Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Autism West Limited
Centre ID:	OSV-0002065
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Autism West Limited
Provider Nominee:	Michael Dooley
Lead inspector:	Lorraine Egan
Support inspector(s):	Nan Savage
Type of inspection	Announced
Number of residents on the date of inspection:	5
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 July 2014 10:35	09 July 2014 17:40
10 July 2014 09:35	10 July 2014 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

As part of the inspection, inspectors met with residents, members of management and staff members and interviews were held with the person in charge and the provider.

The inspectors observed practice and reviewed documentation such as residents' personal plans, health plans, medical information, medication records, the centre's policies and procedures, staff training records and staff files.

There was evidence the provider and the person in charge had implemented measures in response to the previous inspection report and action plan, such as

improvements to the physical environment, training for staff, the completion of personal plans and the facilitation of opportunities for some residents. However, significant improvement was required to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Inspectors found on this inspection that the designated centre did not comply with the requirements of the Regulations in regard to residents' rights and consultation, resident communication needs, resident family and personal relationships, contracts for the provision of services, resident social care needs, resident health care needs, resident general welfare and development, medication management, health and safety and risk management, safeguarding and safety, governance and management, workforce, notification of incidents, use of resources, statement of purpose and records and documentation.

The inspectors' findings are detailed in the body of the report and the areas for improvement are set out in the Action Plan at the end of the 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was improvement since the previous inspection in regard to consultation and the implementation of the complaints process. However, further improvement was required to the policy and procedure for responding to complaints and ensuring residents were aware of their right to make a complaint. While external advocacy services had been booked, improvement was required to the provision of advocacy for residents, consultation with residents and terminology used in documentation.

An inspector viewed documentation pertaining to resident meetings which had been held in the centre. Meetings had commenced in June 2014 and five meetings had taken place. Minutes of the meetings showed that residents had been given an opportunity to have their say in the running of the centre, for example, residents had an input into the recently improved decor of the centre and choice of personal furniture. However, improvement was required to ensure that this consultation was strengthened on an ongoing basis to include all aspects of residents' lives, such as day to day support, personal plans and use of restraint.

Residents had not been supported to access an advocacy service to-date, however, an inspector was informed that the national advocacy service were due to visit the centre in August 2014. The person in charge told inspectors that residents would be supported to access this service.

The terminology used by some staff and in some documentation required improvement as it was not contemporary or respectful to the residents. For example, use of the word patient as opposed to resident.

A psychologist had carried out individual assessments with residents and there was evidence that some of these recommendations had been facilitated while others had not been facilitated and some residents had not been supported to access facilities for occupation. In addition, the assessment for eliciting residents' interests was not adequate.

An inspector viewed the arrangement for assisting residents to manage their financial affairs and not all residents had control over their financial affairs resulting in limitations on their day to day choices.

Some residents were supported to participate in and consent to decisions about his or her personal care while others were not afforded the same support. For example, some residents had not participated in decisions in relation to their day to day support or consented to the use of physical restraint in response to their behaviours that challenge.

The policy for the management of complaints in the centre required improvement. Some aspects of the policy did not provide adequate guidance. For example, it did not state who would appoint the investigation team should one be required and it stated that a review officer would be appointed by the Health Service Executive (HSE). The appeals process was not clear and stated that appeals must be made to the Ombudsman.

The policy did not identify the person nominated to deal with complaints and maintain a record of all complaints. The person in charge told the inspector that she was responsible for the management of complaints in the centre. In addition, the policy did not identify the person nominated by the provider to ensure that all complaints were appropriately responded to and records maintained.

The policy outlined a range of measures which had not been implemented in practice. For example, the policy stated that information and training would be provided for residents and that an information booklet detailing residents' right to make a complaint would be provided. However, an inspector found that these were not in place in the centre.

The procedure was not available in an accessible format appropriate to the needs of the residents and was not displayed in a prominent position in the centre.

Judgment:
Non Compliant - Major

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors viewed the arrangements for assisting residents to communicate and found that improvements were noted in some areas since the previous inspection. However, further improvement was required to ensure residents' communication needs were met.

Some resident personal plans contained a basic assessment of residents' communication needs which were reflective of practice. However, some of these plans did not provide clear guidance to ensure the resident was supported in relation to their communication needs.

Some residents had access to personal technology devices and an inspector noted staff supporting residents to use these devices. However, residents had not been formally assessed to determine their communication needs and develop an associated plan to support residents and guide staff practice. As a result appropriate assistive technology and aids had not been adequately identified to promote residents' full capabilities.

Since the previous inspection a psychologist had carried out an assessment which identified some ways in which residents could be supported to communicate. However, the person in charge and staff had not responded adequately to ensure all residents were supported in line with these assessed needs and recommendations.

The person in charge told an inspector that she had made a referral for speech and language therapy for all residents and was awaiting appointments.

Judgment:
Non Compliant - Major

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Improvement in the contact between the centre and the residents' family members since the previous inspection was evident. Inspectors found evidence of good contact between residents and their families. Residents were supported to spend time with their

families and loved ones on a regular basis and family members had been updated on changes to the centre and on the arrangement for the national advocacy service to visit the centre. However, some questionnaires received from families indicated that families required further support to participate in and be actively involved in the lives of residents.

Some residents had been supported to gain work experience in the local community. However, further improvement was required as some residents were not assisted to develop and maintain personal relationships and links with the local community.

