### Centre name: Ard Na Greine

### Centre ID: OSV-0001522

### Centre county: Cork

### Type of centre: Health Act 2004 Section 39 Assistance

### Registered provider: Peter Bradley Foundation Limited

### Provider Nominee: Donnchadh Whelan

### Lead inspector: Margaret O'Regan

### Support inspector(s): None

### Type of inspection: Unannounced

| Number of residents on the date of inspection: | 4 |
| Number of vacancies on the date of inspection: | 1 |
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 15 November 2016 13:30  
To: 15 November 2016 19:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection
Background to the inspection:
This was an inspection carried out to monitor compliance with the regulations and standards and to follow up on matters from the previous inspection. It was the fourth inspection of the centre by the Health Information and Quality Authority (HIQA). The last inspection was carried out in December 2015. Since the last inspection there was a change of senior management and commitment had been received by HIQA from Acquired Brain Injury Ireland around the provision of more appropriate accommodation for residents.

How evidence was gathered:
As part of the inspection, the inspector met with the four residents who were residing in the centre. Residents were able to express their views of the service provided. Overall, residents appeared satisfied with the care provided to them, the services made available to them and the approach of staff who assisted them. However, as noted on previous inspections, and articulated on this inspection by residents, the layout and design of the centre impacted on some residents' mobility around their home. The inspector noted that since the December 2015 inspection, a number of improvements had been made in relation to the fire safety arrangements, staff training and updating of policies.

The inspector spoke with staff who shared their views about the care provided in the
centre, aspects of the service which worked well and areas which could be improved. The inspector spoke with the person in charge and gained an insight into their role in the operation of the centre.

The inspector examined documentation such as care plans, risk assessments and staff records.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. This document described the centre as one which aimed 'to enable people with neuro-rehabilitation needs to live meaningful lives in the community'. This was to be achieved by 'providing personalised, quality rehabilitation and support'. The inspector found these aims had been accomplished.

Accommodation was in a four bedroom detached dormer bungalow. Four residents were accommodated in single occupancy bedrooms. The house had a sitting room, kitchen cum dining room, two shower rooms, an office and a garden. The house was well maintained.

Male and female residents were accommodated in this service. Residents were able to get out and about on a daily basis. Transport was available to support residents avail of trips to local shops and other local amenities.

Overall judgement of our findings:
The flexibility around care practices helped to ensure that residents retained their independence yet obtained the support they required as their needs dictated. Some of these needs were complex both medically and socially. Staff and the person in charge were acutely aware of these complex needs and were committed to supporting each resident to achieve a good quality of life.

The inspector found that care was provided in a holistic environment where respect was a core element of all interactions. The inspector saw residents going out to activities, enjoying a board game, meeting family and going shopping. Residents had opportunities to spend leisure time together and develop friendships.

The inspector found the service to be in compliance with two of the seven outcomes inspected. Improvements were identified as being required under Outcome 6 (Safe and Suitable Premises), Outcome 7 (Health and Safety and Risk Management), Outcome 8 (Safeguarding and Safety Management), Outcome 14 (Governance and Management) and Outcome 17 (Workforce).

These findings are outlined under each outcome in 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 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:
Residents were involved in an assessment to identify their individual needs and choices. Care plans were implemented, regularly reviewed and resulted in improved outcomes for residents. For example, three residents were provided with day services and a process was underway for the fourth resident to access such services. Staff provided transport to and from day services in the wheelchair adapted vehicle available to them.

Residents were provided with a social model of care. Residents reported to the inspector that they were happy with the care provided, the support they received from staff and the activities made available to them. However, residents did identify issues with the appropriateness of the premises to meet their needs. This is further discussed under Outcome 6.

The varied activities programme included involvement in local community events such as card games, visiting local pubs and restaurants and accessing the local library.

Judgment:
Compliant

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
Theme: Effective Services

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

Findings:
Findings under this outcome remained similar from the findings of the previous inspection. The centre did not adhere to best practice in achieving and promoting accessibility. The narrow doorways and corridors continued to be a challenge for a resident who required a wheelchair. While the centre's accessibility was reviewed, there was considerable delay in finding a solution to the matter. Since the last inspection one resident moved to alternative accommodation. This provided more personal space for the remaining four residents. However, plans were in place for another resident to move to the centre.

