Re-organise our HIQA Implementation Group into a Quality, Assurance and Protection Group (with staff, family, external and board input) to audit various areas, including the restrictive practices

Process for Case

- Weekly meetings with PBS, OT, Team Leader, Keyworker and other core staff – In place
- Recording actual restrictions on a timeline – In place.
- Add additional staff member as required – In place
- Increase outings – In place.
- Change environment in line with OT and PBS recommendations – May
- Reduce restrictions while monitoring changes to behaviour and impacts of changes – March to May.
- Review bi-weekly with Management
- Review restrictions register with committee including PBS and signoff- May

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

Not all residents had a clear plan in place that identified and gave guidance on how to alleviate the cause of the residents behaviour.

Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

- Write a full positive behaviour support plan for all residents.
- o Monthly rollout of residents - April 2015 to Jan 2016
- Double the amount of time for the behavioural psychologist – Implemented in April.
- Three trained staff also working in this area, with dedicated time allotted for these

roles.- Implemented in April

Proposed Timescale: 31/01/2016

Theme: Safe Services

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

The policy in place to set out the procedure for protecting residents from abuse did not give clear instruction to guide staff practice.

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:

- Stream-line the policy and write a new guide of staff/families/volunteers.
- Circulate the new procedure via booklets/flyer/posters.
- Provide information sessions to staff and audit their knowledge and practice.
- Employ the services of an expert in this field to address the area of protection from abuse with staff and develop a practice guide which will be incorporated into staff training.

Proposed Timescale: 30/06/2015

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 recommendations from allied health professionals had not been implemented.

Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

- Review all healthcare/multi-disciplinary recommendations and make changes to the care plans/IPP's.
- Review all care plans to ensure all healthcare needs are reflected in the care plans/IPP's.

Proposed Timescale: 30/06/2015

Outcome 12. Medication Management

Theme: Health and Development

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

Systems around 'as required' (PRN) medication did not state maximum dose in 24 hours in all cases. Protocols around giving the medication did not always match the prescription.

Action Required:

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

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

- Review all MAR sheets and prescriptions with the GP and Pharmacist.

Proposed Timescale: 30/04/2015

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:

There were gaps in the knowledge of the people covering the person in charge role in relation to restrictive practice.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

- Management team will arrange sessions with specialist engaged to provide specific training to management in relation to national policies and evidence-based best practice.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

There were not effective systems in place to ensure that the service provided is safe, appropriate to the residents' needs, consistent and effectively monitored.

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:

- Change the charter of the HIQA Implementation Group to focus more on the areas of Quality, Assurance and Protection. Including audits and reporting of compliance and standards.

Proposed Timescale: 31/05/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staff did not have access to training that reflected the all the needs of the residents using the service, including restrictive practice.

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:

- Positive Behaviour Support training program to be developed – June 2015.
- Increase Protection of Vulnerable Adults training based on HSE modules as made available. – September 2015
- Include more training for staff on working with adults with learning disabilities in the training plan. September 2015
- Staff training in the area of restrictive practice. – June 2015

Proposed Timescale: 30/09/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Policies on residents property and the retention and destruction of records were not available.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

- Both of these policies are now available.
- The resident's property policy has been distinguished from the resident's funds policy.
- The retention and destruction of records policy has been re-introduced.

Proposed Timescale: 31/03/2015