

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Clarey Lodge
<b>Centre ID:</b>	OSV-0003386
<b>Centre county:</b>	Kildare
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Nua Healthcare Services Unlimited Company
<b>Provider Nominee:</b>	Shane Kenny
<b>Lead inspector:</b>	Helen Thompson
<b>Support inspector(s):</b>	Jillian Connolly
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
18 May 2017 10:15	18 May 2017 17:30
19 May 2017 09:45	19 May 2017 17:55

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

**Background to the inspection**

This was an unannounced inspection that was conducted in line with HIQA's remit to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted over a two day period by two inspectors. This was HIQA's third inspection of the centre. The previous inspection in February 2015 had formed part of the centre's application for registration and no actions were required from that inspection.

**How we gathered our evidence**

The inspectors met with a number of the staff team which included social care staff, a team leader and the person in charge. The inspectors were afforded the opportunity to meet with all residents. Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement and interactions with residents.

As part of the inspection process the inspectors spoke with the aforementioned staff and reviewed various sources of documentation which included the statement of purpose, residents' files, centre reports, data sets and some of the centre's policy

documents. The inspectors also completed a walk through the centre's premises. In general, residents appeared contented in the centre and were observed to direct, and be facilitated with daily activities. Over the course of the two days, the inspectors especially noted the positive and respectful manner in which the staff team engaged with and supported all residents.

#### Description of the service

The service provider had produced a statement of purpose (SOP) which outlined the service provided within this centre.

The SOP stated that the centre's primary objective was to ensure the best possible quality of care in accordance with the applicable regulations and standards. The centre aimed to provide 24 hour care to adults with autism and intellectual disabilities. The SOP noted that residents' specific healthcare needs would also be looked after.

The centre was located in a rural area close to a village. It consisted of a bungalow dwelling with gardens to the front and rear. There was also an apartment to the side and back of the house. There was capacity for 5 residents in the centre and at the time of inspection it was home to three gentlemen and two ladies over 18 years of age.

#### Overall judgment of our findings

Nine outcomes were inspected against and overall the inspectors found that the level of compliance with the regulations had decreased significantly since the previous inspection. Major non-compliances were found with the centre's safety and safeguarding systems for residents. The centre's premises was also found to be inconsistent with residents' needs and presentation. Improvements were also required with the premises' upkeep, decoration and cleaning. The admission process for residents was not found to be conducted in line with the regulatory requirements or the centre's SOP.

Areas for improvement were also required with residents' social and healthcare needs. Additionally, the centre's workforce required the facilitation of further training and education in line with residents' specific support needs. The inspectors found the centre's medication management system to be compliant.

In summary, given the level of non-compliance found on this inspection, the inspectors concluded that the centre's governance and management systems had not ensured the consistent delivery of a safe and quality service.

These findings along with others are further detailed in the body of the report and the action plan at the end.

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

**Outcome 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:**

Overall, the inspectors found that the centre's admissions process did not comprehensively consider the needs and safety of the individual, and the safety of other residents living in the centre. Also, the process was not in keeping with the centre's statement of purpose.

From review of residents' files and interviews the inspectors observed that the initial needs assessment for residents was generic to the service provider and not specific to the centre itself. The centre management team were not involved in the decision making process regarding some resident's application for admission.

Additionally, the assessment process did not identify, consider and assess all possible risks prior to admission. Subsequently, residents were admitted without assessing if the centre could adequately meet their needs, or assessing the impact of their admission to other residents living in the centre.

Inspectors observed that the centre's statement of purpose stated that a medium level of support was provided to residents. However, it was found that some residents required a high level of staff support on a daily basis.

**Judgment:**

Non Compliant - Major

**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:**

Overall, the inspectors found that arrangements to inform and support residents' needs were outlined in their personal plans which reflected their needs and interests. However, improvement was required with the review and evaluation process. Also, the plans required improvement to ensure that they maximised residents' personal development.

Reviews of residents' files demonstrated that personal plans had been developed for residents. They were involved in this process and inspectors observed that residents' individual needs and wishes were considered. Residents were noted to be supported through a key working system. Also, there was some evidence of multidisciplinary team (MDT) involvement in the assessment process. Outcomes were identified in the planning phase and on a monthly basis three outcomes were selected to focus and work on. Residents were observed to participate in a number of activities, which included outings in the local and wider community.

