

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003951
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Marie Grimes McGrath
Lead inspector:	Julie Hennessy
Support inspector(s):	Geraldine Ryan; Michael Keating
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 January 2015 09:00 To: 27 January 2015 17:00

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 06: Safe and suitable premises
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

This was the first inspection of this centre by the Health Information and Quality Authority (The Authority). The purpose of the inspection was to assess the level of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and to discuss concerns raised in both unsolicited information and a previous notification received by the Authority.

The areas raised in either the concern or the notification received related to: allegations of poor hygiene and cleaning standards; poor medication management; lack of activities for service users; lack of respect for the dignity of service users; smoking in the vicinity of service users and; poor practices that could constitute abuse. Overall, care staff demonstrated that significant changes had been made to address many of issues that formed the original concerns. However, further improvement in relation to hygiene and safeguarding and safety was required and is further discussed under Outcomes 7: Health, Safety and Risk Management and Outcome 8: Safeguarding and safety.

The designated centre (Group H) can accommodate six residents, all of whom exhibit behaviours that challenge. Inspectors interviewed the staff on duty, who were all

care staff and the acting area manager, who visited the house during the inspection. The acting person in charge was off-duty and was not interviewed during this inspection. Inspectors also reviewed documentation including communication books, training records, personal plans, risk assessments, health plans and documentation pertaining to restrictive practices, medication management and behaviours that challenge. Inspectors observed staff interactions with residents.

Inspectors assessed ten outcomes in total. Inspectors found significant deficiencies in the governance and management of the house in that 9 of the 10 outcomes inspected were at the level of major non-compliance. These were Outcomes 1: Residents' Rights Dignity and Consultation, 5: Social Care Needs, 6: Safe and Suitable Premises, 7: Health, Safety and Risk Management, 8: Safeguarding and Safety, 10: Notification of Incidents, 11: Healthcare Needs, 14: Governance and Management and 17: Workforce.

Overall, inspectors found that the provider had failed to ensure that effective systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively managed. Inspectors found evidence of an unacceptably high level of risk to both residents and staff arising from a number of factors including: inadequate staff training and skills; an unsuitable premises; the unsuitable mix of residents within the centre; insufficient specialist support to staff in terms of managing behaviours that challenge and poor guidance for staff in relation to the use of restrictive practices. Inspectors also found that the provider had not taken adequate measures to ensure that residents' dignity and privacy were upheld or that all residents' health and social needs had been suitably assessed and met.

Inspectors spoke with staff and observed staff interactions with residents. Inspectors found that staff knew the residents very well and endeavoured to support residents in their day to day lives. Inspectors found that despite the efforts of staff to support residents in a very challenging environment; staff were not provided with the support, training or skills that they required to fully support residents and meet their needs.

Given the number of outcomes at the level of major non-compliance and the associated risks involved, the Assistant Chief Executive Officer (A/CEO) of the Daughters of Charity accepted an invitation to attend a meeting with the Authority on 5 February 2015 to discuss the findings further.

Findings are outlined in the body of this report and required actions are included in the 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 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):

This was the centre's first inspection by the Authority.

Findings:

Overall inspectors found that the provider had not taken adequate measures to ensure that residents' rights, dignity and consultation were upheld.

There were policies in place for the management of complaints. However, the policy was not in a format that was user-friendly to all residents. A complaints log was maintained, as required.

Staff outlined a number of ways in which they consulted with residents and facilitated residents' choice. For example, weekly house meetings took place, during which the weekly shop was planned. However, there was no pictorial or other form of aiding communication with some residents who did not express themselves verbally.

There was an organisational policy in place for the installation of CCTV. However, inspectors found that practices were not in line with the policy and the policy did not guide the use of CCTV in the centre. For example, there were no signs to indicate that CCTV was in use and the policy did not guide the use of CCTV in areas where there was a reasonable expectation of privacy. The decision on the use and protocol of CCTV was discussed as part of restrictive practices. Inspectors found that while the use of CCTV in one resident's bedroom was included as a restrictive practice for that resident, the rationale for its use was not supported by the resident's medical notes. As a result, inspectors found that practices in place for the use of CCTV impinged on the privacy and dignity of that resident. Also, inspectors were unable to find a record of consent in relation to the use of CCTV from the resident or his representative.

Inspectors also identified a second practice that impinged on the privacy and dignity of

the residents in the centre. Staff were carrying out hourly checks on all residents throughout the night. This practice involved staff going into bedrooms to check upon residents. For five of the six residents, no acceptable reason for this practice was provided to inspectors on the day of inspection.

In addition, the mix of residents within the centre impacted on one individual resident's right to privacy. Inspectors found that a resident did not have free access to his own belongings as a result of environmental restrictions in place in the centre for another resident.

Inspectors found that the opportunities available to residents to participate in meaningful activities were limited. Although each resident had an individual activities record; activities were not based on an assessment of each resident's interests, capacities and preferences. For example, one record contained a range of activities that were in fact life skills. These included emptying the dishwasher, bringing in groceries, putting clothes away, doing laundry and making tea. While the development of life skills was an important part of that resident's personal plan, an understanding of the difference between activities and life skills was not demonstrated as is necessary to ensure that both areas of developmental need are met. Care staff had not received specific training to support residents to engage in activities that were meaningful to them. In addition, care staff reported that activities were often dictated by the level of behaviours that challenge occurring at any one time in the centre.

Finally, residents had limited opportunities to engage in activities outside of the centre. Inspectors reviewed residents' personal plans and found examples where activities had been cancelled due to staffing issues or for undocumented reasons. This will also be addressed under Outcome 17: Workforce.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the social care needs of residents in the centre were not fully met. The personal planning process was inadequate. The unsuitable mix of residents in the centre and in some cases, the design and layout of the centre had a negative impact on individual residents. Inspectors found that the failure to meet the personal and social care needs of each resident was at the level of major non-compliance.

Inspectors reviewed the files of all six residents and discussed social care needs with the care staff on duty.

Residents' files included a range of information including personal information, plans of care, personal plans, behaviour management plans and a record of multi-disciplinary input (MDT) input. Overall, inspectors found significant gaps in the documentation contained in the residents' files. Documentation was not easy to retrieve, disjointed, unwieldy, often not in chronological order and in some cases, unsigned, undated or not current.

