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<th>Seahaven</th>
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<td><strong>Centre county:</strong></td>
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<td><strong>Registered provider:</strong></td>
<td>Gateway Community Care Limited</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Eamon Murphy</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Maureen Burns Rees</td>
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<td><strong>Support inspector(s):</strong></td>
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<td><strong>Number of residents on the date of inspection:</strong></td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: 07 June 2017 12:00
To: 07 June 2017 17:00
08 June 2017 09:30
08 June 2017 15:00

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| 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 a nine outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. The previous 18 outcome inspection was undertaken on the 02 February 2016. As part of the current inspection, the inspector reviewed the actions the provider had undertaken since the previous inspection.

The centre was registered in November 2015 with Gateway Organisation as the registered provider. The company Gateway Community Care, Ltd recently submitted an application to become the registered provider for the centre. Other than the change to the company name and company number (the legal entity), the other governance structures and staffing arrangements are to remain unchanged. This inspection report will be used to inform the decision of the registration panel in relation to this application.

How we gathered our evidence:
As part of the inspection, the inspector met and spoke with the three service users staying in the centre on the day of inspection. Although these service users were unable to tell the inspector of their views of the service, the inspector observed warm interactions between each of them with the staff caring for them. All three service users were in good spirits.

The inspector interviewed the person in charge, director of service and two social care workers. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff supervision files.

Description of the service:

The service provided was described in the providers statement of purpose, dated February 2017. The centre provided full time residential care for one service user and shared care arrangements were in place for an additional four service users. A maximum of three service users stayed in the centre at any one time.

The centre was located in close to a town in the west of Ireland. It comprised of a dormer bungalow set in its own grounds. There was a secure garden and recreational facilities to the rear of the centre.

Overall Judgement of our findings:

Overall, the inspector found that service users were well cared for and that the provider had arrangements in place to promote their rights and safety. The person in charge demonstrated adequate knowledge and competence during the inspection and the inspector was satisfied that he remained a fit person to participate in the management of the centre.

Good practice was identified in areas such as:

- The well being and welfare of those living in the centre or availing of shared care was maintained by a good standard of evidence-based care and support. (Outcome 5)
- The health and safety of service users, visitors and staff were promoted and protected. (Outcome 7)
- There were appropriate measures in place to keep service users safe and to protect them from abuse. (Outcome 8)
- Service user’s healthcare needs were met in line with their personal plans and assessments. (Outcome 11)

Areas for improvement were identified in areas such as:
- The systems in place to ensure the safe management and administration of medications required improvements. (Outcome 12)
- The provider had failed to meet regulatory requirements in relation to monitoring the quality and safety of the service. (Outcome 14)
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Service users rights and dignity were upheld by practices in the centre.

At the time of the last inspection, inspectors found that the personal possessions policy was not clear about which items or activities the centre would pay for and which the service user would pay for. Since that inspection the policy had been revised to clearly meet requirements.

Also at the time of the last inspection, the arrangements in place for the management of complaints were not considered adequate. On this inspection, the inspector found that the complaint log had been revised to include the outcome and whether or no the complainant was satisfied. The details of the nominated person to deal with all complaints was detailed in the complaints policy and their contact details were on display in the centre. There had been a small number of complaints within the last 12 months and these had been appropriately managed.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to
meet each resident’s assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

**Theme:**
Effective Services

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

**Findings:**
The well being and welfare of those living in the centre or availing of shared care was maintained by a good standard of evidence-based care and support.

Each service user’s health, personal and social care needs were fully assessed. There was documentary evidence to show that service user’s parents or representatives were involved in assessments to identify individual needs and choices. In addition, there was a multidisciplinary input into assessments. There was evidence that assessments were regularly reviewed at care review meetings.

The arrangements to meet each service user’s assessed needs were set out in a personal plans that reflected his or her needs, interests and capacities. A separate user friendly version of personal plans and an ‘all about me’ document was available for all service users. Personal goals were set for service users and their implementation was monitored. Multidisciplinary input was incorporated into each service users personal plan by the service user’s keyworker following all review meetings and on receipt of updated multidisciplinary reports. An individual work log was maintained by the service user’s key worker on a monthly basis of all work undertaken in meeting goals set in personal plans.