However, the inspectors noted that residents' goals and outcomes did not appear to link/integrate with their actual daily schedule, and they were not evaluated and reviewed in a systematic manner. Residents' daily planners were generic in nature. Additionally, the inspectors were not assured that this process was facilitating some residents optimal personal development.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Overall, the inspectors found that the centre's premises was inconsistent with some residents' individual needs and presentation. Significant improvements were also required with the premises' maintenance, decorating and cleaning. Additionally, some Schedule 6 matters needed to be addressed.

The premises consisted of a bungalow with all rooms located at ground level and with a separate single apartment facility to the side/rear of the house. In practice, the main premises building was observed to operate as two separate areas with one side for the ladies and the other for the gentlemen. There was private and some communal accommodation available to residents in both areas. All residents had their own separate bedroom.

The inspectors observed that the layout of the premises did not comprehensively meet and optimally support some residents' assessed needs and specialised support requirements. The inspectors particularly noted that there was no en-suite bathroom facility available for residents on the ladies' side of the house. Also, the bathroom and corridors in some areas of the centre were noted to be narrow in nature. The environment had not been proactively adapted in line with some residents' particular requirements, for example, the upholding of their privacy needs.

During a walkabout of the premises, the inspectors also observed that cleaning and decorating was required to ensure that the premises was homely for residents. Some walls were grubby and stained, with cobwebs noted in some rooms. Painting was required in several rooms.

A number of areas were also found to be poorly maintained with no floor covering, fittings and fixtures hanging off walls, broken door frames, torn furniture and old phone wires exposed.

The inspectors found that all Schedule 6 matters were not provided for, as there was limited storage on the gentlemen's side of the house and also no separate kitchen area with sufficient cooking facilities on that side. Also, the bathroom on the ladies' side of the house was uninviting and required attention to bring it up to an acceptable standard. This finding was endorsed by the staff team.

Deficits were also noted with lighting and ventilation as bulbs were gone in an area and there was a malodour in several areas of the premises. The laundry/utility room was not found to be well maintained.

The inspectors acknowledge that the local management team had identified some of the above regulatory non-compliances, had communicated with the provider and that some improvements were planned.

**Judgment:**

Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Overall, the inspectors found that significant improvements were required with the centre's health and safety and risk management systems.

The centre was found to have policies in place regarding risk management and emergency planning which noted the risks as required by regulation 26. There was also a health and safety statement. Individual risk assessments were completed for residents and a number had a high level of control measures identified. A corporate risk register was available.

However, the inspectors found gaps in the centre's risk management system. It was noted that there was a lack of clear assessments of clinical, environmental and operational risks at a centre level. Additionally, the risk assessment review process was not dynamic in nature as it was embedded in a three monthly cycle and was not found to be conducted post incidents. Analysis of the incident review process revealed that they were not completed in a systematic manner which forensically analysed and reviewed the cited control measures.

The centre had appropriate fire equipment in place. Inspectors found that fire equipment extinguishers, the fire alarm and emergency lighting was serviced. However, the inspectors observed that the fire evacuation procedure was generic rather than centre specific.

Also, there were no individualised personal emergency evacuation plans to inform staff supports to residents in the event of a fire. This was noted to be particularly significant in light of some residents' complex presentations. Fire drill procedures were found to be inadequate, particularly as none had been completed at times of full occupancy and lowest staffing levels.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Overall, the inspectors found that significant improvements were required to ensure that residents' safeguarding needs were comprehensively supported. Improvement was also required with the centre's behavioural support approach, and the process around the implementation of restrictive practices with residents. Staff also required the facilitation of further training.

The inspectors found that residents' behavioural needs were acknowledged and some supports/interventions were evident. Residents' needs were outlined in behavioural support plans and staff were found to be familiar with their content.

All residents in the centre were supported by a behaviour specialist and by a psychiatrist. However, residents were not observed to be supported by a full multidisciplinary team (MDT) that included access to psychology and psychotherapy supports. This need was identified on some residents' files. The inspectors noted that all efforts were not made to identify and alleviate the underlying cause of behaviour that was challenging for each resident.

There was a high level of physical restraint utilised in the centre as a response to residents' challenging behaviour. However, there was a lack of due process mechanisms to protect residents. No assessments were completed to assess all possible risks and to underpin the usage of this restriction for the resident. There was no separate protocol document that clearly outlined an incremental process of moving from the least to most restrictive response. Additionally, there was a lack of a timely or appropriate system of MDT review in response to the implementation of a restrictive practice. Individualised protocols were also not available to inform and guide staff in the administration of PRN psychotropic medication as a response to a resident's challenging behaviour.