Inspectors found that each resident had a personal plan, as required by the Regulations. However, inspectors found that each resident did not have a comprehensive assessment of their personal, social, developmental and support needs. Inspectors found that overall, the residents' social care needs were not fully assessed. Some personal plans focussed on limited aspects of a resident's life (such as their healthcare needs or behaviours that challenge). Where other personal plans had identified individual social needs and choices, these were not fully met. For example, for one resident, eight goals had been identified. Of the eight, one could not be described as a goal as it was a necessary health care need. None of the eight goals were based on an assessment of the resident's needs, choices or preferences. There was little evidence of whether goals had been achieved for that resident.

Inspectors found that where residents' social care needs had been assessed, they had not always been fully met. For example, a physiotherapy assessment carried out in 2013 recommended the provision of quiet spaces, deep touch pressure, use of a knapsack, the 'snoozland', the Jacuzzi, music, a rocking chair, use of lavender and a bean bag for the resident. There was evidence that all of the above had been introduced in the day service. However, some but not all had been introduced in the centre and some had not been introduced in an optimal way due to premises constraints. For example, the only area in the centre where the resident used the bean bag was on the first floor landing. It was also recommended in the assessment that visual and auditory distractions be reduced as noise aggravated the resident.

Residents were not supported to move between services, in accordance with their individual wishes, capabilities and choices. In some cases, there was no link between residents' personal plans and the support that was delivered. For example, staff told inspectors that one resident had been identified as having the capacity to move to a more independent house. Although there was a long-running 'immersion plan' to facilitate more independent living for this resident; the area manager confirmed during the inspection that there were no costed and time bound plans in place to progress such a move. Also, the resident had no access to training and limited coaching in life skills. Life skills provided in-house focussed on areas such as cooking and other task-

orientated skills. Three goals that were relevant to participation in activities and the development of life skills outside of the house had not been achieved in 2014. Two of those three goals were not achieved due to staffing arrangements or "staffing issues". In addition, the environmental restrictions in place for another resident were having a negative impact on that resident's capacity to exercise personal independence.

It was not clear from the documentation that the residents' personal plans were done in consultation with residents or their representatives, as appropriate. There was however, evidence of family involvement and that residents were supported to maintain positive family links.

As previously discussed under Outcome 1: Residents' Rights, Dignity and Consultation; there was an unsuitable mix of residents within the centre, which had a negative impact on individual residents. Inspectors found different types of negative impacts on individual residents including on their behaviours that challenge, their personal safety, their capacity to exercise personal independence and their need for their privacy or dignity to be maintained.

For example, staff identified a number of residents who preferred and needed a quiet environment and this was supported in the residents' personal plans. However, the number and mix of residents in the centre did not provide for this preference or need to be met and staff described it as a noisy house. For one resident, this had a negative effect on his behaviour. This was evidenced by charts that identified noise as a recurring trigger to challenging behaviours exhibited by that resident. Also, while one resident needed space and room to move about freely, another resident preferred for doors to be kept closed. From speaking to staff, this incompatibility of needs may have contributed to behaviours that challenge in both residents. In addition, the unsuitable mix of residents contributed to peer-on-peer assaultive behaviour. The fact that the premises did not meet the needs of all residents and the unsuitable mix of residents in the centre will be further discussed under Outcomes 6: Safe and Suitable Premises; 7: Health Safety and Risk Management and; 8: Safeguarding and Safety.

Overall, inspectors found little evidence that the failure to fully assess and meet the social care needs of residents was not solely due to the poor standard of documentation in the house but rather the evidence indicated that this non-compliance was due to deficiencies in the governance and management of the centre. This will be further discussed under Outcome 14: Governance and Management.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the design and layout of the centre did not meet residents' individual or collective needs in an acceptable way and that this failure was at the level of major non-compliance.

The premises did not provide adequate rooms or facilities to meet a number of individual resident's need for quiet. There was no suitable purposeful room in the centre that residents could access as part of a coping strategy to manage their own behaviours that challenge or simply to have some quiet time. For two residents, the design and layout reduced their capacity to exercise personal independence. For the same two residents, they were also restricted in their movements in different ways due to the design of the building. Finally, the environmental restrictions in place for one resident impacted negatively on another resident's capacity to exercise personal independence. The impacts on one resident's right to privacy and two other residents' capacity to exercise personal independence were previously discussed under Outcome 1: Residents' Rights, Dignity and Consultation.

The premises is a two-storey house and each resident had his own bedroom. The premises was clean, tidy and warm. The bedrooms were personalised and tastefully decorated. Staff told inspectors that re-decoration had been carried out recently. This was in response to previous issues relating to the premises as mentioned in the summary of this report. There was adequate heating and ventilation in all areas. There were suitable staff facilities for changing and storage and for resident's personal belongings.

However, inspectors found that some parts of the premises were in a poor state of repair and could no longer be effectively cleaned, in particular the kitchen. The kitchen units were dated and parts of the worktop was damaged. Parts of the bathrooms were also in poor state of repair, for example, grouting was stained or missing from shower and sinks seals. Although overall, the premises was visibly clean, parts of the premises that were difficult to reach or access needed closer attention including: an area behind the sink in the kitchen; gaps between the cooker and kitchen units on both sides and; junctions and corners throughout the premises. The floor covering in the laundry room was also damaged and could no longer be effectively cleaned.

Residents had access to equipment which was appropriate to their needs including shower chairs, hand rails and grab rails. There was evidence of assessment of residents for new equipment which would improve their comfort, for example by an occupational therapist. An assessment for the use of a wheelchair for one resident was outstanding and will be further discussed under Outcome 11: Healthcare Needs.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

There were policies and procedures in place relating to health, safety and risk management. However, overall inspectors found that the arrangements in place to protect the health, safety and welfare of staff and residents were not adequate. Inspectors found this to be at the level of major non-compliance due to the high level of risk identified.

There was a risk management policy in place, which identified the risks specifically required by the Regulations and the arrangements in place to control named risks. There was a safety statement in place and an incident management policy in place that were both up to date.

Although there was a system in place to log any maintenance issues, inspectors found that there was no system in place to complete regular hazard inspections, as necessary to identify new or changing hazards. A system was in place to complete risk assessments and a range of risk assessments had been completed in November 2014. However, inspectors found that the risk assessment system in place was not sufficiently robust. For example, there was no risk assessment for one resident with behaviours that challenge. Also, systems in place relating to the completion of pregnancy risk assessments of staff were not satisfactory. Inspectors reviewed such a risk assessment and found that: it was not comprehensive; it was not clear how the level of risk had been determined; the control measures had not been implemented in full and; the risk assessment had not been reviewed to reflect changes as they arose.