The plan that was in place for residents to move to alternative accommodation by December 2016 was not progressing as anticipated. The inspector was informed that the organisation was in the process of securing alternative accommodation but it was unclear when the premises would be ready for occupancy.

Judgment:
Non Compliant - Moderate

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

Theme: Effective Services

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

Findings:
The centre had policies and procedures relating to health and safety. There was a health and safety statement. There were satisfactory procedures in place for the prevention and control of infection. The risk management policy was implemented and covered the identification and management of risks, the measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. There were also arrangements in place for responding to emergencies. Reasonable measures were in place to prevent accidents. Most staff had received
training in moving and handling of residents. However, a number of staff were overdue updated training in this area and in particular updated training specific to the needs of residents in the house.

Suitable fire equipment was provided. While there were adequate means of escape, the narrow hallways impacted on the ease in which wheelchair users could navigate the corridor. There was a procedure displayed for the safe evacuation of residents and staff in the event of fire.

Since the last inspection a new fire alarm panel had been installed and extra fire fighting equipment had been purchased. Emergency lighting was in place. The fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. The person in charge confirmed fire drills were carried out monthly. However, documentation was not available with regards to this.

The provider action plan response to the December 2015 report indicated all staff were to receive updated fire safety awareness training. However, the training records did not record that this training had taken place. Staff with whom the inspector spoke confirmed they had received fire safety training.

It was identified in the December 2015 inspection that there was a risk around residents smoking. Some measures were put in place subsequent to the inspection to address this matter. In minutes of staff meeting from June 2016 it was clear that to mitigate further against this risk, work had commenced on sourcing a fire protection apron. However, at the time of this inspection (November 2016) the apron had still not been provided. It was unclear when or if it would be sourced.

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:
The person in charge informed the inspector that she was actively involved in the
management of the centre. There was also a social care leader who was on duty on a regular basis in the centre. The person in charge stated that she was aware of her obligation to report any allegation of abuse to HIQA.

Residents spoken with by the inspector said that the staff were kind and the inspector observed interactions between staff and residents which demonstrated a respectful attitude. Residents said they felt safe in the centre.

There was a policy on the management of allegations of abuse and there was a named person identified as the person responsible for investigating allegations. Training records indicated that eight of the 12 staff rostered to the house had received training on the prevention and detection of abuse. This training was provided in March 2016. Four staff (as per the records viewed) awaited safeguarding training. Residents were aware of the name of key workers and understood that they could access an advocate and were familiar with the concept of advocacy.

There was a policy on restrictive interventions which outlined measures to promote a restraint free environment. All but two staff had received training in positive behaviour support.

There was also a policy on behaviour that challenges and this contained details of support for both residents and staff in understanding behaviour issues. The inspector found that the measures in place for the management of residents' finances were robust. Records were made of transactions conducted by and on behalf of residents. They were signed by two staff members or by the resident and one staff member. Residents in general, had control over their finances and were appropriately supported in budgeting their finances by staff members.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Residents had access to general practitioner (GP) services and appropriate therapies such as dietician, podiatry, physiotherapy, and dentist. There was evidence in residents' notes that access to specialist consultants was organised and facilitated to meet the medical needs of the residents.
The centre focused on neuro-rehabilitation and staff spoken with explained that residents had an individual rehabilitation plan (IRP) which was reviewed annually and more often when required. Residents were supported to identify and fulfil their goals by their key-worker, who was their rehabilitation assistant (RA).

The inspector noted that residents were supported to make healthy living choices. Visits to the gym were facilitated by staff and healthy eating plans were in place for some residents, as recommended by the dietician. Residents informed the inspector that menu plans for the week were developed, usually on a Sunday, in consultation with residents. Some residents shopped independently. The inspector observed that staff were aware of the healthcare and social needs of residents in the centre.

An end of life care plan was completed for residents and documented in their notes. Minutes of multidisciplinary team meetings and case review meetings were available for inspection. Residents with behaviours that challenge were supported by the relevant team members. Some allied health services were facilitated by the primary care team. Staff advocated on behalf of residents who needed to access primary care services. Updated care plans were seen to be in place for residents and residents were supported to attend their GP on a regular basis.

