Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Highwater Lodge
Centre ID:	OSV-0005407
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stepping Stones Residential Care Limited
Provider Nominee:	Steven Wrenn
Lead inspector:	Julie Pryce
Support inspector(s):	Gary Kiernan
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 July 2016 15:00	19 July 2016 20:00

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 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

Highwater Lodge was registered as a designated centre in May 2016. This was an unannounced inspection conducted in response to information submitted to the Authority. This information related to another centre operated by the organisation which was unknown to the Authority, and from which residents had been transferred to this designated centre (Highwater Lodge) at short notice.

A meeting was held with the provider on 16 June 2016 to discuss the criteria on which the decision not to register the unknown centre was based. The information provided by the provider at this meeting and subsequent to the meeting did not provide sufficient assurance regarding the actions of the provider. Further to this meeting, the provider had moved the residents of the unknown centre into this designated centre on 25 June 2016.

How we gathered our evidence:
The inspectors spent time with all the residents in the centre. The inspectors also met with staff members, persons participating in management and the person in charge of the centre. Inspectors observed practices and reviewed documentation such as personal plans, risk assessments and accident logs.

Description of the service:
The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. However the service being provided did not correlate with the information in this document. For example the document excluded residents with mobility issues, but one of the residents recently moved into the centre at short notice had mobility difficulties.

The centre was a large spacious house in a rural setting which was close to the nearest town. The service is available to adult men and women, however inspectors found that the mix of residents at the time of the inspection was not appropriate.

Overall findings:
The provider had not put adequate arrangements in place to safeguard residents. Inspectors found that there was a significant level and frequency of aggressive behaviour which required residents to be moved from the room in order to protect them from injury. In addition there was inadequate safeguarding in place in relation to a vulnerable adult with a history of absconding. This resident had managed to leave the centre unaccompanied on the evening prior to the inspection, had been missing for several hours, and was eventually located in the company of strangers.

Inspectors were not satisfied that the provider had put system in place to ensure that the Health Act 2007 (Care and Support of Residents in Designated Centres for People (Children and Adults) with Disabilities) Regulations 2013 were being met. The lack of effective governance and management systems had resulted in poor outcomes for residents in the following areas:
• the admissions process and compatibility of residents (Outcome 4)
• personal planning (Outcome 5)
• the management of risk (Outcome 7)
• the protection of vulnerable adults from abuse (Outcome 8)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

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

Findings:
Inspectors were concerned that recent admissions to the designated centre had not been managed appropriately.

Following information received by HIQA in relation to two residents of another centre operated by Stepping Stones, which had not been registered with HIQA, two residents were moved into the designated centre at short notice. This was despite the fact that the provider had informed HIQA at a recent meeting that the designated centre would not be suitable for at least one of the residents; who was subsequently moved in.

There was insufficient evidence that the residents were involved in the decision to move to the designated centre. Staff and residents told the inspectors that one of the residents was particularly distressed by moving home, and that this was the third move in just over a year. There was no evidence of consultation with the resident in relation to these moves.

Transition plans were requested by the inspectors but were not available during the course of the inspection. They were subsequently submitted by email for each resident. However, there was no evidence that the documents were in place at the time of the inspection. The requested record of implementation of the transition plans was not submitted.

One of the residents presented with behaviours that challenge which posed a risk of peer to peer aggression. Another of the residents told inspectors they did not feel safe in the centre as a result.

An impact assessment was also submitted to HIQA subsequent to the inspection, and inspectors found information in this document that indicated that the mix of residents

was inappropriate. In addition the document included the recommendation that a two-to-one staffing ratio was required for one of the residents who had recently moved in, but this was not in place, as further discussed under outcome 17.

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:
Personal plans were not in place for residents, including the resident who had originally moved into the house.

There was a personal planning template in place, but for the most part these had not been completed, and those sections which had been completed included further assessment information rather than guidance or goals.

There was a personal plan for one resident which had been developed by their previous service. While there was some important information in this document, for example in relation to communication, it was undated and had not been reviewed. The service had not completed a personal plan for this resident within 28 days of admission as required by the regulations.