Inspectors found evidence of an unacceptably high level of risk to both residents and staff arising from a number of factors including: the unsuitable mix of residents within the centre; a premises that did not meet the needs of all residents; inadequate staff training and skills; insufficient specialist support to staff in terms of managing behaviours that challenge and poor guidance for staff in relation to the use of therapeutic interventions. These contributing factors are also discussed under Outcomes 4: Admissions and Contract for the Provision of Services, 8: Safeguarding and Safety, 14: Governance and Management and 17: Workforce and in the associated actions.

Inspectors reviewed the incident recording book and residents' files and found that the arrangements in place for investigating and learning from serious incidents/adverse

events involving residents were not sufficient. Adequate measures had not been put in place following serious adverse incidents to prevent them reoccurring. A review of the incident book indicated frequent injury to some residents from peer-to-peer assault (i.e. assault between residents). This will be further discussed under Outcome 8: Safeguarding and Safety and in the associated action.

While there was an incident book in the house, a full record of all incidents occurring was not maintained. Inspectors found that examples of incidents recorded in residents' files that did not have a corresponding incident form completed.

Also, incident recording sheets in residents' files did not correspond with the incident recording book; the incident recording sheet for one resident had not been maintained since June 2014 making it difficult to track and analyse incident patterns and trends. In addition, some incident forms had not been reviewed within a 48 hour period, as required by the organisation's policy on incident recording and reporting. Two incidents for example that occurred on the 9 January and 10 January 2015 had not yet been reviewed on the day of inspection (17 and 18 days following the original incident respectively).

Inspectors found that there were a range of fire safety arrangements in place. All staff had received fire safety training and fire marshal training had taken place. Suitable fire equipment was provided. Fire exits were unobstructed. Inspectors found that all of the required checks and services were in order. Inspectors viewed documentation of regular fire drills, which were carried out on a regular basis. The inspector spoke with staff and found that they were knowledgeable about what to do in the event of a fire. There was a prominently displayed evacuation plan in place.

However, two areas were identified that required improvement in relation to fire safety. First, the evacuation plan was not current as it identified a fire exit that staff said was no longer in use. Also, inspectors noted that this fire exit was locked and a key was not available. It was not clear whether the fire manager had signed off this practice as being safe. Second, a record of the most recent drill (26 November 2014) indicated that the plan in place to manage an individual resident required further review and had not been signed off by the fire manager. The inspector discussed this issue with the area manager during the inspection.

The inspector found that a significant amount of work had taken place in response to previous issues raised in an internal complaint relating to hygiene and infection control in the centre. Staff had received training in hand hygiene and food safety. A cleaning rota had been introduced. Cleaning schedules were in place and were maintained. The premises was clean and tidy. However, inspectors identified three areas for further improvement. First, staff had not received training in relation to environmental cleaning to reduce the risk of the spread of healthcare associated infection. Second, there was no clear system in place for environmental cleaning in line with approved guidelines. Finally and as previously discussed under Outcome 6: Safe and Suitable Premises, parts of the premises could no longer be effectively cleaned.

Judgment:

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found significant gaps in relation to the management of behaviours that challenge and restrictive practices in use in the centre. Inspectors found that the systems in place, including MDT input and specialist behaviour support were not sufficient to support staff to manage the complex range and nature of behaviours that challenge in this centre. Also, the unsuitable mix of residents in the centre was contributing to peer-to-peer abuse in the centre. Inspectors found this to be at the level of major non-compliance due to the high level of associated risk arising from these identified gaps.

Relevant policies were in place, including in relation to the protection of vulnerable adults, restrictive practices, behaviours that challenge, the provision of personal intimate care and residents' personal finances and possessions.

However, inspectors found significant gaps in relation to the management of behaviours that challenge and restrictive practices in use in the centre. Overall, documentation to the management of behaviours that challenge and restrictive practices was confusing, difficult to retrieve and disjointed.

Overall, behaviour management plans did not provide adequate guidance for staff. Inspectors reviewed the files of all six residents and found that only one of the six behaviour management plans provided adequate guidance for staff.

For example, inspectors observed a number of different types of behaviour management plans in use, some relevant information was not dated and it was not clear what recommendations arose out of reviews that had been signed as having taken place. Also, one resident had two behaviour charts in use, one of which was also used for hourly checks at night. Care staff were unable to explain the rationale for this.

In addition, charts that tracked 'antecedents, behaviour and consequences' to a particular behaviour (known as 'ABC charts') were not adequately completed and

contained phrases that could be open to interpretation. For example, inspectors observed repeated references to residents being "re-directed" when displaying behaviours that challenge but it was not clear from behaviour management plans what this meant for each individual resident. There was also an entry in an ABC chart about a resident being "reprimanded" by staff. The inspector discussed this with the acting area manager who said that the entry was of concern to him.

Not all behaviour management plans reflected the current status or situation of the resident. This was found to be the case for three of the six residents. For example, the most recent behaviour management plan for one resident was dated 18 October 2013. However, there was evidence of significant changes to the resident's behaviours since that time and numerous incidents of agitation, aggression and self-injurious behaviour without any corresponding changes to the resident's plan.

For another resident; a report dated 7 May 2014 outlined findings in relation to supporting a resident to manage environmental changes that were having a negative impact on the resident's behaviours. However, no follow-up actions were identified. The report also referred to the fact that the resident required 1:1 staff support in the day service to ensure his and others' safety. However, it was documented that the day service did not have the resources to ensure this ratio and it would result in other residents having decreased staff supports. There was no evidence that this was followed up and addressed and there was no evidence of any further tracking of behaviours since June 2014 (or whether the tracking was no longer required if that was the case).

As previously discussed, there was an unsuitable mix of residents in the centre. Inspectors found evidence of peer-to-peer abuse and care staff reported that individual residents 'targeted' other residents. Some measures had been taken to address this, for example, one staff was assigned to a resident to prevent the targeting of another resident. However, information provided from care staff and evidenced in the incident book indicated that measures in place were not sufficient and the provider had failed to satisfactorily address this issue. For example, care staff identified another resident who was particularly vulnerable and was targeted by one resident; incident records demonstrated that this resident had been pulled out of bed and thrown on the floor by the resident who targeted him on two recorded occasions. This will be further discussed under Outcome 14: Governance and Management.

