Health Information and Quality Authority
Regulation Directorate

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

Centre name:	No.2 Seaholly
Centre ID:	OSV-0004572
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Una Nagle
Lead inspector:	Julie Hennessy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 May 2017 10:00	19 May 2017 15:30

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

Outcome
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of this centre. A certificate of registration was issued for this centre in September 2015.

The purpose of this inspection was to follow up on a notification of allegations of abuse in one bungalow that forms part of this centre. The notification had been made to the designated person in the Brothers of Charity and in turn to HIQA on 24 April 2017, as required by the regulations. The allegations related to neglect, unmet needs, institutional abuse due to inadequate response to complex needs and non-implementation of recommendations, inadequate multidisciplinary support, medicines management and the use of unsanctioned restrictive practices. This was a focused inspection in relation to safeguarding and safety of residents. Where other outcomes were identified as being relevant, these were also included.

The most recent inspection of this centre took place in January 2017, during which major non-compliances were identified in relation to governance and management of the centre, safeguarding and safety and risk management. The provider had submitted an action plan following that inspection to address those failings. At that inspection, the type of inspection that took place in the bungalow that is the focus of this inspection was a medicines management inspection. That inspection involved the exploration of practices around the safe management of medicines and the use of chemical restraint.

How we gathered our evidence:
Inspectors visited one bungalow that formed part of this designated centre due to the focussed nature of this inspection. Inspectors met individual residents and spoke with the person in charge, area manager and members of the staff team about their understanding of individual resident's key support requirements and how they supported residents to meet those requirements. The unit leader was not working on the day of this inspection. The representative of the provider attended the feedback meeting at the close of inspection. Inspectors also reviewed documentation such as personal plans, healthcare records, information pertaining to restrictive practices, meeting minutes and training records.

Description of the service:
The centre provides residential and respite services for residents with an intellectual disability, including autism, who require high supports. The centre comprised seven bungalows, three of which had been reconfigured to include or form separate apartments. The centre is located in a congregated setting in a large campus on the outskirts of Cork city. The capacity of each apartment and bungalow varied between single-occupancy and six residents.

Overall findings:
The provider had taken a number of steps since allegations of abuse had been notified to HIQA three weeks prior to this inspection. Structures had been implemented to ensure review of the quality and safety of the service going forward. This included holding case review meetings in this centre and the commencement of a joint management and multidisciplinary forum to review complex cases across the service. The provider had also arranged for an internal assessment of basic assurances, which considered the quality of the service being provided. An internal investigation had been completed and the provider had commissioned a full investigation into the allegations, which would involve an external investigator.

In addition, and prior to the allegations being made, a new area manager had commenced in November 2016 who had being working to improve the quality and safety of care and support provided in this bungalow. Improvements made to the service since that time were outlined. The most notable change involved a change of staff team and recruitment of a new unit leader and senior social care worker.

Members of the staff and management team facilitated the inspection and described how they endeavourer to meet residents' day to day support requirements.

However, failings were identified in a number of key areas to ensure that the service would meet acceptable standards. Major non-compliances were identified in four areas:

A comprehensive assessment of needs had not been completed for individual residents that would in turn inform a care plan. Adequate reassurance was not provided that the service was suitable to meet residents' changing needs. The provider was required to take immediate action to address this failing. The provider responded appropriately and arranged for a comprehensive assessment of needs to

be completed within an acceptable timeframe. The provider also undertook to submit a plan in relation to the service being provided in this centre and how changing needs would be met going forward (outcome 5);

The design and layout of the centre did not reflect the age, gender and needs of residents who lived there. While plans for the centre had been discussed, consensus had not been reached (outcome 6);

Unsanctioned restricted practices were in use in the centre for a period of approximately three years. While there had been discussions around the use of these practices, a consensus had not been reached. These practices were significant in nature, involving locked doors and restricted access to the kitchen. This was a significant breach of the regulations and of residents' rights. At the time of inspection, the area manager was progressing the review of these unsanctioned restrictive practices and dates were provided of when the multidisciplinary team would be meeting to consider their use (outcome 8);

Previous recommendations relating to staff training in the areas of autism and supporting different means of communication had not been implemented (outcome 17).