There was no evidence that some residents had appropriate opportunities to make friends external to the centre or were supported to develop relationships outside the centre. Documentation viewed showed that a resident's contact with friends was documented as an incident by staff. This had not been addressed by the person in charge.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Residents had been living in the centre for many years. Questionnaires submitted to the Authority from family members stated they had visited the centre with the resident prior to admission to the centre. The provider told the inspector that residents had received a contract from the previous organisation the centre was affiliated with. However, contracts issued by the current provider were not available for review during the inspection.

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

Findings:
Staff had received training in developing personal plans and an improvement was evident in that a number of personal plans had been reviewed and updated since the previous inspection. There had also been some multi disciplinary input into the creation of personal plans. However, a number of personal plans required further improvement as some plans were more detailed and comprehensive than others and there was no evidence that the plans were consistently being reviewed.

A number of assessment tools were being utilised and multiple assessments were used in some areas. It was difficult to ascertain how the information being gathered was used to inform development of some plans. The follow up from these assessments was not adequate and all personal plans did not outline the supports required to maximise residents' personal development.

There was no evidence that residents had been involved in the preparation of the plan or in the identification of goals. Some goals were identified through an assessment which was carried out by a psychologist however, there was no specific plan in relation some recommendations arising from the psychological assessment. Furthermore, most plans in place did not identify who was responsible for supporting the resident to achieve identified goals.

There were inadequate arrangements in place to meet the needs of residents in accordance with their assessed needs. In addition, the person in charge did not have an adequate knowledge of the findings of the assessments such as the recommendation of support for some residents to work in the polytunnels on the grounds of the centre.

Personal plans were not available in an accessible format suitable to the residents' needs.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The centre was a five bedroom detached house with a large enclosed garden and was located in the countryside within a short drive to the nearest village. The communal area consisted of a kitchen, utility room, two shower rooms, a sitting room and a conservatory/dining room. There were two port-a-cabins located in the back garden with two rooms in each. One port-a-cabin contained an art room and a general use room for the residents while the other contained a staff room and a relaxation room for residents. There was a separate building located to the side of the house which contained a staff bedroom with en suite and an extra bedroom and bathroom. There was a large enclosed garden and two polytunnels which were utilised by external workers.

There was evidence of significant improvement to the centre since the previous inspection. The areas which had been identified as requiring improvement had been redecorated and the centre had been painted externally. Two staff had been appointed to complete cleaning duties on a daily basis. While there was a noticeable improvement in the cleanliness of the centre, further improvement was required. Dirt and dust in vents and on some windows was observed.

In addition, there was no evidence available at the time of inspection to confirm that the boiler had been serviced.

Judgment:
Non Compliant - Minor

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

Theme:
Effective Services

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

Findings:
An inspector found that the centre had implemented measures to address the non compliances identified at the previous inspection. However, improvement was required to the identification and management of risk in the centre including a significant risk in relation to the water temperature.

Inspectors found the temperature of the water supplied to hand wash basins was very hot and this posed a potential risk to residents and this risk had not been assessed. This was brought to the immediate attention of the provider who stated this would be addressed.

Risk management procedures were in place which included a risk management policy and a risk register. Measures to control risks identified on the last inspection had been implemented. However, further improvement was required as all risks in the centre had not been identified. For example, risks in relation to infection control had not been identified in regard to cleaning equipment being inappropriately stored in the centre's boiler house and the use of communal hand towels. In addition, the step from the kitchen to the utility room had not been risk assessed.

Improvements were required to the risk management policy as it did not identify the arrangements in place for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents. Furthermore, there were no measures or procedures in place to prevent or respond to the unexpected absence of any resident, accidental injury to residents, visitors or staff, aggression or violence or self-harm.

An emergency plan had been formulated since the last inspection. It clearly outlined the measures to be taken in the event of a fire including alternative accommodation and a list of emergency contact phone numbers. However, the emergency plan did not identify the measures to be taken in the event of other emergencies occurring in the centre such as a power outage or an interruption to the water supply.

Personal emergency plans had been formulated for each resident which outlined the level of support residents required in the event of an emergency evacuation of the building.

The vehicle used to transport residents had insurance in place and had recently been serviced.

Measures had been implemented since the previous inspection to ensure the safety of residents in the event of an emergency. These included emergency lighting throughout the building, individual fire alarm systems in the port-a-cabins and keypad systems to exit the garden. In addition, the centre had a box containing a torch, phone, high visibility vests, fire safety information, a list of residents and the emergency evacuation procedures which was intended for use in the event of an emergency. Furthermore, checklists had been commenced in June 2014 for checking fire equipment, emergency exits, the security of doors and windows at night and the fire alarm.

Records showed that fire drills had taken place for all staff and the record included an assessment of the effectiveness of the drill. Staff had received training in fire prevention which included how to use fire equipment such as fire extinguishers and fire blankets.

There was evidence that a consultant had assessed the building in relation to fire compliance. However, written confirmation from a competent person that all statutory requirements relating to fire safety had been complied with in respect of the building had not been submitted with the centre's application to register the centre. The provider subsequently submitted the required written confirmation.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
A policy on the prevention, detection and response to abuse had been implemented in May 2014. The policy outlined the measures in place to investigate allegations of abuse. However, some improvement was required to the policy and this is discussed further under Outcome 18: Records and documentation.