Restrictive practices in place, including physical, chemical and environmental restraint, were not always in accordance with national policy and evidence-based practice. The evidence did not demonstrate that every effort had been made to identify and/or alleviate the cause of residents' behaviour; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure was used. Examples include as follows: As discussed above, there was an unsuitable mix of residents in the centre which contributed to peer-on-peer assaultive behaviour in the centre. There was no link between one resident's behaviour management plan and the use of chemical restraint i.e. it was not sufficiently clear at what point chemical restraint could or should be administered. A seclusion protocol was in place for one resident and inspectors found conflicting and contradictory information pertaining to the use of this procedure. For example, MDT minutes indicated that the use of seclusion should be phased out and that during the phasing out period, incidents relating to the use of the

area for seclusion should be tracked. These recommendations were not contained in the resident's personal plan or risk assessment. As a result, some staff still used the seclusion area while others did not. Also, no current document was being maintained to log incidents or the use of seclusion, as had been recommended by the MDT. Finally, seclusion had been used for a second resident and this had not been approved by MDT.

In addition, not all staff had up to date training in intervention techniques that had been approved for use by the MDT. Relevant issues regarding staff training, skills and knowledge are further discussed under Outcome 17: Workforce and in the associated action.

The inspector spoke with staff on duty who displayed awareness and understanding of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. However, not all staff had up to date training in relation to the protection of vulnerable adults. This is further discussed under Outcome 17: Workforce and in the associated action.

Judgment:

Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

Adverse incidents were notified in writing to the Authority. However, incidents of peer-on-peer abuse were not notified to the Authority as abuse, as required.

A written report at the end of each quarter in relation to incidents occurring in the house was submitted as required. However, the quarterly submission did not include all of the incidents that are required to be notified to the Authority. For example, not all incidents of chemical or environmental restraint were included.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

Although staff supported residents in meeting their day to day health and nutritional needs, some residents' health needs were not fully met. The part of the residents' personal plans that related to health did not always reflect the actual needs of residents. Also, access to allied healthcare professionals was not always facilitated. Inspectors found that these failings were at the level of major non-compliance.

Inspectors reviewed a sample of residents' care plans.

Residents had access to a general practitioner (GP) and specialist consultants where required (psychiatry, respiratory).

While residents had access to allied health care services and there was evidence of assessments in residents' files; not all assessments were facilitated. For example, a sensory assessment for one resident with sensory needs had been cancelled twice and there was no evidence in the resident's file of a new assessment date. The file of another resident referenced that the resident was to be assessed for the use of a wheelchair, however, there was no evidence that this assessment had been carried out.

While care plans were in place, there was no evidence that clinical risk assessments had been carried out prior to establishing the care plans. As a result, the part of the residents' personal plan that relates to health did not always reflect the actual needs of residents. In addition, where risks or needs had been identified, care plans had not always been completed. Inspectors found examples where care plans had not been completed for residents with complex healthcare needs or risks relating to the areas of hydration, oral care, fluid intake, communication, falls, continence and the administration of medications.

The centre's method of the transcription of medication was not as per the centre's policy or as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. The inspector reviewed four residents' medication prescription charts and medication administration charts and found that: transcribed medications did not have any signatures of the transcribing nurse/s; transcribed medications were not dated and; it was unclear when the General Practitioner (GP) reviewed the medications transcribed by the nurse/s, which in turn made it difficult to ensure that the organisation was adhering to its own policy in relation to the practice of transcribing.

Staff were knowledgeable about individual residents' health needs and were observed supporting and assisting residents (where required) in a dignified manner. A daily record of care was recorded in a care plan note. There was evidence of a continence

programmes for residents. Staff had received training on the assessment of incontinence wear to ensure that residents benefited from the correct incontinence wear. Fluid balance charts and medication prescription/administration charts accompanied the residents when they went to their day services. Care staff stated that the charts were filled in accordingly by the staff in the day centre. However, the fluid balance chart for one resident with specific hydration instructions was not filled in while the resident was in the day service that month (i.e. weeks beginning 5, 12, 19 January 2015) and the person in charge had not taken suitable action to remedy this deficit in recording care.

Overall, residents' food and nutritional needs were met by staff in the centre. Staff were able to describe each individual resident's food likes and dislikes. There was evidence that residents had an input into the weekly menu. However, there were no pictorial menus or other means in place to aid residents in making meal choices. Snacks were readily available, the fridge and cupboard were well stocked. Residents had their meals in the dining room adjacent the main kitchen. A risk assessment had been completed for a resident at risk of choking and the resident had been assessed by a speech and language therapist. Staff were able to demonstrate that medical and allied health advice provided in relation to food and nutrition was being followed. However, most, but not all staff had received relevant training in food safety (HACCP training), as required under relevant food safety legislation. Staff had also received training in relation to assisting residents with their meals and some staff had received training in relation to the identification and assessment of residents at risk of malnutrition. There was evidence that staff had attended in-house training on the use of Percutaneous Endoscopic Gastrostomy (PEG) tube for nutritional support.

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):

This was the centre's first inspection by the Authority.

Findings:

The centre had an up to date policy on medication management practice. However, the medication management policy did not guide or inform care staff on the administration of oxygen, which was in use in the centre.

Medication, via a blister pack system, was supplied by a local pharmacist.

The inspector saw that medications were securely stored and no medications requiring

stricter controls (MDAs) were currently in use.

Each resident had a medication prescription and administration record, signed and dated by the relevant GP. The maximum dosage and time for medication prescribed and administered on an as required basis (PRN) was documented. Medications no longer prescribed were clearly signed and dated as discontinued.

However, the centre's method of the transcription of medication was not as per the centre's policy or as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. The inspector reviewed four residents' medication prescription charts and medication administration charts and found that: transcribed medications did not have any signatures of the transcribing nurse/s; transcribed medications were not dated and; it was unclear when the GPs reviewed the medications transcribed by the nurse/s, which in turn made it difficult to ensure that the organisation was adhering to its own policy in relation to the practice of transcribing. This was previously addressed under Outcome 11: Healthcare Needs and in the associated action.

One resident was prescribed oxygen on as required basis (PRN). While staff demonstrated knowledge with regard to medication management and administration, staff had no knowledge of oxygen therapy, the dosage of oxygen, the precautions that should be in place or of how or when to administer oxygen to the resident. Staff stated that they had not received training on this matter. This will be further discussed under Outcome 17: Workforce.

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):

This was the centre's first inspection by the Authority.

Findings:

Overall, inspectors found that the provider had failed to ensure that effective systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively managed.