Residents' restrictive practices were not reviewed from a rights perspective nor were residents observed to be supported by any independent advocacy service. Documented informed consent from the resident/their representative to utilise physical restraint was not observed.

Staff had not been provided with all the necessary training and education to facilitate them in fully supporting the needs of some residents that engaged in challenging behaviour. The inspectors noted especially that staff were not trained with regard to the usage and wider implications of restrictive procedures.

The inspectors found that there were systems in operation for responding to incidents, allegations and suspicions of abuse. However, the inspectors found that the centre lacked a proactive approach to recognising, risk assessing and supporting all safeguarding matters for some residents.

Residents' were noted to be treated in a warm and respectful manner by staff. Residents' personal and intimate care needs were outlined in plans which informed staff practices. The policies as required by legislation were available in the centre.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

In general, the inspectors found that residents' healthcare needs were supported but some improvements were required.

The inspectors observed that residents' healthcare needs were recognised and assessed with plans present to inform staff practices.

However, the inspectors noted that a recognised assessment tool was not utilised to assess a resident's skin related issue. Also, assessments and subsequent healthcare plans were not available to support residents' needs, for example, at times of an acute infection.

There was a nurse on the staff team who co-ordinated residents' healthcare needs. As part of that role the nurse prepared weekly reports that were forwarded to a number of operational and clinical personnel at service level. This included a clinical nurse.

Residents were found to be supported by a general practitioner and were facilitated with access to multidisciplinary supports which included occupational, and speech and language therapy. Residents also attended allied health professional such as chiropody and dental services.

Residents' food and nutritional needs were assessed and documented in their care plans and the inspectors noted that a dietician was available to residents as required.

Specialised diets were facilitated and residents' weights were monitored. Staff were observed to be knowledgeable with regard to residents' particular dietary supports. The inspector found that residents' choice and preferences were acknowledged and supported. Drinks and snacks were available outside of residents' mealtimes. However, the inspectors observed some issues with food storage. For example, items in the fridge lacked dates of opening and some cleaning products were stored alongside dry food products. This issue was highlighted to the person in charge at the time of inspection.

<p><b>Judgment:</b> Non Compliant - Moderate</p>

**Outcome 12. Medication Management**  
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Health and Development

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

**Findings:**  
Overall, the inspectors found that residents were protected by the centre's policies and procedures for medication management. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Medicines in the centre were stored as required and residents' medication records were kept in a safe and accessible place.

A pharmacist service was available to the residents and there was evidence of review of the residents' medical status and their medication. Medication in this centre was administered by a registered nurse and by staff that had completed training in the safe administration of medication. All residents in the centre were supported with their medication needs.

There was a system in place for reviewing and monitoring safe medication management practices.

**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:**

Overall, the inspectors found that the centre's governance and management systems had not ensured oversight and accountability for the provision of an appropriate, safe and quality service to residents. This was evident from the level of non-compliance found across all outcomes inspected, but particularly from findings that related to residents' health, safety and safeguarding needs.

The inspectors observed that there was a management structure in situ for the centre which did have clear lines of authority and accountability. This encompassed the local team leaders, person in charge (PIC) and regional manager. There was evidence of some meeting structures and the PIC stressed that the regional manager was very available.

The inspectors noted that there were established reporting systems where required information/data sets were forwarded to operational management at service level. Self-monitoring and audits were also completed in the centre.

However, the inspectors observed that there was a lack of robust systematic oversight and feedback that drove improvements in day to day outcomes for the residents. This was evident from the inspection findings. Also, the inspectors observed that frontline management were not involved in clinical or operational meetings.

Additionally, no 2016 annual review of the quality and safety of care and support provided in the centre was available for the inspectors.

The PIC had been in the post a number of months and was familiar with the residents' needs. He outlined the manner in which he had orientated himself to this new service, particularly with regard to particular/current issues associated with the residents' profile. The position was fulltime and supernumerary. The PIC noted plans for him to undertake the PIC position for another centre and discussed his proposed arrangements for the additional responsibilities. The PIC was committed to his own professional development. The PIC worked alongside the staff team who acknowledged his support and leadership.

The inspectors noted that the PIC was very recognisable to the residents.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

Overall, the inspectors found that the centre's workforce was stable and that there were adequate numbers of staff to support residents' needs. Continuity of care and support was also found to be maintained for residents. However, improvement was required in the provision of training and education to staff.