Staff had received training on the prevention, detection and response to abuse and staff spoken with were clear on the measures to be taken in response to an allegation of

abuse.

Systems and procedures had improved for supporting residents to manage their finances such as maintaining account balances and receipts. However, the record keeping was not transparent which was discussed with the person in charge who agreed to implement a more robust system to capture all transactions in detail. In addition, the associated procedure had not been signed as adopted into practice.

Some improvements had been implemented since the previous inspection including the introduction of a policy and associated documentation. However, improvements were required regarding the use of restraint in the centre.

Although the person in charge stated the resident's general practitioner (GP) and psychiatrist were aware of the use of physical restraint, documents viewed did not show that the use of restraint had been discussed with or reviewed by the GP or psychiatrist.

In addition, there was inadequate guidance for staff in relation to the use of physical restraint and there was no evidence that interventions used were implemented with the informed consent of the resident or his or her representative, that all alternative measures were considered before restrictive procedures were used and that interventions were reviewed as part of the personal planning process.

Staff had not received up to date training in responding to behaviour that is challenging. The person in charge told an inspector that this training was scheduled for September 2014.

A number of different forms were being used to record incidences of residents' behaviours that challenge. While these forms were being used to identify reasons for episodes of behaviours that challenge there was no evidence that the information in the forms was used to identify and alleviate the cause.

Improvement was required to staff understanding of restrictions and in completing behaviour risk assessments for residents. For example, some behaviour risk assessments pertained to a restriction in place for the safety of another resident. There was no evidence the resident had agreed to this restriction.

Residents did not have a plan to guide staff in relation to the management of behaviours that challenge. The person in charge told an inspector that some staff were scheduled to undertake specific training to develop positive support plans for residents.

The information provided in the centre's quarterly returns pertaining to the use of physical restraint in the centre was inconsistent with the information provided by the person in charge on the day of the inspection. It showed that physical restraint had been used on another resident in the past three months.

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):

Findings:
From the sample of records reviewed, inspectors noted that most accidents and incidents were documented as required. However, some incidents submitted as part of the centre's required quarterly returns were inconsistent with information provided to an inspector by the person in charge on the day of the inspection.

Inspectors found that a recorded incident in a resident's file relating to the unexplained absence of a resident from the designated centre had not been notified to the Authority as required. The record of the incident was inconsistent with the verbal information given to an inspector by staff members.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
Inspectors found some improvement since the previous inspection. Some residents had been supported to access work experience and there was a plan in place regarding supporting these residents to access this employment.

Psychology assessments had been carried out in relation to all residents and the

assessments identified opportunities regarding training and employment for residents. However, residents required a more comprehensive assessment of their education, training and employment requirements as not all residents had been supported to access opportunities for education, training and employment.

In addition, opportunities for training which were identified in the assessments had not been implemented and the person in charge was not aware of some of these recommendations.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There had been some improvements since the previous inspection however, improvement was required to ensure residents were supported in relation to their healthcare needs.

Residents had attended their GPs for a baseline health review and the results were contained in the residents' personal files. There was documentary evidence that residents were supported to access medical appointments as necessary and there was improvement in the documented detail regarding the appointments and follow up required.

Plans were in place to support residents in relation to specific health needs. The plans included guidelines for staff, records of relevant medical emergencies related to the specific health needs and medical test results.

There was evidence that all residents had been supported to access dietetic services and plans had been put in place to ensure residents were receiving adequate nutrition. The plans clearly identified the areas of priority for individual residents. Staff spoke of the positive impact this was having on the health and welfare of residents.

There was evidence that the centre had introduced assessments to record residents' health needs. However, the assessments had not been completed for all residents and there was no evidence that completed assessments had been reviewed by the person in

charge this is actioned under outcome 5..

An annual health assessment had been introduced since the previous inspection. While the assessments outlined residents' requirements in a range of areas, some improvement was required as not all areas had been assessed in line with the template. In addition, the assessment had not been completed for all residents this is actioned under outcome 5.

Residents who required speech and language therapy (SALT) services had not been supported to access SALT. The person in charge told inspectors a referral had been made for all residents.

There was no evidence that residents would be supported to live in the centre until their end of life as care plans had not been developed to address this aspect of their future care. Furthermore, the person in charge was not clear regarding whether or not residents would be supported to remain in the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There had been improvement since the previous inspection however, improvement was required to the policy and procedures in place, medication prescription sheets, protocols to guide staff in administering PRN (as required) medications and the person in charge's response to medication errors in the centre. An immediate action was issued in relation to the protocols to guide staff in administering some medications which were prescribed for use in a specific medical emergency.

The policies relating to the ordering, prescribing, storing and administration of medicines to residents were not centre specific as they referred to some practices which were not in use in the centre and were inconsistent with some practices in the centre.

Some medications were not signed by the general practitioner (GP) and the maximum daily dose was not recorded for all PRN medications. In addition, some prescription sheets contained symbols and the person in charge did not know the meaning of these. Furthermore, she stated that staff had not been trained in the meaning of the symbols.

The protocols in place to guide staff in administering PRN medication required improvement. The protocols did not provide adequate guidance to ensure staff administered PRN medication in line with residents assessed requirements.

An inspector viewed a sample of medication errors and it was not clear if medication errors had been adequately responded to by the person in charge. In addition, measures which had been implemented by the person in charge to prevent reoccurrence of medication errors in the centre were not adequate.