The person in charge was on leave at the time of inspection and the person deputising in her absence was off-duty. A new person in charge was due to commence in the role the following month on a permanent basis. The area manager was also on leave and there was an acting area manager in place, who also looked after other areas. Inspectors met with care staff on-duty and the acting area manager, who visited the centre during the inspection.

Inspectors reviewed the duty roster, which identified who was in charge on any particular day.

There were systems in place to support the person deputising in the absence of the person in charge, including an acting area manager. Staff confirmed that the both parties were supportive and approachable.

Regular house meetings took place and a recent system had been introduced whereby house meetings had an agenda and minutes were kept of such meetings. Inspectors viewed such minutes and found that included discussion of issues relevant to the care delivered to residents.

There was a system in place for the completion of annual staff appraisals. Inspectors spoke with staff who confirmed that such appraisals took place.

An unannounced visit by the provider nominee had taken place in December 2014, as required by the Regulations. The visit covered a range of key outcomes. However, the inspector found that a number of issues identified in the visit had not been translated into actions. For example, the need to repeat an infection control audit was not included as an action and the need for all fire risk assessments to be signed off by the fire manager had not been adequately addressed.

As mentioned in the summary of this report, this inspection was carried out in part on foot of a notification received outlining areas of concern in the house. Although a number of improvements had been implemented at local level to address issues relating to poor hygiene and cleaning standards and poor medication management; some areas had not been addressed in full. For example, although increased staffing levels had been introduced in the house since the internal investigation took place; it was unclear whether these levels met the specific ratios required by individual residents. This will be further discussed under Outcome 17: Workforce. Also, the lack of activities for service users had not been adequately addressed. In addition, while a new person in charge was commencing in the role, it was not clear whether a review of the governance systems in place had commenced or been completed.

The provider had failed to ensure that effective systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively managed. Inspectors found major non-compliances across nine other outcomes: Outcomes 1: Residents' Rights Dignity and Consultation, Outcome 4: Admissions and Contract for the Provision of Services, 5: Social Care Needs, 6: Safe and Suitable Premises, 7: Health, Safety and Risk Management, 8: Safeguarding and Safety, 10: Notification of Incidents, 11: Healthcare Needs and 17: Workforce. As discussed in the

aforementioned outcomes, the provider had failed to ensure, insofar as is reasonably practicable, that: residents were protected from abuse by their peers; incidents of peer-to-peer abuse were notified to the authority as abuse; the centre was managed in a way that maximised residents' capacity to exercise personal independence and choice in their daily lives; the design and layout of the centre met residents' individual or collective needs in an acceptable way; staff received the support they needed to deliver safe, quality care; that staff had the right skills, qualifications and training to meet the assessed needs of residents at all times or that the assessed social and health needs of residents were fully met.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that overall, the number and skill mix of staff was not appropriate to the number and assessed needs of the residents. Not all mandatory training was up to date and staff required training in some areas relevant to their roles and responsibilities.

An actual and planned staff rota was maintained and indicated who was in charge at any one time. Care staff on-duty explained that staffing levels had been increased from three to four staff during the day; this was in response to the notification and issues mentioned in the summary of this report. A number of staff said that this had made a very positive difference. Inspectors reviewed the duty roster and noted a number of occasions when only three staff members were on duty. This was in breach of a risk assessment that specified a control measure as having four staff on duty at all times.

Despite the recent increase in staffing levels from three to four staff (on most days), staffing levels required further review as it was not evident that the staffing levels met the needs of the residents. As previously mentioned under Outcomes 1: Privacy, Dignity and Consultation and 5: Social Care Needs; staff reported that that activities were often dictated by the level of challenging behaviours occurring at any one time in the centre and personal plans evidenced times where activities had been cancelled due to staffing issues or for undocumented reasons.

In addition, a physiotherapy report dated 7 January 2015 noted that a resident who was blind required the assistance of two staff when mobilising and it was stated in the report that it was unsafe for the resident to use the stairs. The current staff compliment required review to ensure that this recommendation was adhered to as two of the four staff on-duty were already engaged on a 2:1 assignation with one resident and a second resident required 1:1 supervision.

Inspectors found that despite the efforts of staff to support residents in their day to day lives, to meet individual resident's diverse and often conflicting needs and to keep residents safe from injury; staff did not have the support, training or skills that they required to fully achieve this. This finding was evidenced in a number of ways including: the poor standard of documentation overall; the lack of guidance provided in five out of six behaviour management plans; the use of broad terms when completing ABC charts; one inappropriate entry in an ABC chart; the finding that some of the residents' health needs had not been met; gaps in mandatory training and; the low level of staff with specialist behaviour training in the house.

Also, staff reported that they had not received specific training to support residents to engage in activities that were meaningful to them. As previously mentioned in Outcome 1: Privacy, Dignity and Consultation; there was evidence that opportunities for residents to engage in activities that were appropriate and meaningful to them were limited.

There was a system in place for the induction of new staff an induction log was completed for new staff members. This included centre policies, routines, observation skills, incident reporting and fire safety.

There was a training plan in place and the annual staff appraisal system facilitated the identification of staff training needs. Inspectors spoke with staff who confirmed what training they had received and records of training were reviewed. Mandatory fire safety training was up to date.

However, other mandatory training as required under the Regulations was outstanding. As previously mentioned under Outcome 8: Safeguarding and Safety, not all staff had received up-to-date training in the protection of vulnerable adults. Not all staff had received up-to-date training in the management of behaviour that challenges or refresher training for the Therapeutic Management of Aggression and Violence (TMAV). This was noteworthy as inspectors identified three TMAV moves that had been approved by the MDT for use.

All staff had up to date manual handling training. However, not all staff had received training in food safety as required by relevant food safety legislation for food handlers. As previously mentioned under Outcome 12: Medication Management, staff required training in relation to oxygen therapy. Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to medication management, hand hygiene and infection control. Some staff had received training in relation to the use of a tool to assess an individual's risk of malnutrition and dehydration, basic first aid and challenging behaviour with autism.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place.

Staff files were not reviewed on this inspection as they are held centrally off-site and not in the designated centre.

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 report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003951
Date of Inspection:	27 January 2015
Date of response:	23 February 2015

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Three practices were identified that impinged on the privacy and dignity of the residents in the house. Staff were carrying out hourly checks on all residents throughout the night and a CCTV system was in place in one resident's bedroom. The privacy of another resident was impinged upon due to the unsuitable mix of residents in the centre.