The notification included a concern that related to the dose of a prescribed medicine. In January 2017, as part of the medicines management inspection, this also came to the attention of the medicines management inspector. At that inspection, it was demonstrated that practices in place in the centre were underpinned by clear clinical decision-making and that there were systems in place in the residential service to ensure adequate monitoring and review of any side effects. Oversight was provided by suitably qualified medical professionals. This finding is unchanged at this inspection.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met can be found in an action plan at the end of this 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Overall, the service provided at the time of inspection did not fully met residents' needs, including healthcare, communication, sensory and behaviour support needs in a person-centred way. The provider was required to take immediate action to address a key failing that related to a comprehensive assessment of needs for individual residents. The provider responded satisfactorily to the immediate action plan within the agreed timeframe.

On the day of inspection, a key failing identified related to the need for a comprehensive assessment of needs for individual residents. Adequate reassurance was not provided that the service being provided was suitable to meet residents' changing needs. The area manager, person in charge and representative of the provider all said that they could not confirm whether the current service had the capacity or capability to meet individual resident's needs during periods of time that those needs increase. The provider responded satisfactorily to the immediate action plan within the agreed timeframe by providing dates by when any further required assessments would be completed. In addition, the provider undertook to submit a plan in relation to the service being provided in this centre and how changing needs would be met going forward.

At the time of inspection, access to required supports, while generally provided, was not coordinated and failed to inform a care plan. There was regular review by individual resident's general practitioner and psychiatry. The most recent behaviour support assessment was dated 2013, although it was documented that this assessment remained relevant to inform a behaviour support plan. Joint recommendations from the

psychiatrist and behaviour support worker were current and dated October 2016. However, gaps were evident. A review of documentation and discussion with the area manager confirmed that a resident's communication skills were more advanced at their day service than in their residential service. Recommendations from speech and language therapy in 2015 had not been implemented. Communication aids referenced as being used by a resident in 2015 were not being used in the centre at the time of inspection, including symbols, LAMH signs (a manual sign system), a visual schedule and a picture exchange system. Since the notification had been submitted to HIQA, a sensory occupational therapy assessment had been completed and further support from speech and language had been provided. A psychology assessment was not available for review. Also, behaviours that challenge were more pronounced in the residential service than in the day service. While supports to encourage dietary intake were discussed, a food diary indicated the need for further dietary review and assessment. Since the inspection, the provider provided reassurance in their immediate action plan response that these gaps would be addressed within a short timeframe.

At the time of inspection, it was not clear how such assessments and inputs and any outstanding referrals or supports were coordinated. The assessment of needs on file had been completed by the unit leader and key worker and it was not informed by clinical assessments of need, namely in the areas of sensory, communication, diet and nutrition, behaviour support, mental health and other identifiable healthcare needs. While some areas of need were reviewed in different forums, a comprehensive care plan was not in place to support all areas of need and to explore why residents were presenting with such different abilities and behaviours between day and residential services. Since the inspection, the provider provided reassurance in their immediate action plan response that these gaps would be addressed within a short timeframe.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Overall, the premises was not suitable for its stated purpose and was not in line with the Statement of Purpose or floor plans for this centre.

The décor did not reflect the age and gender of those who lived there. The environment was bare and under stimulating and there were significant environmental restrictions in place. The area manager had been working to improve the environment over the past few months, with additional improvements made more recently. A new couch had been purchased, the centre had been painted in a more welcoming colour and a separate activities room had been designated. External blackout blinds now replaced black plastic bags that had previously been hung on the outside of the bedroom window (internal window furnishings were reportedly not tolerated by individual residents). However, despite the recent alternations, the environment remained unappealing and it was demonstrated that it did not meet the assessed needs of residents who lived there. An environmental assessment had also been completed at the end of 2016; this outlined what a more appropriate environment would look like. While options for providing a more suitable environment had been considered, a decision had not been made in this regard.