The inspectors observed gaps in the provision of training to the centre's workforce. Staff were not facilitated with all training and education requirements to enable them to provide care that reflects contemporary evidence based practice. This was particularly pertinent to the resident group that they were supporting. Gaps included training in autism, mental health in intellectual disability, and the recovery model. This matter was highlighted and discussed during the feedback meeting.

During the inspection process, inspectors particularly noted the warm, respectful and person centred engagements of staff with residents. A pleasant and calm atmosphere was noted to be promoted.

There was a system of staff supervision in operation in the centre and additionally the person in charge was available when he worked shifts alongside the team members. A planned and actual staff rota was maintained in the centre.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Helen Thompson  
Inspector of Social Services



## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
<b>Centre ID:</b>	OSV-0003386
<b>Date of Inspection:</b>	18 May 2017 and 19 May 2017
<b>Date of response:</b>	12 June 2017

### Requirements

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

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

### Outcome 04: Admissions and Contract for the Provision of Services

**Theme:** Effective Services

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

Centre admission practices did not consider all safety and safeguarding risks for residents.

**1. Action Required:**

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

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

Nua Healthcare aim to protect all residents living in a Nua Healthcare Designated Centre's including Clarey Lodge, with the residents' safety as well and the safety and protection of current residents residing in the Centre paramount to the Admission Process.

1. The admissions process within Nua Healthcare is undergoing a full review at present to achieve:

- A prominent focus on Impact Risk Assessments for the Designated Centre based on each service user currently residing in the Centre.
- Validation of the pre-assessment outcomes prior to admissions by the PIC.
- Greater involvement from the PIC in the assessment of residents when they are being considered for the Centre, rather than decisions made primarily by the ADT committee.
- Formal agreement from the ADT Committee and the PIC when a resident is to be admitted to the Centre.
- A clear transition processes for residents deemed suitable to reside in the Designated Centre following the full assessment process. The transition process shall include at least one pre admission visit from the resident and representative where possible. The transition process shall also include routine and detailed monitoring of residents when they are admitted to a Centre and the impact that this has on other residents in the service, with the priority to protect residents from abuse by their peers.
- A 'Fast-Track' escalation process for communication of issues that arise when a resident is introduced to the Centre and where issues are identified.

2. Process mapping of the Admissions Policy and Procedure has been scheduled to commence in June 2017.

3. This draft document shall be approved and made available in all Designated Centres by July 2017.

4. The updated policy shall be communicated to staff in Clarey Lodge by July 2017, and all staff shall be required to acknowledge same.

**Proposed Timescale:** 31/07/2017

**Theme:** Effective Services

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

The admission process was not in keeping with the centre's statement of purpose.

**2. Action Required:**

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

Nua Healthcare aim to protect all residents living in a Nua Healthcare Designated Centre's including Clarey Lodge, with the residents' safety as well and the safety and

protection of current residents residing in the Centre paramount to the Admission Process.

1. The admissions process within Nua Healthcare is undergoing a full review at present to ensure:

- An updated Admission Process which incorporates full consideration of the scope of services set out in the Centre's Statement of Purpose.

**Proposed Timescale:** 31/07/2017

### **Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Some residents' plans did not robustly outline the supports required for their maximum personal development.

#### **3. Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

1. Training to be provided to the Key-workers in relation to the identification, recording and promote skill building and development for all residents'.
2. Personal Plans are developed with the resident in a manner that is age appropriate and consistent with their level of understanding. Realistic goals are agreed in consultation with the resident and supports given to the resident to achieve these goals while promoting skill building and development for all residents'.
3. Personal Plans are being reviewed in their entirety to ensure it allows personal development for all residents'.
4. Staff team meeting to take place on the 20 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include Residents' goals, with key recommendations and supports required for the promotion of skill building and development for all residents'.
5. All of the above points will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 31/07/2017

**Theme:** Effective Services

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

**in the following respect:**

Reviews of residents' plans were not conducted in a systematic outcome focused manner.

**4. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1. Resident's plans are to be maintained as a live document. Personal plans will be reviewed on a weekly basis or as required by the Key-workers to ensure that all relevant information is reflected in the residents' plans.
2. The PIC will ensure that all personal plans reviews will review the effectiveness of each plan and take into account changes in circumstances and new developments for all residents' in the Centre.
3. All of the above points will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 31/07/2017

**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 layout and design of the premises was not in keeping with some residents' needs and presentation.