An immediate action was issued in relation to some PRN medications which were prescribed in the event of a medical emergency. Residents' medication protocols provided conflicting information regarding the administration of these medications and the person in charge was unaware of which procedure to follow in the event of the medical emergency. In addition, the maximum daily dose of these medications was not recorded and the information regarding the measures to be taken following the administration of these medications were inconsistent with the measures stated by the person in charge. The person in charge responded immediately and this risk was resolved on the day of the inspection.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
An inspector viewed the centre's statement of purpose and found it did not include all information specified in Schedule 1 of the Regulations. For example, it did not include the fire precautions and associated emergency procedures in the centre. In addition, it did not provide information on the facilities which are to be provided by the provider and a description of the rooms in the centre or the respite services.

The statement of purpose did not reflect the service provided by the centre. For example, the statement of purpose stated that residents would be supported to access training, education and employment and are provided with a range of services including independent living skills, community participation and gardening and horticulture. In

addition, the statement of purpose was in conflict with information received by inspectors. For example, the organisational structure in the statement of purpose differed to the outline provided by the person in charge on the inspection.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
There was evidence of improvement since the previous inspection in the governance and management of the centre. The person in charge had been allocated full time hours to complete the person in charge role and some improvement was noted across all outcomes inspected on the previous inspection. However, significant further improvement was required.

As part of the inspection the person in charge was present throughout both days of the inspection and an interview was carried out. Inspectors found the person in charge was knowledgeable of the Regulations, her legal responsibilities and was clear in regard to her role as person in charge.

While there was a defined management structure it did not adequately identify the lines of authority and accountability and detail responsibilities for all areas of service provision. The provider's roles and responsibilities were not set out and the person in charge was not fulfilling her role as set out in her role description.

The inspectors carried out an interview with the provider. While he demonstrated adequate knowledge of the Regulations and his legal responsibilities, the provider had not fulfilled his regulatory responsibilities, for example unannounced visits to the centre had not been carried out. In addition, the provider had not adequately ensured the service provided was safe, appropriate to resident needs, consistent and effectively monitored in areas such as rights, communication needs, social care needs, healthcare needs and medication management.

There was no review of the quality and safety of care in the designated centre. The person in charge told an inspector this would take place by September 2014 in line with the previous action plan response.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
Suitable arrangements were in place in the absence of the person in charge and the provider was aware of his responsibility to notify the Authority if there was a proposed absence of 28 days or more for the person in charge.

The centre's Coordinator took responsibility for the person in charge in her absence.

An inspector interviewed the Centre Coordinator and found that she was knowledgeable of the Regulations and her legal responsibilities.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
There was insufficient evidence made available to the inspectors to demonstrate that the resources necessary to ensure the effective delivery of care and support in accordance with the statement of purpose were available.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
An inspector viewed a sample of staff files. Items identified as requiring improvement on the previous inspection had not been fully addressed. The majority of the information required in the Regulations in respect of the staff files had been obtained however, some information was not available. For example, some staff files did not contain a reference from the staff member's most recent employer. In addition, an inspector was concerned that the person in charge and provider had not followed up and verified all staff records.

Training had been provided in a number of areas since the previous inspection including training in fire prevention, manual handling and the completion of personal plans. However, staff required additional training. An inspector found that staff did not have adequate understanding of restrictions and in completing behaviour risk assessments for residents. In addition, staff had not received up to date training in supporting residents with behaviours that challenge. The person in charge stated that all staff were scheduled to attend this training in September 2014. Furthermore, some training had not been completed in line with the centre's policies, for example the competency assessments for medication training had not been completed.

There was evidence that some staffing levels had been allocated in line with residents assessed needs, for example to support residents to access work experience in the community. However, improvement was required to the allocation of staff at weekends as staffing levels were having a negative impact on residents as they were prevented

from accessing the community or partaking in activities on some weekends.

Staff were not receiving appropriate supervision. For example, assessments of residents' needs were inconsistent and the person in charge had not adequately supervised or supported staff in relation to the completion of these assessments.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Significant improvement was required to maintenance of records and documentation in the centre. The centre did not have a directory of residents or a guide for residents in respect of the designated centre. In addition, the centre did not have all of the policies and procedures as specified in Schedule 5 of the Regulations and some policies in place required improvement.

Some improvement was required to the policy on the prevention, detection and response to abuse as it did not identify the person who would receive and investigate allegations of abuse in the absence of the designated person. In addition, the wording in the policy required improvement as it referred to allegations of abuse as complaints and referred to the resident as a patient.

The policies relating to the ordering, prescribing, storing and administration of medicines to residents referred to some practices which were not in use in the centre and were inconsistent with some practices in the centre.

The use of physical restraint reported in the centre's quarterly report to the Authority had not been recorded in the 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:

Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Autism West Limited
Centre ID:	OSV-0002065
Date of Inspection:	09 July 2014
Date of response:	16 October 2014

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:
The terminology used in some documentation required improvement to guide staff in best practice that instils respect towards residents and their diverse needs.

Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability,

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

family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
a) Briefing held on the 1st of September 2014 in relation to the use of appropriate and person centred language ensuring the dignity and privacy of all residents is respected.

b) External training will take place on the 29th of September 2014, this will include report writing skills, record and report writing and will make reference to respect and language used in formulating these documents.

Proposed Timescale: 29/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not consulted with in relation to the use of physical restraint.

Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
a) Resident house meetings are now taking place each Friday and include a broader range of subjects. All five residents, in the presence of their parental advocates, have been consulted in respect of their day to day support, crisis prevention and intervention and the use of restraints.

b) Personal plans of all of the residents have been updated by their keyworkers, in consultation with the resident. This has been supported by their parental advocates.

Proposed Timescale: 05/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to advocacy services and information about his or her rights.

Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:
a) The National Advocacy Service for People with Disabilities (NAS) were invited and attended the centre on the 6th of August 2014. All residents, staff and families were invited to attend the information day. The NAS spoke to each resident and further meetings are planned for the 20th of October 2014.

b) We have registered with the Galway Volunteer Centre, on the 28th of August, requesting advocates. This group seeks volunteers to act as advocates and we are looking forward to building a relationship with the volunteer centre. The use of volunteers will enable our residents to form new friendships outside of the centre.

Proposed Timescale: 31/10/2014

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents were not being supported to manage their financial affairs.

Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
a) Each resident now has a resident's personal property register. This includes a record of property/material value purchased by or on behalf of each resident. This register includes date of Purchase, description of item, cost/value, date disposed of. The register will be kept with the resident's financial records and audited by the PIC as part of a monthly audit.

b) Each resident has their own money box, to which their picture is affixed. It is stored in a locked cabinet. When a resident requires access to their monies the resident with support from a staff member will take out money and staff will ensure each transaction is recorded in a personal ledger sheet. The personal ledger sheet records the date, details of receipt or payments, credit/debit amount and balance. Residents hold their monies in their wallets. A Finance protocol in accessible format is being developed to support residents to manage their own finances. At the end of every day the night staff as part of their nightly duties will count the money of each resident and sign each ledger confirming a correct balance. If the money does not balance this is brought to the attention of management for further audit. The PIC as part of the monthly audit will count and cross check each ledger in respect of each resident.

c) Since August the 28th, we have initiated correspondence with a bank with a view to all five residents having their own bank account and an ATM card. However, not all parental advocates have signed the required consent in line with best practice. We endeavour to have all bank accounts and ATM cards operational by the 19th of December 2014. We are also in the process of reviewing existing accounts to ensure

appropriate number of signatories are in place.

Proposed Timescale: 19/12/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents were not receiving support in accordance with their assessed needs.

Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
a) Assessments have been undertaken for all residents by a MDP (Multi-Disciplinary Professionals) in the following areas: - Psychiatrist (where required), Psychologist, Speech and Language Therapist, Occupational Therapist, Nutritionist and a Behavioural Support Specialist.
b) One resident has been seen by a Consultant Psychiatrist on the 29th of August. A referral has been made to the women's health clinic for this resident.
c) The Behavioural Support Specialist is liaising with the staff team with regard to putting in place positive behaviour strategies to support all residents.
d) All recommendations are being actioned.

Proposed Timescale: 28/11/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents had not been supported to access facilities for occupation.

Action Required:
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
Access to facilities for occupation are now in place for four residents. In respect of the fifth resident a staff member has been assigned the task of preparing an occupational focus initiative (pre-employment programme) for delivery by 16th of September using the TEACCH approach and format. This resident is being assessed more closely in recent months by the MDP and with this in mind and in consultation with the resident and parental advocates the PIC it was decided to introduce opportunities for training and employment on a gradual basis. This will be reviewed by the Person in Charge on a month by month basis.

Proposed Timescale: 16/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure had not been provided in an accessible format for residents.

The appeals procedure was not adequate.

Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
A complaints procedure leaflet identifying stages in the complaints process has been developed for residents and is now available in the centre. This is being discussed at our residents meeting on 5th of September 2014. NAS have visited the centre and a further visit has been arranged for the 20th of October 2014. The revised procedure which has added improvements in the areas of advocacy, appeals mechanisms as well as identifying complaints officer will be circulated to the parents on its completion by 10th of September 2014.

Proposed Timescale: 10/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the management of complaints in the centre did not identify the person nominated to deal with complaints.

Action Required:
Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

Please state the actions you have taken or are planning to take:
The complaints procedure is being reviewed with a view to naming the complaints officers identified and trained in the management of complaints. Training for these identified staff members is being held on the 15th of September 2014 and is being facilitated by the HSE.

Proposed Timescale: 15/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the management of complaints in the centre did not identify the person nominated to maintain a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The procedure now clearly identifies the person nominated by the Board to manage complaints in their entirety. The named person will maintain appropriate records of all complaints as well as actions, dates and outcomes as identified under 34 (2) (f) of SI 367.

Proposed Timescale: 15/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the management of complaints in the centre did not identify the person nominated by the provider to ensure that all complaints were appropriately responded to and records maintained.

Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
The procedure now clearly identifies both the nominee of the Board in the management of all complaints as well as the Complaints Officers who have been designated the role of managing complaints, either informally or formally as provided for in the procedure.

Proposed Timescale: 15/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An accessible format of the centre's complaints procedure was not displayed in a prominent position in the centre.

Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
A leaflet identifying the stages of the complaints process as well as photos of the Complaints Officers has been developed and is now in place in the centre. This leaflet is being discussed with residents at the next house meeting on the 5th September 2014. This will be on display on the noticeboard in the hallway as well as each resident having a copy of same in their room.

Proposed Timescale: 05/09/2014

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' communication needs and wishes had not been adequately assessed.

Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
As referred to above a comprehensive assessment of needs has been undertaken by . The recommendations on foot of these assessments will be managed by the PIC and the staff team. To date three staff have undertaken LAMH training with a further three staff attending a LAMH training session on the 27th September 2014. Remaining staff await a further session and the PIC is liaising with an organisation in Galway hoping to organise a further date.
The goals identified by residents in their PCP's have now been put in accessible format and are available to residents in their bedrooms. Areas within the house have also been made more accessible to residents ensuring a total communication environment.
A policy and procedure document will be drafted by 31/10/2014 to enable us meet the communication needs of our residents.

Proposed Timescale: 31/10/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had not been facilitated to access assistive technology and aids and appliances to promote their full capabilities and residents had not been facilitated in line with their assessed needs.

Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
Occupational Therapist has visited the centre and their recommendations will be actioned. In addition to this issues such as access to internet in the centre, access to television and radio in four of the resident's rooms has been achieved as well as three of the residents have iPads.

A risk assessment has been undertaken on the fifth resident having a TV in their room and this is deemed unsafe at this point in time but will be reviewed by 31/10/2014 following the next psychiatry appointment.

Proposed Timescale: 31/10/2014

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have appropriate opportunities to make friends external to the centre and some residents' contact with friends was inappropriately documented.

Some residents were not supported to develop and maintain personal relationships and links with the wider community.

Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
The co-ordinator in consultation with the PIC is actively liaising with four volunteers at present. Garda vetting is under way for two volunteers and as of the 5th of October 2014 we await documentation form the remaining two. We have defined roles as befriending/mentor to allow all of our residents the opportunity to form friendships and to connect to the wider community whilst being supported by unpaid member of our community. The co-ordinator is attending volunteer management training on the 15th and 22nd of October 2014 and we are fully registered with this volunteer organisation.

Keyworkers are now keenly aware of their responsibilities in developing and maintaining contact with families and the resident's community in so far as that is possible. This will be addressed at any meetings held with families, MDP as well as our staff meetings.

Training on the area of report writing and records is being undertaken on 29th September and will ensure that dignity and respect of our residents is paramount in our record keeping.

Proposed Timescale: 29/09/2014

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Current contracts for the provision of services were not available for review.

Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Contracts of Care have been developed by the Registered Provider and will be provided to residents and their parental advocates. This document has been circulated since 29/08/2014

Proposed Timescale: 29/09/2014

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:
improvements was required to the assessment of the health, personal and social care needs of residents.

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:

All residents' personal plans contain a copy of reports from MDP. All recommendation from the MDP are being actioned and implemented. These recommendations will be reviewed on a three to twelve monthly basis, in consultation with the residents and their parental advocates.

Proposed Timescale: 09/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to the arrangements to meet all the assessed needs of residents.

Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Arrangements have been put in place to meet the assessed needs of all residents. Referrals have been made to the Women's Health Clinic. A Behavioural Support Specialist is involved to introduce a positive behaviour support plan and associated strategies for all residents.

Proposed Timescale: 29/11/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plans did not outline the supports required to maximise residents' personal development in accordance with his or her wishes.

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

Please state the actions you have taken or are planning to take:
An individual support plan has now been included in each resident's personal plan and this has been carried out in consultation with the residents, their key workers and parental advocates at their circle of support meeting.

Proposed Timescale: 05/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents had been supported to participate in the preparation of their personal plans.

Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, 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:
All five residents have been consulted on the development and completion of their personal plan. This was achieved by using visual pictures to ascertain the residents likes and dislikes. All of the residents have had their circle of support meetings.

Proposed Timescale: 05/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not available in an accessible format.

Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
Personal plan are now available in accessible formats and are accessible to the residents in their own rooms.

Proposed Timescale: 05/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the personal plans were consistently being reviewed.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
As the personal plans were being completed, review dates were agreed, of between three and twelve months and recorded in the centres review diary. Keyworker meetings are held monthly with the Co-ordinator and each resident.

Proposed Timescale: 05/09/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to the cleanliness of the centre.

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

Please state the actions you have taken or are planning to take:
External services were sought in relation to exterior cleaning and this has been completed satisfactorily. All cleaning is now scheduled on either a daily or weekly basis and this is audited regularly by the Person in Charge.

Proposed Timescale: 03/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence available that the boiler had been serviced.

Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
The boiler will be serviced by a registered plumber from a plumbing and heating service on or before 5th September 2014 and a service contract with them will be put in place on that date.

Proposed Timescale: 05/09/2014

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:
There were no arrangements in place for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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:
The risk management policy has now been updated and includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Proposed Timescale: 10/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no measures or procedures in place to prevent or respond to the unexpected absence of any resident.

Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
The Risk Management policy has now been updated to include measures and actions to control the unexplained absence of any resident.

Proposed Timescale: 10/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no measures or procedures in place to prevent or respond to any accidental injury to residents, visitors or staff.

Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management

policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
The Risk Management policy has been updated to include measures and procedures to control accidental injury to residents, visitors or staff.

Proposed Timescale: 10/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no measures or procedures in place to prevent or respond to aggression and violence.

Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
The Risk Management policy has been updated to include measures and procedures in place to prevent or respond to aggression and violence.

Proposed Timescale: 10/09/2014

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
There were no measures or procedures in place to prevent or respond to self-harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
The Risk Management policy has been updated to include measures and actions to control self-harm.