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:
The organisation had undergone significant changes in its management structure and management personnel since the previous inspection. A meeting was held between the Chief Executive Officer of Acquired Brain Injury Ireland and HIQA management in June 2016 to discuss, amongst other matters, the long standing issue around the suitability of this premises to adequately meet the needs of residents. Subsequent to the meeting, information was provided to HIQA outlining the plan for the residents in this centre to move to more suitable accommodation by December 2016.
However, when this inspection took place on 15th November 2016, there was no evidence that a house move was imminent. Neither had there been an application submitted to HIQA to register a new premises. Staff and residents were unaware of what stage the plan was at. The person in charge informed the inspector a new premises was in the process of being purchased. However, the management systems in place had not adequately progressed the plan to secure alternative safe and appropriate accommodation for residents.

Work had been undertaken since the previous inspection in improving the fire safety arrangements in the house and one resident moved to alternative accommodation. This improved the fire safety arrangements and gave the remaining four residents more personal space. However, this occupancy level was temporary as the inspector was informed another resident was to be move to the house.

The arrangements in place to support, develop and performance manage all members of the workforce were deficient. For example, the inspector was informed that staff performance management and review meetings took place annually with a six month interim review. The centre’s policy also confirmed this was the practice. However, from examination of staff files this had not occurred.

A team leader managed the day to day operation of the centre and staff reported to her. The team leader also carried out front line duties. The person in charge had a number of centres for which she held a managerial role resulting in her presence in the centre being limited. She was accessible by email and phone however, there were gaps in staff supervision and in the completeness of documentation.

Staff identified the limited managerial oversight as a shortcoming in the governance of the centre. Given these findings, the inspector was not satisfied that the person in charge was ensuring the effective governance, operational management and administration of the designated centre for which this report refers.

Judgment:
Non Compliant - Moderate

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

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

**Findings:**
There were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents. Staffing levels took into account the statement of purpose and size and layout of the building. There was a staff rota in place. It was displayed on the notice board in the centre's office. The inspector saw that residents received assistance, interventions and care in a respectful, timely and safe manner.

Overall, there was a good staff training programme in place and training was offered to staff in many areas including food hygiene, report writing and medication management. However, the records indicated there were some gaps in the mandatory training requirements. For example, not all staff had received appropriate updates on moving and handling training.

Staff were aware of the policies and procedures related to the general welfare and protection of residents. Staff had a good awareness of the regulations and standards. A copy of the regulations and standards were available in the centre.

Staff were supervised. However, as discussed under Outcome 14 (Governance and Management), the frequency of formal supervision was not in line with the centre's policy.

There were effective recruitment procedures that included checking and recording required information. The requirements of Schedule 2 had been met.

**Judgment:**
Non Compliant - Moderate

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**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:*

Margaret O'Regan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report¹

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Peter Bradley Foundation Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001522</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>15 November 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 December 2016</td>
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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 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The stairs and narrow hallways were problematic for residents' requiring wheelchairs.

1. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
1. New premises has been identified and secured with deposit
2. Survey of Premises and boundaries to be completed by Architectural firm
3. Meeting with County Council Housing Department to progress project.
4. Criteria identified for the 5th resident placement includes no pending physical needs that require wheelchair access and any behavioural issues that might impact and compromise on the needs of the current residents.

Proposed Timescale:
1. Completed 14th of November 2016
2. To be completed by 30th January 2017
3. To be completed by 30th January 2017
4. Completed as part of allocations meeting 8/12/16

Proposed Timescale: 30/01/2017

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:
The risk management control measures were not fully implemented, in that the identified need for a fire safety apron had not provided for.

2. 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:
1. Purchase of Fire Apron

Proposed Timescale:
1. Completed: Fire safety Apron purchased on 16/12/16 .

Proposed Timescale: 16/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Deficits were noted in the manner in which aspects of fire safety management were managed; namely the absence of records for fire drills which were reported to have taken place and absence of records showing recent staff fire safety training.

3. 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:
1. 17th Nov 2016 Fire drills were present but not in folder required. These are in place and available for review if so required.
2. Staff attendance sheet and Training Cert was in place for fire safety training completed on 25th of February 2016 in training log folder. This is now updated on the training matrix. All doc available for review if required.