**5. Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

1. A Key Events Schedule of planned works in the Centre was provided to the inspector on the day of inspection.
2. Building works commenced in the Centre on the 2 June 2017. The works are due to be completed on the 17 June 2017.
3. The works being completed in the Centre are being completed in line with residents' specific needs and presentations.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

As outlined in the body of the report the premises was not in a good state of repair.

**6. 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:**

1. A Key Events Schedule of planned works in the Centre was given to the inspector on the day of inspection.
2. Building works commenced on the 2 June 2017. The works are due to be completed on the 17 June 2017.
3. These building works will ensure that the Centre is compliant with Schedule 6 requirements while maintaining a homely environment.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

As outlined in the body of the report, some areas of the centre's premises required cleaning and decoration.

**7. Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

1. A Key Events Schedule of planned works in the Centre was given to the inspector on the day of inspection.
2. Building works commenced on the 2 June 2017. The works are due to be completed on the 17 June 2017
3. These building works will ensure that the Centre is compliant with Schedule 6 requirements.
4. During the building process, the Centre is being redecorated/painted to ensure that it is clean and provides a homely environment.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

As outlined in the body of the report, all Schedule 6 matters were not provided for in the centre's premises.

**8. Action Required:**

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

1. Schedule 6.5: Storage is being made available in the Centre. This will be completed along with the planned building works that are taking place.
2. Schedule 6.6: The lights in the Centre are being changed to better suit the needs of the residents. At the time of the inspection a maintenance request had previously been submitted for a more suitable external light at the front of the Centre.
3. Schedule 6.7: The kitchen area's in the Centre to be reviewed to ensure they are adequate for the needs of the residents that use those facilities. One kitchen in the Centre is used for the preparation of meals for all residents. This kitchen is capable of meeting the needs of the residents as per Statement of Purpose.
4. A Key Events Schedule of planned works in the Centre was given to the inspector on the day of inspection.
5. Building works commenced on the 2 June 2017. The works are due to be completed on the 17 June 2017
5. These building works will ensure that the Centre is compliant with all Schedule 6 requirements.

**Proposed Timescale:** 30/06/2017

**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:**

Some possible risks/hazards in the centre were not identified and risk assessed.

**9. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

1. Risk assessments were reviewed following the inspection. New risks were identified in regards to one resident's incidents of physically assaultive behaviour. These risk assessments will be reviewed in accordance with needs of the resident and internal policy.
2. Staff going forward will review individual risk assessments after any incident or when a change in need has occurred. Individual risk assessments will be live documents that are required to have a full review 3 monthly or as required.
3. Provide further training and development for the Person in Charge and staff team in risk assessment and the management and ongoing review of risk.
4. The PIC to undertake a review of the Risk Register to ensure that all the risks have

been identified and all actions have been taken to mitigate identified risks.

5. A standing agenda item to be added to the Safety Committee meeting which specifically asks question of our systems in place in each Designated Centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.
6. Senior management and a rota of representatives from the PIC's to take a more proactive role in the monthly Safety Committee meetings. Their key focus will be on risk management (prevention before mitigation).
7. The PIC will ensure that they all RA/SOP's in the Centre are reviewed as per the Centre's Policy.
8. All of the above points will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 31/07/2017

**Theme:** Effective Services

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

The system for review of incidents and risk related matters in the centre was inadequate, particularly given the level and complexity of incidents.

**10. 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:**

1. Personal Plans are being reviewed in their entirety to ensure the information is accurate and of support to the staff team. This includes identifying key risks for each resident.
2. Key risks for the resident and for the staff will be compiled in a summary document. Risks shall be risk rated and controls shall be reviewed to ensure all potential controls are in place. The summary risk document shall be reviewed on a weekly basis by the PIC to ensure it is fully up to date and reflective of the needs of the residents and staff.
3. The summary risk document shall be communicated to all staff on a weekly basis and shall be displayed prominently in the staff area.
4. Shift Handover meetings are being held at the commencement of each shift, and during the shift as required. At these meetings, any change to the needs of the residents shall be highlighted.
5. Staff team meeting to take place on the 20 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, Personal Plans will be presented at team meeting in draft format, each of them will then be reviewed at team meeting to include revisiting assessments completed, with key recommendations and supports required.
6. All residents have been reviewed by the Clinical Team and are being reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met.

**Proposed Timescale:** 31/07/2017

**Theme:** Effective Services

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

Residents did not have personal emergency evacuation plans to inform their evacuation support requirements.