Proposed Timescale: 10/09/2014

Theme: Effective Services

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

Improvement was required to the identification and assessment of risks throughout the designated centre. For example, risks in relation to infection control, the storage of cleaning equipment in the centre's boiler house and the step from the kitchen to the utility room.

The temperature of the water to sinks posed a potential risk to residents and this risk had not been assessed.

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

Please state the actions you have taken or are planning to take:
The cleaning equipment no longer is stored in the boiler house. The risk associated with the step at the doorway into the kitchen has addressed and actioned. A thermostat has also been fitted to regulate the temperature of the hot water.

The risk management policy has been updated and now includes hazard identification and assessment of risks throughout the designated centre.

Proposed Timescale: 10/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency plan did not identify the measures to be taken in the event of emergencies other than those related to fire in the centre.

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:
The Risk Management policy now addresses the assessment, management and ongoing review of risk. The emergency plan has also been updated to include responses to emergencies other than fire.

Proposed Timescale: 10/09/2014

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 training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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:
Five staff members are undertaking Studio 3 training on the 16-18th September with further sessions scheduled for October 15-17th and November 4-6th.

Proposed Timescale: 06/11/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that effort was being made to identify and alleviate the cause of residents' challenging behaviour.

There was no evidence that all alternative measures were considered before restrictive procedures were 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:
The Behaviour Support Specialist has put in place a process whereby staff are to record risks with regards to the residents as well completing a number of recording documents for their behaviours in order that a comprehensive assessment of their needs can be carried out. Once completed a positive behaviour management plan with associated strategies can be put in place for residents. These plans will require review every six months to ensure that the least restrictive procedure possible is being used with regards to each resident.

Policy and procedure on managing behaviours that challenge is being developed and will incorporate management and reviewed of restrictive procedures.

Proposed Timescale: 30/11/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate guidance for staff in relation to the use of physical restraint for residents and improvement was required to staff understanding of restrictions. Some behaviour risk assessments pertained to a restriction in place for the safety of another resident was required.

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:
Our Restrictive Practice Policy has been updated in accordance with regulation 07 (4) Best practice in respect of restrictive procedures and the HIQA guidance document on Restrictive procedures will be discussed in detail with staff before the 29th of September 2014 and thereafter monthly staff house meetings will include a briefing session on restrictive procedures and practices.

Proposed Timescale: 29/09/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that interventions used were implemented with the informed consent of the resident. In addition, there was no evidence that interventions were reviewed as part of the personal planning process.

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

Please state the actions you have taken or are planning to take:
A Crisis Development Model with specific behavioural interventions for each resident has been developed and implemented. This document has been consented to by the residents and their representatives and review dates have been established.

Proposed Timescale: 13/08/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some personal care plans did not adequately outline how residents should be supported in their personal care and there was no indication as to who had completed the form. In addition, there was no evidence that the person in charge had reviewed these forms.

Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
All residents have in place a current intimate and personal care plan which has been signed and dated by the keyworker. A review date for this plan is now in place and these plans will be reviewed yearly or earlier if deemed required. The Person in Charge will ensure that these plans are reviewed.

Proposed Timescale: 03/09/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Financial systems in place were not sufficiently robust.

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:
The policy and procedure in relation to management of financial affairs for residents is being reviewed.

Proposed Timescale: 31/10/2014

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:
An incident relating to the unexplained absence of a resident from the designated centre had not been notified to the Authority.

Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained

absence of a resident from the designated centre.

Please state the actions you have taken or are planning to take:
The Person in Charge is fully aware of the requirements in relation to the reporting of any unexplained absences of any resident in line with HIQA regulations. All staff have been briefed on the notification requirements with a copy of this document on the noticeboard in the centre. A file has been set up in the centre in relation to the management of HIQA notifiable events.

Proposed Timescale: 03/09/2014

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents had not been supported to access opportunities for education, training and employment.

Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
OT and Psychological assessments have made recommendations in relation to education, training, employment. An action plan with associated implementation plans have been formulated from these assessments.

Proposed Timescale: 03/09/2014

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:
There was no evidence that residents would be supported to live in the centre until their end of life.

Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
Autism West has developed a policy on End of Life Supports (completed 9/10/2014).

This policy requires the PIC to prepare a care plan for each individual's final years and months, and to include that plan in each person's personal plan. The PIC will discuss the plan formally with the resident and his or her family twice a year and will record the outcome of that discussion in the resident's end of life plan.

Proposed Timescale: 15/10/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents who required speech and language therapy (SALT) services had not been supported to access SALT.

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:
A full Speech and Language assessment has been undertaken with each resident. Associated recommendations being actioned.

Proposed Timescale: 31/10/2014

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:
Medication management practices were not adequate.

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:
A Medication procedure is in place in respect of required practices in relation to ordering, prescribing, disposal, recording and administration of medication.

An updated medication management procedure will be completed by 31st October 2014 and rolled out to all staff. Designated staff have been trained in the safe administration of medication. GP's and pharmacists with whom we engage will be sent our revised policy and procedure. Our staff meeting agenda will also include medication

management as a set item. A new incident form has been implemented which captures more appropriate details around medication, near misses and errors. This is reviewed by the PIC weekly.

Proposed Timescale: 31/10/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not include all information specified in Schedule 1 of the Regulations.

The statement of purpose was not an accurate reflection of the services provided to residents in the centre. .