There were processes in place to formally review service user’s personal support plans on a yearly basis. There was documentary evidence to show that the service user's family and or representative and multidisciplinary team were involved in the revision of personal plans as per the requirements of the regulations. The inspector found that reviews focused on improving the lives of the service users.

Service users were involved in a good range of activities within the local community. These included horse riding, swimming, bowling, cinema, walks in local forest, scenic area and pet farm, and visits to local shops and restaurants. There was a good supply of games and arts and crafts material for children to use in the centre and a good sized garden to the rear of the centre with suitable recreational facilities.

Two young people living in the centre were due to transition to adult services in the following 15 month period. Although placements had not yet been confirmed at the time of inspection, transition plans were in the early stages of development. There was evidence that some work had been undertaken with the young people on life skills to support them to live as independently as possible.
Judgment:
Compliant

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

**Theme:**
Effective Services

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

**Findings:**
The health and safety of service users, visitors and staff were promoted and protected.

At the time of the last inspection, the risk management policy in place did not meet with the requirements of the regulations. This had since been revised and on this inspection, the risk management policy, dated May 2016 was found to meet the regulatory requirements. Since the last inspection the centre had also put a risk register in place which was being maintained as a ‘living’ document and was regularly reviewed. The inspector reviewed a sample of individual risk assessments for service users which contained a good level of detail, were specific to the individual and had appropriate measures in place to control and manage the risks identified. There was a client risk assessment policy and procedure, dated July 2015.

There was a safety statement, dated July 2016, with written risk assessments pertaining to the environment and work practices. Hazards and repairs were reported to the providers maintenance department and records showed that requests were attended to promptly. Records of monthly health and safety checks and risk assessments of all areas were maintained. There was an identified health and safety officer on the staff team.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving service users. This promoted opportunities for learning to improve services and prevent incidences. There was a significant event notification policy and procedure, dated September 2015. An incident report log was maintained which showed that there had been a total of eight minor incidents since the start of 2017. The inspector reviewed a sample of incident report forms and found that an appropriate record was maintained of actions taken and follow up proposed. All forms were signed off by the person in charge. The inspector reviewed staff team meeting minutes which showed that specific incidents and trends were discussed and learning agreed at these meetings.

There were procedures in place for the prevention and control of infection. There was an infection control policy and procedure, dated July 2015. A cleaning schedule was in place and records were maintained of tasks undertaken. There was evidence that this was reviewed on a monthly basis. Colour coded cleaning equipment was used and
appropriately stored. There were sufficient facilities for hand hygiene available and paper hand towels were in use. Posters were appropriately displayed. There were adequate arrangements in place for the disposal of waste. An online infection control training course had been identified for all staff.

Adequate precautions against the risk of fire were in place. There were fire safety and emergency procedures, dated May 2017. Adequate means of escape were observed and all fire exits were unobstructed. A procedure for the safe evacuation of service users in the event of fire was prominently displayed. Each service user had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the service user. Staff who spoke with the inspector were familiar with the fire evacuation procedures. There was documentary evidence from an external company, that the fire alarm was serviced on a quarterly basis and fire safety equipment were serviced on a yearly basis. They were also checked regularly as part of internal checks in the centre. Fire risk assessments had been undertaken. A fire safety audit check list was completed by the person in charge on a three monthly basis. Fire drills involved service users and were undertaken on a regular basis. There was an identified fire safety officer on the staff team.

There was a site specific emergency plan in place to guide staff in the event of such emergencies as power outages or flooding.