**11. Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

1. Personal Emergency Evacuation Plans are in place for all residents residing in the Centre. Personal emergency evacuation plans are in place to inform staff of residents' needs & evacuation support requirements.
2. Residents' Personal emergency evacuation plans will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

Procedures to be followed in the case of a fire were not robust as :

- the fire evacuation procedure was not centre specific &
- fire drills were not appropriately completed, particularly at times of highest risk.

**12. Action Required:**

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

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

1. The Process for conducting Fire Drills in Clarey Lodge is under review.
2. A schedule for Fire Drills for the next 12 months is been put in place. This shall incorporate drills with the full complement of staff as well as with the lowest complement of staff.
3. All relevant information to be recorded to include those attending fire drills, time required for full evacuation and issues encountered if any. The response of residents and staff to the procedure to be recorded and reviewed to ensure learning which is to demonstrate that residents could be effectively evacuated from the Centre.
4. All of the above points will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 30/06/2017

**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:**

Staff were not provided with all necessary training to facilitate them in comprehensively supporting residents' needs.

**13. Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Safeguarding training/Autism and Intellectual Disability training to take place for all staff working in the Centre as outlined below;

- Safeguarding: Training took place on the 7 June 2017 and 12 staff attended. The remaining 11 staff to complete the training on the 30 June 2017
- Autism and Intellectual Disabilities training specific to the Centre: Training took place on the 7 June 2017 and 12 staff attended. The remaining 11 staff to complete the training on the 30 June 2017

**Proposed Timescale:** 30/06/2017

**Theme:** Safe Services

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

Evidence of documented informed consent was not observed for the usage of physical restraint as a response to a resident's challenging behaviour.

**14. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

1. Process for obtaining Informed Consent from residents for therapeutic interventions is under review. The organisation will ensure this is fully person centred and in line with HIQA regulations and standards.
2. Where therapeutic interventions are required for any resident of Clarey Lodge, informed consent shall be obtained from each resident, or his or her representative, in line with the Regulations.
3. A section is to be identified in the residents' Personal Plan where residents can sign

to state that they have been involved in the process of developing their Personal Plans and that they are in agreement with them. This shall also include the option where the resident does not wish to sign, to acknowledge that they have been provided with the option of doing so.

4. All Individual Personal Plans are to be reviewed by the resident's Key Worker and the Person in Charge to confirm that the information in the Personal Plans are up to date and reflective of the resident's needs. As part of this process the Personal Plans will be discussed with the resident and the section referred to in (3) above shall be completed with the resident (preferably by their signature or alternatively to note that they wish not to sign).

5. Where interventions are changed, the consenting process shall be repeated.

6. This process shall be overseen by the Person in Charge, Regional Manager.

**Proposed Timescale:** 31/07/2017

**Theme:** Safe Services

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

As per the body of the report, there were deficits in the supporting of, and implementation of interventions to meet residents' behavioural needs.

**15. 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:**

1. In addition to the full review of restraint as identified above, Personal Plans are being reviewed in their entirety (including Risk Assessments/SOPs and the Multi-element Behaviour Support Plans were in place) to ensure the information is accurate, to ensure key risks are identified and managed for residents, and that every effort to identify and alleviate the cause of residents' behaviours has been made.

2. The Person in Charge is responsible for ensuring appropriate referrals are being made for Service User's therapeutic needs. Full review to take place to ensure all residents' needs are identified.

3. The aim includes to ensure the most effective interventions are in place for staff to alleviate the cause of behaviour and manage escalation with low arousal techniques insofar as possible if it does occur.

4. As per Outcome 7 above, a summary risk document for the resident will be compiled in a separate summary document and communicated to all staff on a weekly basis. It shall be available prominently in the staff area.

5. Shift Handover meetings shall be held at the commencement of each shift or as soon as possible thereafter, and during the shift as required. At these meetings, any change to the needs of the residents shall be highlighted.

6. Staff team meeting on the 20 June 2017 to include a review of the Personal Plans for each resident and ensure staff are familiar with the needs of each resident, including

triggers to behaviour that challenges, support required and interventions to prevent and manage escalation of behaviour.

7. All residents have been reviewed by the Clinical Team and continue to be reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met.

**Proposed Timescale:** 31/07/2017

**Theme:** Safe Services

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

Restrictive procedures for residents were not utilised in accordance with national policy and evidence based practice.

**16. Action Required:**

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

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

A restraint free environment is promoted in Nua Healthcare insofar as is possible. The policy of Nua Healthcare is that if restraint is used, they are applied in accordance with national policy and evidence based practice.