In addition, inspectors found that a resident's living environment had been significantly altered. This was relevant as a living and television room that were previously available were no longer available to individual residents. The dining room had been halved in size and was dark and narrow. The main sitting area was, according to the statement of purpose, previously an entrance hall. This was neither a pleasant nor a comfortable space. Also, consultation around the impact of these changes on existing individual residents living in this part of the centre was not evidenced in their personal plan.

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

Findings:
A significant failing identified on this inspection was that four unsanctioned restrictive practices had been in use in the centre for a prolonged period of time. At the time of inspection, the area manager was progressing the review of these restrictive practices

and dates were provided of when the multidisciplinary team would be meeting to consider their use.

Inspectors viewed two letters from 2015 from speech and language therapists to the person in charge raising concerns about restrictive practices in place, namely locked doors and restricted access to the kitchen, to food and to drink. Speech and language therapists highlighted, at that time, their concerns that these restricted practices were not sanctioned by the organisation's relevant authorising committee. Although there was evidence of discussions around the use of these practices, a consensus had not been reached. Other unsanctioned restrictive practices related to staff withdrawal and mechanical restraint during transport in the form of an unbreakable separating window. The use of unsanctioned restrictive practices meant that it could not be demonstrated that every effort to identify and alleviate the cause of residents' behaviour had been made, that all alternative measures had been considered before a restrictive procedure was used and that the least restrictive procedure, for the shortest duration necessary, was used.

Also, it had not been identified on quarterly reports submitted to HIQA that unsanctioned restricted practices were in use. Inspectors highlighted that the use of any unsanctioned restrictive practice was a significant breach of the regulations and of residents' rights.

At the time of inspection, the area manager was progressing the review of these restrictive practices and dates were provided of when the multidisciplinary team would be meeting to consider their use.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Overall, there were systems in place in relation to the administration and management of medication in this part of the centre.

The notification included a concern that related to the dose of a prescribed medication. In January 2017 as part of a medicines management inspection, this also came to the attention of the medicines management inspector. At that inspection, it was

demonstrated that practices in place in the centre were underpinned by clear clinical decision-making and that there were systems in place in the residential service to ensure adequate monitoring and review of any side effects. Oversight was provided by suitably qualified medical professionals.

At this inspection, an inspector found that the required daily monitoring of side effects continued to be maintained by staff in the residential centre to facilitate clinical review, effective decision-making and oversight.

Other aspects were reviewed as they related to pain management and any medicines administered on an as required (PRN) basis. An inspector found that there were protocols in place for any PRN medicines. Pain relief was administered as prescribed and pain triggers were clearly identified in individual resident's files. The management of pain was discussed at periodic service review meetings between relevant healthcare professionals and the unit team. Staff clearly articulated such triggers and demonstrated an understanding of when to administer pain relief in accordance with the prescription.

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

Findings:
Overall, the provider had taken several steps since concerns had been notified to HIQA on 24 April 2017, three weeks prior to this inspection. However, at the time of this inspection, the systems in place failed to provide reassurance in terms of ensuring adequate oversight of clinical care and individual resident's care plans going forward. Since the inspection, progress was made in relation to providing this reassurance.

The provider demonstrated steps that they had taken to review and address the concern's raised in the notification. Structures had been implemented to ensure review of the quality and safety of the service going forward. This included the commencement of a joint management and multidisciplinary forum to review complex cases and a date

for the first meeting of this group had been agreed. The representative of the provider had initiated case review meetings. An inspector reviewed minutes of the most recent meeting. The meeting had been attended by available members of the multidisciplinary team, psychiatry, behaviour support, local and senior management. Actions were identified and responsible persons nominated to follow through on any actions. The provider had also arranged for an internal assessment of basic assurances, which considered the quality of the service being provided. This included the suitability of a resident’s current placement, the adequacy of supports in place, resident’s safety, rights and relationships. The provider had also completed an internal investigation and had commissioned a full investigation into the allegations, which would involve an external investigator.