There was a 'standard operating procedure' in place regarding challenging behaviour for this resident, and some goals had been documented. However these goals were vague, and had not been broken down into meaningful steps. For example one of the goals was that the resident would 'learn to deal with emotions in a more positive way'.

There was evidence of various activities being facilitated for residents in accordance with their needs and preferences. A weekly report was compiled for each resident which included information about the activities they had engaged in during the week.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There was an appropriate system of recording accidents and incidents, and appropriate fire safety systems in place. However improvements were required in the management of risk.

There was a risk register in place which included such risks as slips, trips and falls and environmental risks. However it did not address some risks such as absconding or self harm which were pertinent to this centre. One of the residents was at risk of absconding, and this had been referred to in documented meeting notes. There had been an incident whereby the resident absconded and was missing for several hours on the day prior to the inspection. However there was no individual risk assessment in place, and no reference to this significant risk in the risk register.

A risk assessment relating to absconding was submitted to HIQA following to the inspection, however there was no evidence that the document existed at the time of the inspection. Several other risk assessments were submitted, for example in relation to kitchen safety and swimming which were dated and in place at the time of the inspection.

A risk management policy was in place which included all the information required by the regulations.

Accidents and incidents were recorded in sufficient detail, and from the records reviewed by the inspectors all appropriate notifications to HIQA had been made.

Fire safety systems were in place including weekly checks of equipment and exits. Equipment had been appropriately serviced. A personal evacuation plan was in place for each resident.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
While incidents of allegations were managed appropriately, improvements were required in the management of challenging behaviour, and in ensuring that residents were safe, and felt safe in their home.

One of the residents frequently engaged in challenging behaviour which included physical aggression. A risk assessment in relation to this was submitted to HIQA subsequent to the inspection, but this document only referred to staff, and not to safeguarding other residents. There was a 'standard operating procedure' in place, which guided staff to remove the other residents from the vicinity of any aggressive behaviour, so that inspectors were concerned that residents did not have full access to all areas of their home. For example a recent incident had taken place in the kitchen at a time of day when one of the residents enjoys domestic activities. Another resident was frequently reluctant to leave the vicinity on occasions of aggressive behaviour and required written guidance for staff as to how to ensure that they would leave the area.

In addition inspectors were concerned that one resident stated that they did not feel safe in the house. This issue had been identified and documented in the minutes of meeting with the person in charge and the provider dated 29 June 2016. Information was submitted by the provider following an MDT meeting which was held the day after the inspection. This included the proposal that the resident reporting that they felt unsafe related to their diagnosis. However inspectors were still concerned that there was a high likelihood of residents feeling unsafe due to the high level and frequency of aggressive behaviour.

There was some guidance available to staff relating to other aspects of challenging behaviour, including a token economy system for one of the residents, which was clearly being implemented. However information in behaviour support plans was not in sufficient detail as to guide staff. For example a reinforcement was identified as 'social praise, pair with preferred activities/items'. No preferred activities or items were identified, and there was no record of implementation of the plan available.

Inspectors were concerned that a vulnerable adult had gone missing on the day before the inspection. There was a one-to-one staff for this resident, but not the two-to-one

recommended in the impact assessment. The resident was reported by staff to have been in a 'bad mood' all that day, and to have refused to engage in planned activities. The resident managed to leave the house unaccompanied and was missing for several hours. They were eventually located in the company of strangers. There was insufficient evidence that all appropriate steps had been taken to ensure the safety of this resident.

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:
There was evidence of healthcare needs being managed. For example each resident had their own general practitioner (GP), and the centre had access to an out of hours GP service. Residents also had access to a psychologist and a mental health consultant if needed. Residents accessed other healthcare professionals such as dentist in the community.

Any recent healthcare issues had been appropriately managed by referrals to health care professionals and implementation of recommendations. However, as discussed under Outcome 5, plans of care were not available for identified healthcare issues during the course of the inspection.

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):
No actions were required from the previous inspection.