1. Re-education is being provided to all staff to ensure they understand and acknowledge the use of restraint policy and procedure; including that physical intervention is never the primary intervention.
2. A full review of the use of physical or environmental restraint is being undertaken for Clarey Lodge in line with the Regulations. The review shall include a review of current restraints in place for residents, whether there is effective assessment for restraints in place, including identification of alternatives tried and the outcome, evidence that this is the least restrictive intervention available, and justification of any restraint.
3. The Person in Charge shall oversee the outcomes of
  - i. any use of PRN Psychotropic Medication or Sedative Medication in the designated centre. This shall be supported by the Clinical Team and Behaviour Specialists. Any PRN medication utilised shall be reviewed by the Clinical Team and Person in Charge on a weekly basis. In addition a trend analysis and evaluation shall be provided to the person in charge on a weekly basis identifying any discrepancy in suitability of the use, concerns, and lessons learned to be provided to staff.
  - ii. any incident which occurs involving the use of physical or environmental restraint. This shall include evaluation of whether the restraint was the least restrictive intervention available and was it in line with the refinements in the personal plan and was it utilised appropriately.
4. All staff shall sign to acknowledge they have read and understood each resident's Multi-element Behaviour Support Plan where in place or Reactive Strategies; and the lessons learned provided in relation to evaluation of restraint in Clarey Lodge.

**Proposed Timescale:** 31/07/2017

**Theme:** Safe Services

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

Robust measures were not present to proactively ensure that residents were protected from all risks of abuse.

**17. 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:**

1. A risk assessment is being completed for each resident specifically in relation to the unique vulnerabilities of each resident, the level of risk associated with these vulnerabilities, and a Proactive Safeguarding Plan is being developed for each resident.
2. The Person in Charge is supernumerary and supported by a Team Leader, with a focus on support of the staff team and ensuring appropriate staff are available and rostered.
3. All staff shall be provided with re-education on Resident Rights, Safeguarding, Vulnerable Residents, and the Use of Restraint.
4. At the staff team meeting on the 20 June 2017 the priorities for safeguarding of all residents are to be highlighted and discussed.
5. As above, Personal Plans are being reviewed in their entirety to ensure the information is accurate and of support to the staff team. Key workers for each resident shall review the records and confirm the information is accurate.
6. As above, all residents have been reviewed by the Clinical Team and are being reviewed on an ongoing basis to ensure their clinical and behavioural needs are being met

**Proposed Timescale:** 30/06/2017

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Some residents' healthcare needs were not comprehensively assessed and supported through care plans.

**18. Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

1. All residents Healthcare Plans will be reviewed and updated to include all supports required to ensure that residents' health care needs are appropriately assessed and met

through the residents' Personal Plans.

2. Specific Health Management Plans such as, a Medication Management Plan and Health Relapse Plan are being developed in consultation with the resident' and their Clinical Team. The recording of any acute medical conditions on a "Specific Health Management Plan" and the recommendations from the allied services that need to be implemented and recorded.

3. Monitoring charts are in place as required for resident' and will be reviewed weekly by the key-worker and any issues reported to the PIC or Team Leader.

4. All residents are reviewed regularly by the Clinical Team ensuring residents' health care needs were appropriately assessed and met while monitoring medication.

5. A staff nurse is part of the skill mix in the Centre to monitor residents' health care needs.

6. All of the above points will be discussed at the staff team meeting on the 20 June 2017.

**Proposed Timescale:** 30/06/2017

**Theme:** Health and Development

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

Some food products were not appropriately stored.

**19. Action Required:**

Under Regulation 18 (1) (b) you are required to: Ensure there is adequate provision, so far as reasonable and practicable, for residents to store food in hygienic conditions.

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

1. All staff in the Centre are trained in food hygiene as part of their mandatory training.

2. Food hygiene checks will be completed in line with best practice on a daily basis in the Centre by the care staff.

3. The Team Leader will oversee Food hygiene checks on a weekly basis.

4. All of the above points will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 30/06/2017

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

Robust systems were not in place to provide oversight and accountability for the service provided in the centre.

