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<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Redwood Extended Care Facility</th>
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<td>OSV-0002433</td>
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<tr>
<td>Provider Nominee:</td>
<td>Frances Gargan</td>
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<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
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<tr>
<td>Support inspector(s):</td>
<td>Ann-Marie O'Neill;</td>
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About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: 07 February 2015 11:30
To: 07 February 2015 17:30

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs                      |
| Outcome 08: Safeguarding and Safety                |
| Outcome 17: Workforce                              |

Summary of findings from this inspection
The purpose of this inspection was to follow up on the action plan and response to the previous inspection on 11 and 27 September 2014 that included non-compliances in relation the nature, extent and basis for the use of restrictive practices used at this centre and the impact of the extensive use of restrictive practices on the liberty of residents and their civil rights.

The focus was on establishing if sufficient improvements and appropriate action had been undertaken and/or completed within the specified time frames outlined in the providers and person in charges response. A change in provider nominee, person in charge and deputy were notified to the Authority.

The centre had continued to provide services to a total of 30 residents with varying levels of support needs, including behaviour management issues, in four units. The numbers of residents in each unit remained unchanged; eight residents occupied three units and six were in one unit.

At the time of the last inspection three of the units were mixed gender and one was all male. However, inspectors noted that nine residents had been transferred between units since the last inspection. As a result a female resident was sharing a unit with seven male residents with complex behaviour management issues. Evidence of a risk assessment was not found to demonstrate a rationale for this decision and if it was in the best interest of all the residents.

Since the last inspection one resident previously accommodated in a community house operated by the registered provider was admitted to the centre and one
resident had been discharged from this centre to a community house on the campus operated by the provider.

While a restraint reduction strategy had been initiated and restrictive practices reported a reduction in the overall number and frequency of physical intervention comparable with previous reports, the practice of physical interventions involving over 50% of residents’ in the centre and for some physical interventions exceeding 30 minutes had continued since the last inspection. In addition, there was an increase in the use of as required (PRN) anti-psychotic medication on a regular and frequent basis as a form of chemical restraint. The measures in place and practice negatively impacted on the liberty of residents and their civil rights.

The provider informed inspectors and the Authority that they had contacted the Mental Health Commission (MHC) in relation to becoming an approved centre and that an application as an approved centre had been submitted to the MHC.

Training for staff had been initiated and provided in some key areas and plans for further training were described.

Inspectors found that there continued to be a significant denial of residents’ civil, legal and human rights.
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:
Inspectors were following up on the action plan outlining the provider’s failure to ensure that adequate safeguards of residents’ civil, legal and human rights were in place to ensure that the deprivation of and restriction of liberty was lawful.

The provider had responded to the Authority stating that a plan to transition a significant number of residents to facilitate a person-specific approach with consideration to resident specific assessment of risks and safety issues was to be carried out by 31/01/2015. However, inspectors found that occupancy, routines, practices and facilities had not significantly changed, as 29 of the 30 residents accommodated on the previous inspection remained in the centre. All residents were subject to restrictive measures as a collective decision and the overall service did not fully promote residents personal independence, personal choices or freedom of movement.

Actions required of the provider from the previous inspection was to ensure that each resident, in accordance with their wishes, age and the nature of his or her disability, participates in and consents, with necessary support where necessary, to decisions about his or her care and support which were to be carried out by 31/01/2015.

Staff reported an overall reduction in physical interventions and use of restraint which they primarily attributed to changes in medication, the movement and change of residents between units, and commencement in training staff on positive behaviour support.

While a reduction in the use of physical intervention had been notified to the Authority,
over 100 physical interventions had occurred between October 2014 and January 2015 involving over 50% of the resident group living in the centre. Inspectors acknowledged the reduction in number, frequency and duration, however, there was evidence that the least restrictive methods for the shortest duration were not being employed in accordance National Policy Guidelines or to respect residents’ rights dignity or well-being.

Inspectors read a number of incidents and notification reports that involved up to eight staff and other residents. The manner in which some care and treatment was provided, described and outlined in reports did not ensure that residents’ rights, and privacy and dignity was respected at all times. Documentation read by inspectors highlighted that the behaviour of some residents had a negative outcomes for themselves and on others who shared the unit they lived on. Staff responded to incidents of challenging behaviour which included taking a “couch” or “sofa” to communal areas for the purposes of physical intervention where residents witnessed other residents being restrained for lengthy durations. One intervention carried out on a corridor was recorded to have lasted up to four hours involving 11 persons.