Findings:
Appropriate systems were in place in relation to the ordering and storage of medications, however improvements were required in the guidance for 'as required' (p.r.n.) medications and in the recording of administration of medications.

Not all prescriptions for p.r.n. medications examined by the inspectors included a maximum dose, and there was no clear guidance for the circumstances under which the medication should be administered. There was also over the counter p.r.n. medication available for a resident which had not been prescribed. Inspectors were told this mediation had not been administered to the resident since they moved into the centre.

Administration recording sheets were not completed accurately, in that a tick and a signature was entered to indicate that several medications had been administered, meaning that it was not clear which individual medications were given.

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):
No actions were required from the previous inspection.

Findings:
The governance and management arrangements of the centre required improvement.

Inspectors were concerned that the provider had not ensured sufficient oversight of the service. As described under outcome 4 there were significant concerns regarding the admissions process and the mix of residents in the house. Concerns regarding the management of risk were also evident.

The person in charge was sufficiently skilled, qualified and experienced and was knowledgeable about her responsibilities under the regulations. She was also knowledgeable in relation to the needs of the residents, and described appropriate support of staff.

However, the person participating in management who was deputising in the absence of the person in charge at the beginning of the inspection, and again towards the end of the inspection; had not been provided with the appropriate support and training in order to display sufficient knowledge of the needs of the residents, the management of the centre, or the location of documents. Inspectors were therefore concerned that deputising arrangements were not adequate when the person in charge was not in the centre.

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):
No actions were required from the previous inspection.

Findings:
Two of the residents had been identified as requiring two-to-one staffing, but this was only in place for one of the residents. The other resident had the required one-to-one staffing in place.

There was an appropriate skill mix of staff, and consistency was reported as being managed by the use of familiar staff. The person in charge reported that there was currently only one agency staff, and that this staff member was known to the residents.

However, there was no evidence available that the records required under Schedule 2 of the regulations were in place for the agency staff, including garda vetting.

Training records examined by the inspectors showed that mandatory training was up to date .

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:

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Highwater Lodge
Centre ID:	OSV-0005407
Date of Inspection:	19 July 2016
Date of response:	12 August 2016

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:
Admissions were not based on transparent criteria.

1. 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

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

accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
An internal guidance document outlining the admissions process and responsibilities in this area has been completed on 05/08/2016 to ensure clarity in this regard by the senior management team. This document sets out the responsibilities of the Person in Charge, Directors, Clinical Lead and PPIM in relation to each stage of the admissions process and outlines a number of required governance visits and progress checks to be carried out prior to and following an admission.

The PIC, PPIM and Clinical Lead will draw up a document outlining the main needs of the existing service users and outline the risk factors associated with existing service users and the factors to be considered in relation to matching with any future service users.

All future admissions will be based on transparent criteria and in accordance with the statement of purpose and function of the centre.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Admission practices did not take account of the need to protect residents from abuse by their peers.

2. Action Required:
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:
In any future admission, individualised impact risk assessments will be completed by the PIC and other relevant person which will identify strategies in place to protect residents from abuse by their peers.

Information in relation to strategies and systems to protect service users from abuse by their peers will be included in all service users individual Behaviour Support Plans where relevant.

Proposed Timescale: 09/09/2016

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:
Personal plans had not been put in place.

3. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The PIC, PPIM and Clinical Lead are undertaking reviews of the existing drafts of personal plans in consultation with service users, their representatives and the staff team. This consultation will be completed by 26/08/2016.

The service users Keyworkers will then complete further drafts of the Personal Plans and the PIC, PPIM and Clinical Lead with edit and complete.

Proposed Timescale: 16/09/2016

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:
Adequate systems were not in place in relation to the assessment and management of risks.

4. 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:
A review of all individual service users' risks in the centre will be undertaken by the PPIM in consultation with the service monitor. This will be completed through a review of all existing assessments and a review of all significant events that have occurred since the centre opened.

The Clinical Lead will review all incident reports to identify patterns in relation to significant events. The information gathered through these processes will then be discussed at the team meeting and a comprehensive list of all individual risks will be drafted. On-going staff observations will provide the CL with further data required to identify the determinants of risks.