**20. Action Required:**

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

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

The Provider is dedicated to strengthening the management systems in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. Actions in place to achieve this as follows:

1. Nua Healthcare has compiled a Governance Plan for HIQA to outline its plans to improve the Governance, Leadership and Management within the organisation, and the impact this will have on individual Centres including Clarey Lodge.
2. The Governance Plan shall include a focus on the purpose and function of meetings and forums taking place in the Designated Centre's. One focus shall be on the process for actioning all issues discussed at meetings in a SMART (Specific, Measurable, Action-Oriented, Relevant and Timely) way.
3. A review and restructure of the Quality Assurance is underway to assure the validity and reliability of all audits carried out in Nua Healthcare.
4. To strengthen the accountability for practices, the roles and responsibilities of the individuals in Clarey Lodge are being reviewed to ensure all people are clear of their roles at this time. This includes:
  - a. Specific responsibility of PIC for oversight of, and action with, incident reports, complaints, verbal feedback from residents, and to oversee the actions of all staff in the house.
  - b. Regional Manger to provide support to the PIC to oversee all elements and to ensure the PIC has all required information.
  - c. Social Care Worker/A Support Worker's roles and responsibilities.
5. The Admissions, Discharge and Transition process is under review to ensure safety of residents is not compromised, and to include increased involvement of the PIC.
6. Active Evaluation, analysis and trending and feedback of this information with commentary, actions and lessons learned will take place regarding
  - i. incidents;
  - ii. behaviour support; and
  - iii. the use of restraintin order to strengthen the oversight and assurance of safety for all residents and staff in Clarey Lodge.
7. As above staff shall be required to acknowledge relevant policies and procedures.
8. To ensure staff have the fundamental knowledge necessary to support resident's further, actions planned are:
  - Nua has an extensive induction and training program in place, which will be supported by the introduction of competency bases assessments for key policies and procedures.
  - Resident needs and risks will be communicated in an improved manner on a daily basis (staff handover process improvement).
  - Staff Meetings shall be more effective with SMART goals for all issues developed and actioned.
  - a schedule of education and training is in place for the year ahead providing ongoing refresher education and training for staff.

**Proposed Timescale:** 31/07/2017

**Theme:** Leadership, Governance and Management

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

No annual review of the quality and safety of care and support provided in the centre was completed for 2016.

**21. Action Required:**

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

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

The annual review report is to be finalised for 2016 with a written report complete including areas of improvement identified with action plan.

**Proposed Timescale:** 31/07/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Staff were not facilitated with all the education and training required to enable them to optimally support some residents.

**22. 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. Safeguarding training/Autism and Intellectual Disability training to take place for all staff working in the Centre as outlined below;
  - Safeguarding: Training took place on the 7 June 2017 and 12 staff attended. The remaining 11 staff to complete the training on the 30 June 2017
  - Autism and Intellectual Disabilities training specific to the Centre: Training took place on the 7 June 2017 and 12 staff attended. The remaining 11 staff to complete the training on the 30 June 2017
2. All staff have access to a full suite of continuous professional development training. The suite consists of the following
  1. Basic Continence Care
  2. Basic First Aid
  3. Catheter Care
  4. Chemical Safety Awareness

5. Communication Skills
6. Equality and Diversity
7. Fire Safety Awareness
8. Fire Safety with CHASE
9. Food Hygiene
10. Hand and Power Tools
11. Hand Hygiene
12. How to Administer Suppositories
13. Incident Report Writing
14. Infection Control
15. Key-working
16. Challenging Behaviour 1
17. Challenging Behaviour 2
18. Money Management
19. Monitoring and Recording Blood Pressure
20. Office Ergonomics
21. Personal Protective Equipment
22. Pressure Ulcer Prevention
23. Principles of Person Centred Planning
24. Protection and Welfare of Children and Vulnerable Adults
25. Providing Intimate Care
26. Recognition and Reporting of Elder Abuse
27. Safe Administration and Management of Medication part 1
28. Safe Administration and Management of Medication part 2
29. Slips, Trips and Falls
30. Supporting a person with Diabetes
31. Supporting a person with Epilepsy part 1
32. Supporting a person with Epilepsy part 2
33. Supporting a person with Alzheimer's and Dementia part 1
34. Supporting a person with Alzheimer's and Dementia part 2
35. Supporting a person with Autism and Aspergers
36. Understanding and Dealing with Bullying Behaviour
37. Using Portable Fire Extinguishers
38. Wound Care

3. As part of CPD training, staff are required to undertake refresher training. These trainings are scheduled for each employee as a refresher 3 months prior to the due date.

4. The importance of completing all CPD training will be discussed at the staff team meeting to take place on the 20 June 2017

**Proposed Timescale:** 31/07/2017