Physical interventions and techniques used and described by staff during incidents of physical interventions continue to be unsafe and potentially harmful to residents. These include staff holding residents by their arms, legs and head which restricted their freedom of movement to a significant degree which may place residents at risk of injury, distress or harm.

Despite internal moves affecting nine residents, inspectors found that residents with multifaceted needs and those who present with a high level of aggression and violence requiring additional supports and supervision “specials” continued to live alongside residents with lower levels of challenge and support needs. As a result, residents with greater ability were subject to the same restrictions within the living environment as their peers with more multifaceted and greater support needs.

Inspectors found that the freedom of residents to move within and beyond the centre was restricted and staff working in the centre confirmed that entry and exit by residents was managed and controlled by staff at all times.

Overall, the extent to which residents were adequately supported before, during and after incidents, and/or actively involved in decision making in the use of physical interventions and overall restrictive practices and measures in place continued to lack external examination. Inspectors were informed that little progress had been made to include external professionals on a Rights Review Committee. One meeting in November 2014 had been held where matters involving this and other centres operated by the service provider were referred to. This meeting did not include external professionals.

Inspectors followed up on the action plan outlining the provider’s failure to ensure that each resident had access to advocacy services and information about their rights. Staff informed inspectors that they were in the process of informing residents of an advocacy service and staff were facilitating residents to apply for access to advocacy support services. The provider stated in the response to the previous report that "restrictions are set within the context of an overall plan of care in the best interest of the resident and
are/will be the subject of the review of advocates/representatives”.

Actions in relation to involving external professionals or independent members on the Rights Review Committee had not improved. On this inspection there was no evidence of an independent forum for residents and/or their representatives. The involvement of a social worker discipline had not been provided since the last inspection.

Whilst there was an acknowledgement that efforts were on-going to come into compliance, the overall finding was that the major non-compliances previously reported were recurrent and are restated in the action plan of this report.

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:
Inspectors were following up on the action plan outlining the provider’s failure to ensure that personal plan reviews are conducted in a manner that ensure the maximum participation of resident and where appropriate their representative, in accordance with the resident’s wishes, age and disability.

As previously reported, the statement of purpose and function described this centre as “an assessment and intervention unit for adults with complex care needs and challenging behaviours in a range of conditions”. Inspectors established that one resident had been discharged since the last inspection; some were in the service up to seven years as follows:
- three residents had been admitted to the service between 2007 and 2008
- six residents had been admitted to the service between 2009 and 2010
- eight residents had been admitted to the service between 2011 and 2012
- thirteen resident had been admitted to the service between 2013 and 2014
On enquiry during the inspection staff were unaware of any discharge dates arranged for residents within the centre. Therefore, the actual care pathway and transition plan for residents in the centre remained unclear.

Inspectors were made aware that forensic assessments had been completed for some residents who were involved in frequent and often intense and lengthy, physical interventions. As a result of these assessments, alternative treatment and services plans were recommended. However, these recommendations had not been implemented at the time of this inspection.

The introduction of a new personal plan and a risk and vulnerability assessment for each resident was being implemented following the last inspection. A sample of documents to demonstrate changes in assessment and personal plans on trial were available but had not been fully implemented at this time. The template shown to inspectors demonstrated that the resident and/or relevant others were to be included, however, it was unclear in the sample reviewed what information had been discussed, shared or agreed and when this had occurred.

An additional document such as a debriefing record following an incident of physical intervention was available. Inspectors read in one debriefing record that the resident felt the intervention was “not necessary” and complained of “feeling sore” following a physical restraint that involved eight staff for up to 50 minutes. Verbal, psychological and physical aggression and violence by some residents towards others continued to be a recurrent feature in this communal environment that was deemed to be unsuitable for individual residents following assessments by multiple disciplines’.

As previously reported, there was no evidence in resident records that their clinical observations were monitored or recorded during physical interventions or if residents had been assessed by a medical doctor following periods of physical restraint and in particular interventions that exceeded 30 minutes.

Whilst there was an acknowledgement that efforts were on-going to come into compliance, the overall finding was that the major non-compliances previously reported were recurrent and are restated in the action plan of this report.

**Judgment:**
Non Compliant - Major

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

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

**Findings:**
A restraint reduction strategy was initiated in response to the findings of the last inspection. Despite the reported reduction in the use of restraint, inspectors found that practices and restrictive procedure arrangements were not the least restrictive for the shortest duration necessary to meet residents’ individual needs.