Once this is completed, existing controls will be noted and the Clinical Lead will be asked to review the BSP's in place to ensure they address the identified risks for each service user.

These individual risks will be reviewed by the PIC/PPIM/CL following the occurrence of significant events and at regular scheduled team meetings and risk management board meetings.

Proposed Timescale: 02/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems to alleviate challenging behaviour required some improvement.

5. 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:
Corrective actions have been taken in this regard through the provision of additional staff to one service user. This will ensure that all service users will have sufficient dedicated staff to help them feel safe at all times.

Keyworking sessions are being held with service users to remind and reassure them that they are safe in the care of staff. Keyworkers are engaging with service users to identify key areas where the service users feel improvements can be made and feeding this back to the team through team meetings.

New Standard Operating Procedures have been devised by the PPIM and CL for all staff members to assist in both managing the aggressive behaviour of service users and ensuring that all service users are protected from peer to peer abuse.

Preventative actions are being taken in the form of reviews of Behaviour Support Plans. These are being completed by the Clinical Lead and improvements to the systems to alleviate challenging behaviour will be made. This will work to prevent occurrences of aggression within the centre and as such assist all residents in feeling safe in their home.

Proposed Timescale: 16/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Satisfactory systems were not in place to protect vulnerable adults.

6. 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:
Staffing levels have been adjusted to ensure the safety of vulnerable service users. Two service users have 2:1 staffing during waking hours and 1 service user has 1:1 staffing at all times.

Safeguarding meeting held in relation to one service user on 22/07/2016. Following this consultation, a standard operating procedure regarding one service users unexpected absences from the centre has been devised by the PIC and is being implemented by all staff. This involves one staff member following the service user on foot and keeping them in sight while the second staff member gets a car to allow the staff members to keep the service user in sight. Protocols for contacting local Gardaí have also been put in place.

The Clinical Lead is continuing to monitor and assess behaviour to ensure that Behaviour Support Plans work to address the underlying cause of the behaviour and prevent risk where possible.

Proposed Timescale: 25/07/2016

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 systems in place for p.r.n. medication were not adequate. The recording of administration was inadequate to ensure that medications were administered as prescribed,

7. 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:
PPIM is updating all medication documentation as required. Staff will be advised by PIC and PPIM at team meeting in relation to improvements required in current practice in

the area of recording of administration of medication.

Visual prompts have been put in place to ensure staff are aware of the recording requirements. A monthly medication audit has been drafted and will be carried out by the PIC/PPIM on a weekly basis for 8 weeks to ensure compliance in this area. Individual supervision sessions will address any on-going issues identified by the audits in this area.

Proposed Timescale: 23/09/2016

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:
Deputising arrangements for the person in charge were not adequate.

8. 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 PPIM is being supported by the PIC and Senior Management team through supervision and training to develop required skills to ensure that they are capable of fulfilling the responsibilities of their role.

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Governance and management systems required improvement to ensure that admissions and risks in the centre were appropriately monitored and overseen.

9. 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:
A review of admissions to the centre is to be carried out by the management team and an agreed schedule of senior management visits prior to and following an admission is to be drafted to ensure that all admissions to the centre are appropriately monitored and overseen.

Following the review of individual risks noted in action 4, a schedule of Risk Management Board meetings will be agreed to ensure all risks in the centre are consistently and effectively monitored.

Proposed Timescale: 07/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Checks had not been carried out to ensure the appropriate recruitment documentation was in place for an agency staff member.

10. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
PIC has gathered required documents. Protocol for agency staff has been put in place to ensure this information is gathered prior to agency staff members working in the centre.

Proposed Timescale: 25/08/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The numbers of staff were not consistent with the assessed needs of residents.

11. 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:
Staffing levels have been adjusted by the PIC to meet the assessed needs of residents.

Three new staff members have been recruited to date and now 1 service user receives 2:1 staffing at all times, 1 service user receives 2:1 staffing during the day and 1:1 staffing at night and the third service user receives 1:1 staffing at all times.

Proposed Timescale: 25/07/2016