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

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

- The use of CCTV in the centre will be discontinued on 05/03/2015. Due to the complex medical care needs of the resident, a written protocol will be in place for supervision needs at night time.
- The practice of hourly checks during the night on service users will be reviewed at an MDT meeting, a written protocol will be in place directing the night staff of supervision needs and frequency of the checks required by each of the service users during the night.
- The restrictions in place for some service users that impact on the rights of other residents will be reviewed, alternatives to restrictions will be examined.
- There will be a service user review group commenced to review all service users in the centre and recommendations made regarding future accommodation needs. Service users and their families will be included in this review process.

Proposed Timescale: 30/03/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Opportunities available to residents to participate in meaningful activities were limited

Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

All service users care plans and behaviour support plans are currently under review. There is a specific focus included on the area of meaningful activities for service users in the centre. This will include an assessment and review of individualised activities for each resident, each service user will have a schedule of activities that they enjoy participating in. The PIC and House manager will review rostering of staff so as to facilitate these activities of choice with each individual service user in particular at weekends. The PIC and House Manager in the centre will review the attendance and participation in individualised activities and ensure they are meaningful to the individual. There is a CNM3 from another part of the organisation attending the centre for 2 days on week commencing 23/02/2015 to support the staff around the area of planning activation.

Proposed Timescale: 14/03/2015

Theme: Individualised Supports and Care

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

The complaints policy was not in a format that was user-friendly to all residents.

Action Required:

Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

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

The house manager will facilitate a residents meeting in the centre to outline specifically the process for residents to make a complaint. There is an easy read version of the complaints policy; this will be displayed in an area that can be easily accessed by all residents. One resident has a visual impairment; the key worker will focus additional time to this resident explaining the complaints process for residents. The PIC will liaise with the house manager to determine the understanding of the service users re the process and the easy to read version, if a review of the document is recommended this will be undertaken.

Proposed Timescale: 14/03/2015

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:

It was not clear from the documentation that the residents' personal plans were done in consultation with residents or their representatives, as appropriate.

Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The House manager and PIC will arrange reviews for each service users care plan and person centered plan. The service user and their family/representative will be invited to attend this review also. The service user's key worker from residential and day services will be in attendance along with the house manager and the person in charge. Where review meetings were recently held, if residents and families were not in attendance, they will be rescheduled. Where actions and recommendations were not followed up on, these will also be reviewed by the house manager and the person in charge and

staff/managers will be delegated responsibility for supporting action on these recommendations.

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

Each resident did not have a comprehensive assessment of their personal, social, developmental and support needs.

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:

The newly appointed house manager is a nurse; he is registered on the intellectual disability nursing register. The house manager will with all staff review the care plans for service users in the centre. The person in charge and the assistant director of nursing will also support staff in this process of reviewing all care plans, in particular the assessment of service user care and support needs. Where there are health care needs, this aspect of the plan will be completed by a registered nurse.

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

The house was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the house and in some cases, the design and layout of the house.

Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

- An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. This house will accommodate 5 individuals in total. Residents from this centre and one other designate centre will be prioritised to determine who will reside in the new centre. The number of residents in the centre will then decrease.
- The service users who will move from the centre will be determined through a service

user review group which will include participation from the service users and families. The review group will commence by 20/03/2015.

- The nominee provider, mdt , person in charge and staff from the centre will review each individual service user in the centre, and who have friendships and would enjoy residing together. Also current restrictions imposed on others due to the current environment and peer group will be taken into consideration, and where living away from another peer will benefit both this will be facilitated.

Proposed Timescale: 20/03/2015

Theme: Effective Services

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

The system in place for the review of personal plans did not meet the requirements of the Regulations. For example, personal plans were not always current nor were they reflective of resident's changing needs.

Action Required:

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

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

- The person in charge will audit the care plans in the area.
- The house manager will with all staff review the care plans for service users in the centre. The person in charge and the assistant director of nursing will also support staff in this process of reviewing all care plans, where there has been change in care needs and support needs of a service user these will be included in the revised plan of care.
- There will be training delivered to the staff in house from a CNM3 from another part of the organisation in the area of care planning and documentation of changes to care needs, this will take place week commencing 02/03/2015.

Proposed Timescale: 30/04/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The organisation's policy in relating to incident recording, reporting and management was not being implemented and adequate measures had not been put in place following serious adverse incidents to prevent them reoccurring.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management

policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

- All staff will receive training on the procedure for recording and reporting incidents.
- The person in charge will review incident reports in the house on a daily basis, supporting staff to identify control measures to reduce the likelihood of recurrence. These control measures will be documented on both the incident form and in the service user care plan.
- All risk assessments of service users will be reviewed, and where control measures are not adequate to support the service user to manage in relation to their challenging behaviour, there will be additional control measures included. A CNM3 from another part of the organisation with responsibility for supporting centres in risk assessment and challenging behaviour will this provide in house support to staff and managers in the centre.
- The person in charge assigned to the centre will audit incidents reports 3 monthly. They will feedback to the house manager and staff and nominee provider, and detail actions required from the audit.
- There is a weekly walk around hazard inspection as part of the service policy on management of risks, this will be completed weekly by the house manager and any new hazards identified will be risk assessed and control measures put in place.
- The Quality and Risk officer will deliver training to all staff in the centre on the risk management policy.
- All service users will have MDT reviews arranged and all MDT members involved in service user's care will be included. Recommendations will be outlined and persons responsible for actions and recommendations will be identified. The person in charge will arrange these MDT reviews.

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

Inspectors found evidence of an unacceptably high level of risk to both residents and staff in the centre from frequent assaultive behaviours.

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:

- All risk assessments of service users will be reviewed, and where control measures are not adequate to support the service user to manage in relation to their challenging behaviour, there will be additional control measures included. A CNM3 from another part of the organisation with responsibility for supporting centres in risk assessment and challenging behaviour will this provide in house support to staff and managers in the

centre.

- There is a weekly walk around hazard inspection as part of the service policy on management of risks, this will be completed weekly by the house manager and any new hazards identified will be risk assessed and control measures put in place.
- The behaviour support plans of all individual service users will be reviewed; to include management and support of the service users should their challenging behaviour occur. The staff team are being supported to review these plans by a nurse manager, who is also an instructor for the service in the therapeutic management and aggression of violence, referred to as TMAV training. This is a recognised training programme for staff to equip them with the necessary skills to support service users that present with behaviours that challenge. The psychologist providing support to each individual service user is also involved in the development of the behaviour support plan with this team, and in the training of staff in the management and support of service users that present with challenging behaviour.
- An environmental risk assessment will be completed by the person in charge and house manager, any hazards and contributing factors to challenging behaviour that are identified will be removed or have additional control measures put in place to reduce the risk of injury to service users or staff should a challenging behaviour incident occur.