The use of chemical restraint had not been reported since the last inspection. Inspectors reviewed a sample of residents’ clinical records and found the frequent administration of as required (PRN) psychotropic medication orally (PO) to a resident on a daily basis over a three month period and by intra muscular injection (IM) on nine occasions during an eight week period. On one occasion the administration of IM PRN psychotropic medication was recorded as given in advance of a situation or life event in anticipation that their arousal may heighten. Documentation recording the use of chemical and physical restraint was not in line with best practice procedures. Documentation reviewed by inspectors did not verify that the use of ‘as required’ (PRN) psychotropic medication was in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health.

Based on a sample of nursing and clinical notes reviewed in conjunction with medication prescription charts, inspectors found that clinical indications were not sufficiently documented or identified for the use of PRN psychotropic medication. It was not clear if a medically identifiable condition was being treated. The clinical notes did not outline sufficient detail in relation to episodes where a PRN psychotropic medication was administered. A documented assessment was not completed prior to and after each instance that PRN psychotropic medication was administered. Protocols advising clear administration procedures for psychotropic medications on a PRN basis were not evident.

Inspectors determined that decisions regarding medication made by a resident during a time when they were being physically restrained by staff and when their freedom of movement was restricted and controlled by staff was questionable. Inspectors formed the view that a resident’s functional capacity to consent for PRN medication by IM or PO during the physical intervention was unclear despite records stating “offered and accepted” medication.

Systems in place on previous inspections remained the same such as high numbers of attendant staff comparable with residents and alarm systems used on bedroom and sitting room doors to alert staff to resident’s movements onto the unit corridor. While the overall volume and tone of personal alarms carried by staff for summoning assistance throughout the centre had been lowered, the alarm of individual resident’s rooms sounded loud and impacts on other residents within the communal environment. One resident’s door alarm was heard on three occasions during a twenty minute visit to
one unit by inspectors.

The use of a dedicated room “alert room” as a low stimulus room in each unit where residents were removed to or encouraged to go for de-escalating purposes continued.

Residents were seen to be in view of and within a short distance of staff at all times while in the units and also when out in an enclosed garden that was shared by two units. Therefore, time to undertake personal activities or private matters were restricted. Communications and interactions between residents were seen to be monitored by staff who informed inspectors that the level of monitoring and supervision of residents was necessary due to the nature of their conditions such as epilepsy, previous history such as aggression and violence and potential risks such as vulnerability from others or self harm.

Despite supervision arrangements, changes in occupancy within units and efforts made by staff indicating a reduction in reported incidents following challenging behaviour, some residents’ behaviour continued to negatively impact on others accommodated in the centre.

Whilst there was an acknowledgement that efforts were ongoing to come into compliance, the overall finding was that the people, environment and situation residents find themselves in, increased levels of anxiety and incidents of challenging behaviour. The major non-compliances previously reported was recurrent and is restated in the action plan of this report.

**Judgment:**
Non Compliant - Major

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**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:**
The nursing skill mix on day duty had increased at weekends since the last inspection. The number of staff on one unit was greater than the number of residents, and similarly, the number of staff in the other three units was comparable with resident
numbers. For example, inspectors were informed that there was generally 10 staff required on duty in one unit for six residents, however, there were eight staff on duty at this inspection and a shortage of two staff (“specials”) was confirmed. Inspectors were informed that the management on-call had been informed of the aforementioned but that staff deficiencies had not been addressed.

Inspectors also evidenced that in a number of incidents review forms completed by staff that a shortage of staff available to support and meet residents assessed needs had been raised during incident reviews following the use of physical intervention to manage challenging behaviour.

Staff confirmed they and others working in the centre were attending training in positive behaviour support that was one day per week for four weeks. Staff also confirmed ongoing training in physical management of aggression and violence training had been ongoing to include all staff. Inspectors however noted that staff had reported the lack of guidelines to inform reviews following the use of physical intervention used to manage residents’ challenging behaviour.

The professional registration of nurses on duty during the previous inspection had been confirmed since the last inspection.

A roster to include care staff was available for inspection.

Recruitment and training of staff was described as ongoing, however, the overall finding was that the major non-compliance in relation to staff levels, skill mix and training/guidance needs for staff were recurrent and are restated in the action plan at the end of this report.

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:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

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Requirements

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

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

Outcome 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:
Residents continued to have a significant denial of civil, legal and human rights.