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose now includes all information specified in S.I. No. 367 of 2013 Schedule 1. All of the services which are outlined in the Statement of Purpose are now being provided.

Proposed Timescale: 03/09/2014

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 management systems in place did not adequately ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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:
There has been a change in management personnel in the service since August 2014.

The safety of the service has been significantly enhanced with a renewed focus on resident's needs.

Consistent and effective monitoring by Board Members has been ongoing. Much more significant change including transfer of services to another agency will be initiated before the 15th September 2014 at the direction of the Board of Directors.

Proposed Timescale: 30/09/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not carried out unannounced visits to the centre.

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

Please state the actions you have taken or are planning to take:
Board of Directors have agreed that there will be unannounced visits to centre four times a year and the visitor will prepare a report as is required under SI 367 23 2 (a). A plan will be developed on foot of this report with identified actions and timeframes for completion.

Proposed Timescale: 03/09/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure did not adequately identify the lines of authority and accountability and detail responsibilities for all areas of service provision.

Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
There is now in place a clearly defined management structure and appropriate contracts have been issued to acting Person in Charge and acting Co-ordinator. The PIC has developed a checklist which will enable her to manage effectively. The PIC and Co-

ordinator have also received additional external support since being placed in their new roles.

Proposed Timescale: 03/09/2014

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that the resources necessary to ensure the effective delivery of care and support in accordance with the statement of purpose were available.

Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
Discussions with the HSE are commencing to review the resourcing of the centre into the future. The discussion will need to involve a much larger agency which has been identified by the Directors of the HSE West as the likely agency to take over the centre.

Proposed Timescale: 31/10/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels at weekends were not appropriate to the number and assessed needs of residents.

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

Please state the actions you have taken or are planning to take:
Staffing levels throughout the week have been reviewed and have been enhanced at the weekend following an evaluation of the needs of the residents. The skill mix of staff has also been addressed, are further staff will be sought with appropriate abilities for the positions.

Proposed Timescale: 25/09/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all information as required by the regulations was secured in respect of staff.

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

Please state the actions you have taken or are planning to take:
All staff are being requested to complete new Garda Vetting Forms.

Copies of staff files will now be held at the centre and under the control of the PIC who will have full access to the files. These files will be stored securely on site with the PIC being the only person with access to same. The PIC will ensure that all files are in compliance with Schedule 2 of SI 367.

Any gaps with regards to staff files and specifically in relation to references from previous employers will addressed by 10th of October 2014.

Proposed Timescale: 31/10/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some training had not been completed in line with the centre's policies.

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:
Immediate training requirements have been identified.

Complaints Officer training is taking place for two members of staff on the 15th of September 2014.

Three members of staff have attended a one day training session in regard to Lamh signing. And three further members of staff are scheduled to attend on the 27th of September 2014.

A record of when refreshers fall due has been recorded in the centres computer.

The keyworkers are currently undergoing online training in relation to Positive Behaviour Support.

Five staff members are undertaking Studio 3 training on the 16-18th September with further sessions on October 15-17th and 4-6th of November 2014.

All designated staff have now completed the medication assessment in line with the centres policies.

Proposed Timescale: 06/11/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not receiving appropriate supervision.

Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The PIC is now conducting monthly supervisions with staff, and this has been recorded and kept on staff files.

The co-ordinator also has a monthly review of the personal plans with the keyworkers.

Proposed Timescale: 03/09/2014

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have all the policies and procedures as specified in Schedule 5 of the Regulations.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Autism West Limited are currently working on the preparation of all of the policies listed

on Schedule 5 of S.I. 367 of 2013. We are consulting with another service provider who have agreed to give us strong support in this regard. The policies will be completed on a phased basis and will all be in place and adopted by the Board of Autism West Limited and made available to residents, representatives and staff no later than the 15th of October 2014.

Proposed Timescale: 15/10/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the prevention, detection and response to abuse did not identify the person who would receive and investigate allegations of abuse in the absence of the designated person. In addition, the policy referred to allegations of abuse as complaints and referred to the resident as a patient.

Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The Person in Charge (and in their absences the House Coordinator) will be the person who receives and investigates allegations of abuse in the absence of the designated person. The Client Protection Policy will be reviewed on or before the 31st of October 2014 and will be reviewed again on or before 31st May 2015.

Proposed Timescale: 31/10/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have a directory of residents.

Action Required:
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

Please state the actions you have taken or are planning to take:
The Directory of Residents has been established and will be maintained in the designated centre.

Proposed Timescale: 03/09/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A guide in respect of the designated centre was not available to residents.

Action Required:
Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident.

Please state the actions you have taken or are planning to take:
A guide to the designated centre has been completed and has been circulated to each resident.

Proposed Timescale: 09/09/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear if medication errors had been adequately responded to by the person in charge and measures which had been implemented to prevent re-occurrence of medication errors in the centre were not adequate.

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
A new accident/incident report form has been implemented. This form has amalgamated the previous medication error form, accident form and incident form. These are reviewed and audited by the PIC. A new system of collation has been put in place and is coinciding with the quarterly notification period. All staff have been made aware of the notifiable events and there notification periods. A register of same has also been implemented from the 1st of September 2014 onwards.

Medication errors are audited by the PIC. Measures have been put in place to reduce the re-occurrence of medication errors. Monthly staff house meetings now include medication as a set agenda item.

Staffing levels have also increased in the morning following a review of medication errors by the PIC.

Proposed Timescale: 01/09/2014