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The provider had not ensured that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. For example, staff had not received training in relation to environmental cleaning; there was no clear system in place for environmental cleaning in line with approved guidelines and; parts of the premises could no longer be effectively cleaned.

Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

- All staff will receive further training in standard precautions and hand hygiene. Part of this training includes environmental cleaning and household standards.
- A CNM3 from another part of the organisation, who has specific responsibility for cleaning standards and infection control, will support the PIC, house manager and staff in the house in this area. This will include doing the centres hygiene audit with staff and detailing actions and outcomes from the audit. There will be cleaning logs implemented in the centre, and on a daily basis the house manager will assign staffs responsible for areas in the centre.

Proposed Timescale: 31/03/2015

Theme: Effective Services

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

Improvements were required in relation to evacuation procedures. The evacuation plan was not current and the fire manager had not signed off on the plan in place one resident.

Action Required:

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

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

- The fire evacuation plan for the centre will be reviewed by the fire manger and house manager. All individual service users specific evacuation support plan will be reviewed by the house manager and fire manager. Any changes to these will be in writing and all staff will be informed of changes.
- A fire evacuation drill will be carried out in the centre following review of the evacuation plan to ensure that the revised plan supports the needs of all service users.

Proposed Timescale: 31/03/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff did not have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Action Required:

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

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

- All staff supporting service users in the centre will receive refresher training in Challenging Behaviour.
- Staff in the centre have received in house support since 09/03/2015 from a nurse manager who is also a TMAV (Therapeutic management of aggression and violence) instructor from another part of the organisation, this manager has also given direct support to staff regarding the development and implementation of service user behaviour support plans. This support has been on-going for two weeks and will continue for one day per week for the next 4 weeks.

- All service users will have MDT reviews arranged and all MDT members involved in service user's care will be included. Recommendations will be outlined and persons responsible for actions and recommendations will be identified. The person in charge will arrange these MDT reviews.
- There is since the authority's inspection a written protocol in place for all staff on how to call for support in the event of a challenging behaviour incident in the centre requiring additional staff support from outside of the centre.
- The recruitment process is underway for a CNM2 for the centre; this manager will have experience in management and supporting service users with challenging behaviour. The house has also had a house manager appointed on 09/02/2015, this manager is a nurse trained and registered on the intellectual disability nursing register.
- The recruitment process is underway for CNM3 posts x 2, one of these managers will be a direct link to the centre, while both will be available when on duty to the centre.

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

Not all staff had up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques approved for use in the centre.

Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

- All staff since the Authority's inspection have received training in TMAV. The person in charge and House manager will ensure that refreshers are scheduled for staff, and if additional instruction is required outside of refresher due dates this will be facilitated.
- The behaviour support plans of all individual service users will be reviewed; to include management and support of the service users should their challenging behaviour occur. The staff is being supported to review these plans by a nurse manager, who is an instructor in the therapeutic management of aggression and violence and experience working with people with behaviours that challenge. Documentation in the behaviour support plan includes de-escalation and intervention techniques individual to the service user.
- The psychologist providing support to each individual service user is also involved in the development of the behaviour support plan with this team, and in the training of staff in the management and support of service users that present with challenging behaviour.
- All behaviour support plans for service users have set review dates, however where a plan is not meeting the needs of service user it will be reviewed by the team supporting the individual before the review date.

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

The person in charge had failed to ensure that every effort was made 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.

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:

- All service users will have MDT reviews arranged and all MDT members involved in service user's care will be included.
- Psychological assessments for each service user will be reviewed, where these assessments are out of date, or where new behaviours have presented the service users will be reviewed by the psychologist.
- All restrictive practices in place in the centre will be reviewed by the restrictive practices committee, the PIC and house manager will be included in this review.
- The behaviour support plans of all individual service users will be reviewed; to include management and support of the service users should their challenging behaviour occur. The staff are being supported to review these plans by a nurse manager, who is a TMAV instructor and experience working with people with behaviours that challenge. Staff will identify the behaviour and any triggers to the behaviour, through the review of risk assessments there will be control measures implemented to reduce or remove triggers to behaviour where they are identified. Support for staff in the area of risk assessments will be delivered by a CNM3 nurse manager from another part of the organisation.
- The psychologist providing support to each individual service user is also involved in the development of the behaviour support plan with this team, and in the training of staff in the management and support of service users that present with challenging behaviour.
- All behaviour support plans for service users have set review dates, however where a plan is not meeting the needs of service user it will be reviewed by the team supporting the individual before the review date.

Proposed Timescale: 30/04/2015

Theme: Safe Services

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

Systems in place for the use of physical restraint were not acceptable. Not all staff had up to date training in techniques that had been approved for use by the MDT.

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:

- All restrictive practices in place in the centre will be reviewed by the restrictive practices committee, the person in charge and house manager will be included in this review.
- All staff since the authority's inspection has received training in TMAV. The person in charge and House manager will ensure that refreshers are scheduled for staff, and if additional instruction is required outside of refresher due dates this will be facilitated.
- All staff and the person in charge of the centre will receive training on the national and service policy on restrictive practices from the assistant Director of nursing who sits on the restrictive practices committee.
- All prescribed use of PRN ('as required') medication will be reviewed by the psychiatrist supporting each service user.
- All service user support plans and the recommendations in same will be reviewed by the person in charge and the house manager. The person in charge and house manager will link with meet with all staff in the centre and explain and support them in the process of how to action MDT recommendations in each individuals care plan.
- The nominee provider, staff team and MDT involved in service users care will review the protocols in place for the use of seclusion in the centre, the team members involved in the relevant services users care will meet and agree the least restrictive measures to support service users, this meeting will take place on 04/03/2015. Where seclusion is not an agreed intervention by a full mdt, the practice will not occur with immediate effect.

Proposed Timescale: 14/04/2015

Theme: Safe Services

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

The provider had failed to adequately protect residents from abuse by their peers.

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:

- Recommendations from the concern and welfare process were reviewed to establish that the recommendations and actions have been followed.
- Increased staff support for the vulnerable person, this service user has a 1:1 staff supports for the wakening hours.
- The implementation of greater choice of activities and activity schedule for service

users to support them to have time away from the larger peer group and the centre doing individualised activities. These activities and service users participation is logged in the care plans.