A lack of appropriate support and safeguarding measures to ensure that the deprivation of and restriction of resident liberty was lawful and/or in accordance with a procedure prescribed by law was found.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
Residents are active in the design of their own care plan, activity programme, Behaviour Support Plans, accommodation and environment. They are also involved in residents committee, goal planning meetings, social programme, training, activities scheduling and daily timetable. Additionally, each resident will be supported to exercise their civil, political and legal rights by:
• Our complaints procedure.
• The ongoing development of our Rights Review Committee
• Access to National Advocacy Service.
Each resident will be supported to participate and exercise their political rights by registering to vote.

We will continue to proactively engage with the National Advocacy Service in order to secure the maximum possible access to advocacy in the best interests of the residents.

The PIC working with the MDT will ensure that scheduled, regular, case conference reviews will continue to provide a forum for the resident, family member(s), funding agent, advocate and the service to engage in review of the care and support available with a view to maximising the ability of the resident to exercise their rights and autonomy. Documentary evidence will demonstrate stakeholder involvement in the Case Conference process, and will specifically record where residents choose not to attend in any aspect of their care programme or where it would clinically inappropriate for them to attend. *

In recent months, significant time and effort was expended exploring additional regulatory arrangements. In February 2015, this process concluded.

Accordingly, the Provider is continuing to work with a number of residents, focusing on coordinating discharge to their local HSE area. HSE areas have been informed in writing about these planned discharges. **

The service recognises that there have been certain limitations in service delivery as a result of the environmental design of the building. A Provider-led plan is in place to convert the building into self-contained Independent Living Units, which will enable us to provide a wrap-around service, more closely aligned with each individual’s assessed needs. ***

An initiative was recently commenced to implement an Open Door policy, this will be rolled out in line with the planned discharges and the development of the new Independent Living Units.

Proposed Timescale: *      Immediate
**    April 10th 2015
### Proposed Timescale: 31/12/2015

#### Theme: Individualised Supports and Care

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

The provider had failed to demonstrate that each resident, in accordance with their wishes, age and the nature of his or her disability, participated in and consents, with necessary support where necessary, to decisions about his or her care and support.

**2. 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:**

Residents are encouraged and supported to actively participate in the design of their own care plan, activity programme, behaviour support plans, accommodation and environment, residents committee, goal planning meetings, social programme, training, activities scheduling and daily timetable.

The PIC will ensure that supporting documentation explicitly tracks resident’s participation in these activities. Documentation will be co-signed by residents and/or family/advocates where required. Where this is not possible, or where there are issues in relation to consent/capacity, the residents will be supported to understand and participate in decision making to the best of their ability.

The plans to develop self-contained Independent Living Units (Copy attached) will enable each resident to modulate their own lifestyle pattern and preferences in accordance with their own wishes.

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### Proposed Timescale: 30/04/2015

#### Theme: Individualised Supports and Care

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

All residents did not have ready access to advocacy services.

External scrutiny by legal representatives of residents within the service and restrictive measures was lacking.

The involvement of an independent or internal social worker discipline was not available.
3. **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:**
Redwood has a number of initiatives designed to ensure that residents are aware of and have access to Advocacy Services, including;
Information on the Advocacy Service is promoted in each unit in an easy-read format.
Advocacy, Right Review and Complaints are standing Agenda items on all Unit Meetings (held every Thursday) & Resident’s meetings (8-weekly).
The service is facilitating an Open Day with the National Advocacy Service in the coming weeks which will highlight the range and scope of services that they offer to residents.
Any Resident may choose to avail of independent legal representation if required.
Residents retain access to social work services from their service of referral. Additionally Redwood will secure the services of a professional Social Worker.

**Proposed Timescale:** 30/06/2015
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Personal plans and decisions resulting in interventions and restraint procedures used did not demonstrate evidence of consent or participation by residents about his or her care and support or a legal representative.

4. **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:**
Residents are encouraged and supported to actively participate in the design of their own care plan, activity programme, behaviour support plans, accommodation and environment, residents committee, goal planning meetings, social programme, training, activities scheduling and daily timetable.

Residents with the greatest likelihood of having restrictive procedures applied, such as physical restraint, have been consulted on the use of these practices. These consultations are documented in the easy-read descriptions of these restrictive practices, contained in the resident’s care plan. These descriptions are discussed with the resident and are signed by the nurse in charge and the resident in question to say that the resident has read and discussed the descriptions and has agreed to their use.

On the date of inspection these consultations had been completed with those residents who were prioritised as high risk, high volume, and/or problem prone related to the use
of restrictive physical intervention. This process will be extended to all Redwood residents based upon a MDT assessment of the likelihood of physical restraint being required in their plan of care.