In addition to the steps outlined above, a new area manager had commenced in November 2016 who had provided specific support to this bungalow. Improvements made to the service since that time were outlined. The most notable change involved a change of staff team and recruitment of a new unit leader and senior social care worker.

At the time of inspection, it was found that adequate oversight of the care and support being provided in this centre had not been consistently demonstrated. There had been some delays in responding to individual resident’s needs. For example, recommendations made by speech and language therapists in 2015 and in a multidisciplinary review of a resident’s key support needs in 2015 and in the follow up to that review in April 2016, had not been implemented or adequately progressed. These recommendations related to the use of restrictive practices, the environment, communication and sensory supports. Another recommendation from speech and language therapists related to the provision of autism-specific training, which training records indicated had not been provided. A recommendation relating to a specific healthcare plan had not been actioned and it was not clear whether there was a possible explanation for postponing the commencement of this plan. Improvements were also required to periodic service reviews to ensure that all identified areas of need (such as in relation to sensory and communication needs) were considered and that goals were tracked. Since the inspection, further reassurance was provided by the provider in relation to clinical oversight. Also, the provider was reviewing the management structure for this centre and outlined progress being made in this regard. Confirmation of the final structure was to be submitted to HIQA.

Copies of the biannual unannounced visits by the provider and the annual review for this centre were requested by inspectors as they could not be located on the day of inspection. These were subsequently submitted as requested. The biannual unannounced visit identified the need for dietary input for residents accommodated in this bungalow but did not identify any other significant issues relating to assessment of needs or oversight. The annual review identified staff burnout and issues relating to the premises and restrictions in this specific bungalow but also cited that plans were in place. A new staff team has been assigned to this area since that review took place.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
Overall, while it was reported that a new team had resulted in improvements in this centre, further improvement was required to ensure that the staff team had the skills and support that they required to support residents.

A new staff team and unit leader had commenced in this centre several months prior to this inspection and the area manager described how this had resulted in more positive interactions with residents over the previous few months. Staffing levels were being maintained on the day of inspection in accordance with the staffing roster.

However, inspectors found that the staff team required further support to ensure the provision of a person-centred service that fully met individual resident's complex needs both in terms of training and support from the multidisciplinary team. Previous recommendations relating to staff training in relation to supporting persons with autism through the delivery in understanding autism and supporting different means of communication and sensory needs had not been satisfactorily implemented. However, this was not clear from a review of training records. Some staff required other training to support residents' needs in this centre, including in relation to positive behaviour support and infection control.

Supervision processes were in place. Day-to-day supervision was provided by a unit leader and a formal supervision and appraisal system was in place.

Judgment:
Non Compliant - Major

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:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
Centre ID:	OSV-0004572
Date of Inspection:	19 May 2017
Date of response:	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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment of needs had not been completed for individual residents by appropriate health care professionals that informed a care plan and was reviewed as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

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

Please state the actions you have taken or are planning to take:
1. All staff will be reminded that the relevant multidisciplinary inputs should be requested when completing a comprehensive assessment of need and that the annual assessment should be completed more often if there are indications of changing support needs.
2. The multidisciplinary team members will carry out a full team review of the support needs of one resident with complex support needs. The team members will ensure their individual assessments are updated as necessary and will input into the Team review at meetings on 15th , 20th and 27th June 2017 for this purpose. This process will be complete by 30thJune 2017.
3. The outcome of the multidisciplinary review of the assessment process will inform how the current Comprehensive assessment of needs process may need to be amended and management will ensure that any recommended improvement in the system, especially for residents with complex support needs, are implemented. [30 September 2017]

4. The residents care plan will be updated based on the recommendations arising there from. [14th July 2017]
5. In the event that the recommendations cannot be implemented in the current designated centre, an independent assessment of the residents support needs will be commissioned by 31 July 2017 with a target completion date of 30 September 2017 with a view to agreeing the appropriate future service provider for the resident with the Health Service Executive.
6. A Complex Case Forum, comprising of multidisciplinary and management representatives, has been established to provide oversight to the supports provided to residents with complex support needs. This forum would meet monthly from July and is available to support the Team in this unit.