Proposed Timescale:
1. Completed
2. Completed

Proposed Timescale: 22/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
According to documentation viewed two staff had not received training in positive behaviour support.

4. 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:
1. All staff in residential service to have completed positive support and behavioural planning CPI MAPA training.

Proposed Timescale:
1. The next in-house CPI MAPA training is scheduled for 29/30 March 2017

Proposed Timescale: 30/03/2017
<table>
<thead>
<tr>
<th>Theme: Safe Services</th>
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| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
According to records viewed, four staff awaited safeguarding training. |
| **5. 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:**  
1. Safeguarding training will be organised through ABI-Ireland’s Regional training programme. |
| **Proposed Timescale:**  
1. Safeguarding training to be completed with outstanding staff by Jan 31st 2017 |

| **Proposed Timescale:** 31/01/2017 |

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<table>
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<tr>
<th>Theme: Leadership, Governance and Management</th>
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<td><strong>Outcome 14: Governance and Management</strong></td>
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| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The person in charge had a number of centres for which she held a managerial role resulting in her presence in the centre being limited. The person in charge did not ensure the effective governance, operational management and administration of the designated centre for which this report refers. |
| **6. Action Required:**  
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned. |
| **Please state the actions you have taken or are planning to take:**  
The National Services Manager will conduct a meeting with the PIC to review the current balance of management support and presence that is appropriate to provide for effective governance, operational management and administration of the designated centre. This process will be overseen by the Line Manager to the PIC, National Services Manager Karen Foley and the Provider Nominee, Donnchadh Whelan. |
| **Proposed Timescale:** |

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1. New Governance arrangements in place: By Jan 20th 2017

**Proposed Timescale:** 20/01/2017  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The management systems in place had not adequately progressed the plan to secure alternative safe and appropriate accommodation for residents.

**7. 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:
New premises has been identified and secured with deposit  
2 Survey of Premises and boundaries to be completed by Architectural firm  
3 Meeting with County Council Housing Department to progress project  
4 Criteria identified for the 5th resident placement includes no pending physical needs that require wheelchair access and any behavioural issues that might impact and compromise on the needs of the current residents.

Proposed Timescale:  
1. Completed 14th of November 2016  
2. To be completed by 30th January 2017  
3. To be completed by 30th January 2017  
4. Completed as part of allocations meeting 8/12/16

**Proposed Timescale:** 30/01/2017  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The arrangements in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering were ineffective.

**8. Action Required:**  
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.
Please state the actions you have taken or are planning to take:
1. The PIC will meet with the PPIM to determine a timetable and dates to distribute to staff on Annual Performance Management meeting and 8 weekly support and supervision meeting. The PIC will complete Performance Management meetings with staff from January 9th 2017 and the PPIM will conduct Support and Supervision Meetings will start from 1st week in Feb 2017. A review process will be included as part of supervision and performance management of the PPIM with the PIC to ensure that support and supervision is being completed and documented within the required timeframe.

Proposed Timescale:

1. PIC to meet with PPIM on Tuesday 20th of December 2016.
2. Performance Management meetings to start with PPIM and Res Staff from 9th of Jan 2016
3. Support & Supervision meetings to start for Res Staff with PPIM from 6th of Feb 2016

Proposed Timescale: 06/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not received appropriate updates on moving and handling training.

9. 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:
1. All residential staff will receive training in Moving and Handling training

Proposed Timescale:


Proposed Timescale: 26/01/2017
Theme: Responsive Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps in staff supervision. This was evident in the documentation seen in staff files and from conversation with staff.

10. **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:**
1. The PIC will meet with the PPIM to determine a timetable and dates to distribute to staff on Annual Performance Management meeting and 8 weekly support and supervision meeting. The PIC will complete Performance Management meetings with staff from January 9th 2017 and the PPIM will conduct Support and Supervision Meetings will start from 1st week in Feb 2017. A review process will be included as part of supervision and performance of the PPIM with the PIC to ensure that support and supervision is being completed and documented within the required timeframe.

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**Proposed Timescale:** 06/02/2017