**Judgment:**
Compliant

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

**Findings:**
There were appropriate measures in place to keep service users safe and to protect them from abuse.

The centre had a protection policy and procedure, dated July 2015, which was in line with Children First, National guidance for the protection and welfare of children, 2011. There was a ‘keeping safe from abuse’ information leaflet. The inspector observed staff
interacting with service users in a respectful and warm manner. Staff who met with the inspector were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. Staff had attended training in understanding abuse and the national guidance. The person in charge was the identified designated liaison person for the centre, (as per Children First, 2011) and a deputy was also identified with contact details for both observed to be on display. There had been no allegations or suspicions of abuse in the previous 12 month period.

Service users were provided with emotional and behavioural support. Up-to-date behaviour support plan were in place for a small number of service users who were identified to require such support. There was a behaviour management policy and procedure, dated October 2015. Records showed that staff had attended appropriate training. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviours that were challenging for individual service users. The provider had a behaviour therapist who could be accessed by the centre.

There were a small number of environmental and physical restraints being used in the centre for service user's safety. A restrictive practice register was in place. There was evidence that all restrictive practices were regularly reviewed and monitored by the multidisciplinary team.

Judgment:
Compliant

**Outcome 09: Notification of Incidents**

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

Theme:
Safe Services

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

**Findings:**
A record of all incidents occurring in the centre was maintained and where required, notified to HIQA.

At the time of the last inspection, the inspectors found that an incident which should have been reported as a three day notification had not been and that some restrictive practices had not been reported. On this inspection, the inspector found that all appropriate notifications and restrictions had been submitted to HIQA.

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

**Theme:**
Health and Development

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

**Findings:**
Service user's healthcare needs were met in line with their personal plans and assessments.

The service users living in the centre or availing of shared care had minimal medical needs and or support requirements. Each service user's health needs were appropriately assessed and met by the care provided in the centre. Each of the service users had an up-to-date hospital passport in place with appropriate information should a service user require to be transferred to hospital in the event of an emergency. Each of the service user's had their own general practitioner by whom they were regularly reviewed. Information on specific conditions was available in the centre and individual care plans were in place to guide staff.

The centre had a fully equipped kitchen and separate dining area. There was a food and nutrition policy in place, dated September 2016. The inspector observed that there was an adequate supply of healthy snacks available and that a range of healthy and nutritious meals were prepared for service users in the centre. Pictured menu cards were available to support service users in making choices.

**Judgment:**
Compliant

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The systems in place to ensure the safe management and administration of medications required improvements.

There was a medication policy and procedure, dated August 2015. Staff interviewed had a good knowledge of appropriate medication management practices and medications were administered as prescribed on pharmacy prescription sheets. There was an individual protocol for the administration of some medications which had been signed by the service users general practitioner. There was a secure press for the storage of all medicines. There were processes in place for the handling and storage of medicines. Medication logs were maintained of all medication received in the centre and sent home where appropriate.

However, the prescription records held in the centre were not adequate or in line with best practice in this area. The prescription sheets in use were more suitable for pharmacy dispensing purposes. The inspector reviewed a sample of prescription sheets and found that the times for the administration of medications was not always recorded. A photo of the service user was not available on all prescription sheets. The PRN or as required prescription sheet did not include the frequency or maximum dose that could be delivered within a 24 hour period. Overall, the prescription sheets were overly complicated with medications for some service users documented over a number of prescription sheets. This presented the potential for error.

There were appropriate procedures in place for the handling and disposal of unused and out of date medications, whereby they were returned to service users families or to the pharmacist in the case of the service user living in the centre. It was determined that it was not appropriate for any of the service users to be responsible for their own medications, following a medication assessment. There were no chemical restraints used in the centre. A disposal record was maintained for all medications returned to pharmacy which was signed by pharmacist and staff member returning same.

There was a system in place to review and monitor safe medication management practices but it was not effective. The inspector reviewed records for monthly medication audits undertaken in the centre which showed a good level of compliance and were issues were identified that appropriate actions had been taken. However, the audit tool used had not identified the issues referred to above.

Judgment:
Non Compliant - Moderate

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:**
There were management systems in place to ensure that the service provided was safe, consistent and appropriate to service user's needs. However, the provider had failed to meet regulatory requirements in relation to monitoring the quality and safety of the service.