Proposed Timescale: 30/09/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As described in the findings, the premises was not designed or laid out to meet the aims and objectives of the service and the number and needs of residents.

2. 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. The external blackout blind installed to provide privacy to a resident who could not tolerate internal window blinds has now been replaced by cavity window blind system. [12 June 2017]
2. The sitting room area converted to an activity area to support the resident will be kept under review with multidisciplinary inputs who are not recommending any further change other than for bathroom areas at this time.
3. Management will continue to meet with the multidisciplinary Team to agree the implementation phases of the overall environmental plan as identified on 6 December 2016. The recommendations of the latest meeting of 12 June will be implemented by June 30.
4. The remaining elements of the environmental plan will be reviewed as part of the Comprehensive Assessment of Need implementation plan [14 July 2017]
5. Provider is committed to ensuring that the environmental plan is implement to support the residents once the Assessment process confirms that the Centre can meet the support needs of the resident. [31 October 2017]

Proposed Timescale: 31/10/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unsanctioned restrictive practices had been in use in the centre for a prolonged period of time.

3. 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:
1. Restrictive practice sanctioning process requires all restrictions to be agreed by the local multidisciplinary team and approved by the Services behaviour standards committee. The reasons for previous difficulties in reaching consensus have now been reviewed and further local meetings have occurred on 16th, 29 May 2017.
2. One restriction in relation to access to the dining room has been removed.
3. One restriction in relation to transport has been agreed locally and is to be considered by the Behavioural Standards Committee on 21 June 2017.
4. All other environmental restrictions will be considered with the Environmental Plan as referenced above to ensure that the least restrictive measures are utilised. If consensus cannot be reached at a stage the matter will be referred to the Complex Case Forum for opinion [26 July 2017] and a special meeting of the Behaviour Standards Committee will be convened with a view to finalising on the process. [10 August 2017].

5. All unsanctioned restrictions will be notified to the Authority in the Quarterly Returns for the Centre.

Proposed Timescale: 10/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that every effort to identify and alleviate the cause of residents' behaviour had been made; that all alternative measures are considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was used.

4. 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. The Person in Charge will ensure that the restrictive practice actions plans are kept updated to ensure that the restrictions are reviewed and actions are taken to reduce these restrictions in accordance with procedures.
2. The Person in Charge will ensure that the scoring of outcomes on Periodic Service Reviews, completed with Behaviour Support and Psychology inputs on a fortnightly basis, are kept updated to monitor progress of the effectiveness of the behaviour support plans which in turn should lead to reductions in restricted practices.
3. The Complex Case Forum will provide oversight on the supports provided and will critically review all restriction on residents as part of this oversight.

Proposed Timescale: 10/08/2017

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:
Confirmation of how management systems in the designated centre would ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored was required.

5. 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:
1. We are currently making application to the Authority for the Unit to be registered as a separate Designated Centre with a new Person in Charge arrangement.
2. As part of the assessment of needs review the Person in Charge will co-ordinate and track all recommended multidisciplinary referrals and healthcare plans.
3. The model of service and protocols to support residents and staff supporting the residents will be fully documented in relation to the residents autism and mental health support needs.
4. The complex case forum will provide ongoing oversight in relation to the service delivery issues to support the staff team.
5. The provider will review and amend the scope and focus of the 6monthly statutory unannounced visits to the centre.

Proposed Timescale: 30/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to ensure that the staff team had the skills and support that they required to fully support residents.

6. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. The Person in Charge and Provider has arranged for Positive Behaviour Support, Psychiatry and Psychology to set out staff guidelines as interim guidelines pending the development of the residents Stay Well Mental Health Support Plan. [16 June 2017]
2. The Person in Charge will organised ASD awareness training and mental health awareness training for all staff Team members
3. The Person in Charge will provide additional/refresher training on Positive Behaviour Supports procedures.
4. The Provider and Person in Charge will seek regular updates from the Complex Case Forum on how best to support the staff team to meet the support needs of the residents.

Proposed Timescale: 29/09/2017