- Risk assessments have been reviewed for all service users in the centre.
- Staff received support from an instructor in the therapeutic management of aggression and violence and the psychology team to review and develop behaviour support plans for each service user.
- An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. The house will accommodate 5 individuals in total. Residents from this centre and one other designate centre will be prioritised to determine who will reside in the new centre. The number of residents in the centre will then decrease, the service users who will move from the centre will be determined through a service user review group which will include participation from the service users and families and MDT members. The review group will commence by 20/03/2015. The residents in this centre who are most vulnerable from abuse by their peers will be prioritised for alternative accommodation away from the centre.
- All staff have received up to date training in the management and protection of service users from abuse.
- All staff have received up to date training in the management and support of service users who present with behaviours that challenge.

Proposed Timescale: 14/04/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Incidents of peer-on-peer abuse were not notified to the Authority as abuse. Not all incidents of chemical or environmental restraint were included in the quarterly submission.

Action Required:

Under Regulation 31 (1) (a) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.

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

- All PICs and House managers have received training in their role and responsibilities under the regulations since the authority's inspection. All incidents of restraint be they chemical or environmental will be included in the quarterly reports to the authority. All incidents of peer to peer abuse will be notified to the authority.

Proposed Timescale: 20/03/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Access to allied health services was not always facilitated.

Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

- Any service user requiring the services of other allied health professionals will be afforded same. Referrals to professional outside of the centres MDT supports will be arranged and the service user will be facilitated to attend by staff. The PIC and home manager will review each service users care plans and establish if external supports were advised or recommended, these will be arranged by the staff team or through the service user's general practitioner.
- The supports of a CNS in nutrition will be obtained from another part of the organisation to support staff to meet the needs of service users in the centre, around menu planning etc.
- Where existing MDT staff are not meeting the needs of service users, MDT supports will be contracted on an individual basis to support service users.

Proposed Timescale: 30/04/2015

Theme: Health and Development

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

Where risks or needs had been identified, care plans had not always been completed. Also, the centre's method of the transcription of medication was not as per the centre's policy or as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management.

Action Required:

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

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

- The medication policy has had addendum circulated to include clearer practice on transcribing. A nurse prescriber will link with the medication co coordinator for the centre and ensure that best practice is adhered to. The local guidelines for transcribing will be reviewed and brought to the organisations drugs and therapeutics committee for approval.

- The nurse prescribers will audit the transcribing practices and feedback to the drugs and therapeutics committee.
- All service users care plans in the centre are currently being reviewed; the newly appointed house manager is a registered nurse in intellectual disability and will lead this review with the PIC.
- All risk assessments of service users will be reviewed, and where control measures are not adequate to support the service user to manage in relation to their challenging behaviour, there will be additional control measures included. A CNM3 from another part of the organisation will support staff in the review and completing of new risk assessments for service users.

Proposed Timescale: 20/04/2015

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:

Staff had no knowledge of oxygen therapy, the dosage of oxygen, the precautions that should be in place or of how or when to administer oxygen to a resident prescribed oxygen.

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 has had addendum circulated to include clearer practice on transcribing. A nurse prescriber will link with the medication co coordinator for the centre and ensure that best practice is adhered to. The local guidelines for transcribing will be reviewed and brought to the organisations drugs and therapeutics committee for approval. The nurse prescribers will audit the transcribing practices and feedback to the drugs and therapeutics committee.
- All direct care staff will receive training in the administration of oxygen therapy, this will ensure that at all times there will be a trained staff in the centre competent in the administration of oxygen should a service user require same.

Proposed Timescale: 30/04/2015

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 provider had failed to ensure that effective systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively managed.

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 newly appointed house manager commenced in the centre on 09/02/2015. This manager is a registered nurse in intellectual disability. This house manager is based in the centre and is responsible for the management of the centre and will support the person in charge in the management of the centre.
- A change of Nominee Provider was appointed on 09/02/2015
- The recruitment process for a full time CNM2 has commenced, the appointed person will have experience at management level, have experience working with people with intellectual disability and challenging behaviour needs. This CNM2 will be the PIC when appointed to the centre.
- The recruitment process has commenced for 2 x cnm3 full time posts. The CNM3 post holders will provide clinical leadership and support to the centre.
- The supports of a CNM3 from another part of the organisation two days per week are currently in place, until the new appointments are in place.

Proposed Timescale: 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

It was not demonstrated that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents and the size and layout of the designated centre.

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:

- A newly appointed house manager commenced on 09/02/2015, he is a registered nurse on the intellectual disability register. This house manager is based in the centre and is responsible for the management of the centre and will support the person in charge in the management of the centre.
- The recruitment process has commenced for a Clinical Nurse Manager 2 to be

appointed to the centre, this person following recruitment will be the named person in charge for the centre.

- The recruitment process has commenced to appoint 2 x CNM3 posts who will provide daily support (although not centre based) to the centre, its residents and staff.
- The nominee provider with the house manager and PIC will review the staffing supports to the centre.
- The nominee provider will review complement of staff in cost centre with the Director of Finance and the Director of HR. Recruitment process has commenced to replace vacant posts in the centre and to replace agency staff hours with permanent staff.
- Funding has been approved for the training of staff to FETAC level five; the staff in the centre will be given priority to commence this training. This training course will be rolled out over the year.
- The training needs analysis for internal training needs has been completed by the quality and risk office, this will be reviewed by the quality and risk officer and the nominee provider and training needs

Proposed Timescale: 30/05/2015

Theme: Responsive Workforce

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

Mandatory training as required under the Regulations was outstanding. Not all staff had received up-to-date training in the protection of vulnerable adults. Not all staff had received up-to-date training in the management of behaviour that challenges or refresher training for the Therapeutic Management of Aggression and Violence (TMAV). Other training relevant to staff roles and responsibilities was outstanding: some staff required training in food safety; staff had not received training to support residents to avail of meaningful activities nor had they received training in oxygen therapy.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- The nominee provider and quality and risk offer will meet week commencing 02/03/2015 to review the training records of the centre, and with the house manager schedule dates for outstanding training for all staff.
- Since the authorities inspection the following training has been carried out for staff in the centre, Service User Protection and Welfare training, Challenging behaviour training, TMAV training, Food Safety training, Hand Hygiene refresher training, CNM3 support in the area of meaningful activities for service users, training in oxygen therapy to be organised.

Proposed Timescale: 30/04/2015