Contrary to regulatory requirements, the provider had failed to undertake an annual review of the quality and safety of care in the centre. In addition, unannounced visits by the provider on at least a six monthly basis, to assess the quality and safety of the service, with the production of a written report, had not been undertaken. There was evidence that the director of service visited the centre on a regular basis as recorded in the visitor book. It was reported that relevant matters were discussed with the director of service on these visits. However, there was no documentary evidence of these discussion or of any reviews undertaken on these visits. The inspector reviewed monthly performance reports completed by the person in charge and submitted to the director of service on a monthly basis. These covered operational matters in the centre such as unplanned absences, risk assessments, significant events, fire safety log, number of staff supervisions and any other concerns.

The centre was managed by a suitably skilled and experienced person. The person in charge held a degree in social care and had completed a management course. He had been manager in the centre for the past two and a half years. Staff interviewed told the inspector that the person in charge was a good leader, approachable and supported them in their role. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards. He also had a clear insight into the support requirements for service users living in the centre. The person in charge was in a full time post but also held the title of the assistant director of service. This meant that he held responsibility for the line management of two other designated centres located near by. He provided direct supervision for the person in charge in both of these centres. Despite these additional responsibilities, there was clear evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis. The person in charge reported to the director of the service. There was evidence that the person in charge and director of service met informally on a regular basis where it was reported performance development and review were discussed. However, documentary evidence of these meetings was not available.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. Staff who spoke with the inspector had a clear understanding of their role and responsibility. On call arrangements were in place and
staff were aware of these and the contact details.

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

**Findings:**
There were appropriate staff numbers and skill mix to meet the assessed needs of service users living in the centre or availing of the shared care service.

The full staff complement was in place. There was an actual and planned staff roster in place. The majority of the staff team had worked in the centre for an extended period. This meant that service users had some continuity in their care givers.

There was a staff recruitment policy in place. The inspector reviewed a sample of four staff files and found that the information as required by schedule 2 of the regulations was in place.

There was a staff training and development policy in place, dated October 2015. A training programme was in place for staff and records showed that staff were up-to-date with mandatory training requirements. A staff training needs analysis had been undertaken for 2017. Staff interviewed were knowledgeable about policies and procedures in place. The inspector observed that a copy of the standards and regulations were available in the centre.

There were staff supervision arrangements in place. A policy on supervision, dated October 2015 was in place. The inspector reviewed a sample of supervision files and found that overall staff had received formal supervised in line with the frequency specified in the policy and that supervision provided was of a good quality.

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

**Judgment:**
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:

Maureen Burns Rees
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report¹

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<td>07 and 08 June 2017</td>
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Requirements

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

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

Outcome 12. Medication Management

Theme: Health and Development

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

The times for the administration of medications was not always recorded on prescription sheets.

A photo of the service user was not available on all prescription sheets.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The PRN or as required prescription sheet did not include the frequency or maximum dose that could be delivered within a 24 hour period.

Medications for some service users was documented over a number of prescription sheets.

There was a system in place to review and monitor safe medication management practices but it was not effective.

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

Please state the actions you have taken or are planning to take:
The Medication policy is been amended to include all required information. This will include an updated Kardex system.

Proposed Timescale: 01/08/2017

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:
The person in charge reported to the director of the service, and met informally on a regular basis, where it was reported performance development and review were discussed. However, documentary evidence of these meetings was not available.

2. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
All future meetings will be documented and available for review as per regulation 23.

Proposed Timescale: 06/07/2017
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unannounced visits by the provider on at least a six monthly basis, to assess the quality
and safety of the service, with the production of a written report, had not been undertaken.

3. **Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**
The Provider will carry out an unannounced visit to the designated centre and prepare a written report as per regulatory requirements.

**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:
An annual review of the quality and safety of care in the centre had not been undertaken.

4. **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 Provider will carry out an annual review to adhere to regulatory requirements

**Proposed Timescale:** 07/08/2017