**Proposed Timescale:** 31/05/2015  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All residents were subject to restrictive measures as a collective decision and the overall service did not fully promote residents personal independence, personal choices or freedom of movement.

**5. Action Required:**  
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:  
The Provider has developed a detailed plan to convert the building into self-contained Independent Living Units. Additionally, newly developed accommodation, subject to registration, will facilitate greater choice and flexibility for each resident, independent of the needs or preferences of fellow residents.

Each resident will continue to have an individualised care plan which reflects their specific needs, goals and interests. Staff will support each resident to participate meaningfully in expressing and pursuing their choices and preferences.

Social activities outside of the living accommodation will continue to be arranged on a daily basis, both during the day and the evening. These activities, which are determined by resident's individual preferences, will be reviewed regularly and provided in conjunction with external community partners, and coordinated by the enhanced support provided by the recently developed Social Care Community Integration Team. This initiative will be led by the PIC.

**Proposed Timescale:** 30/04/2015  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The freedom of residents to move within and beyond the centre was restricted as entry and exit was managed and controlled by staff at all times.

**6. Action Required:**  
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.
Please state the actions you have taken or are planning to take:
The Provider has developed a detailed plan to convert the building into self-contained Independent Living Units. Additionally, newly developed accommodation, subject to registration, will facilitate greater choice and flexibility for each resident, independent of the needs or preferences of fellow residents.

Each resident will continue to have an individualised care plan which reflects their specific needs, goals and interests. Specifically related to scope of movement, the care plan reflects the individualised and dynamic assessment of inherent benefits and risks. Staff will support each resident to participate meaningfully in expressing and pursuing their choices and preferences.

An initiative was recently commenced to implement an Open Door policy, this will be rolled out in line with the planned discharges and the development of the new Independent Living Units.

Proposed Timescale: 30/04/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was unclear in the sample of personal plans reviewed regarding what information had been discussed, shared or agreed with the resident or relevant other and when this had occurred.

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

Please state the actions you have taken or are planning to take:
Residents are encouraged and supported to actively participate in the design of their own care plan, activity programme, behaviour support plans, accommodation and environment, residents committee, goal planning meetings, social programme, training, activities scheduling and daily timetable.

The PIC will ensure that supporting documentation explicitly tracks resident’s participation in these activities in order to fully reflect the level of participation of each resident in their own reviews and other meetings that concern them. Documentation will be co-signed by residents and/or family/advocates where required. Where this is not possible, or where there are issues in relation to consent/capacity, the residents will be supported to understand and participate in decision making to the best of their ability.
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Recommendations by health care professionals for alternative treatment and services for residents following assessments carried out had not been implemented.

8. 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:
A resident specific assessment is undertaken which informs the formulation of an individualised plan of care which is completed with the resident and the multidisciplinary team involving qualified practitioners from Psychiatry, Psychology, Nursing, Occupational Therapy, Physiotherapy and Speech & Language therapy. In circumstances where expertise and/or opinion required is beyond the MDT, referrals are made to the appropriate external consultants.

In circumstances where an alternative plan of care and/or specific interventions are recommended, these are sought through a process of engagement with the appropriate care provider(s). Access to any recommended treatment/intervention changes are pursued subject to the availability of services with due regard to the duty of care owed to the person concerned and the obligation upon the service to ensure a safe plan of discharge.

The Provider is continuing to work with a number of residents, focusing on coordinating discharge to their local HSE area. HSE areas have been informed in writing about these planned discharges.

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

Please state the actions you have taken or are planning to take:
All residents receive a pre-admission assessment, which is conducted by at least two professional disciplines. This is followed by a resident-specific assessment is undertaken within 28 days of admission, which informs the formulation of an individualised plan of care which is completed with the resident and the multidisciplinary team involving qualified practitioners from Psychiatry, Psychology, Nursing, Occupational Therapy, Physiotherapy and Speech & Language therapy.

Specifically in relation to the findings in the report;

The physical interventions in use have undergone risk assessment by an appropriately qualified expert. A further risk assessment will be undertaken, specifically of holds involving the head and/or legs, by an appropriately qualified external expert as a matter of urgency.

The risks associated with the use of physical interventions will be emphasised during the PMAV refresher training and reinforced during practical components of training. Resident specific medical evaluations will be sought from the resident’s GP guiding the use of specific physical interventions for each resident. This guidance will inform and supplement the resident-specific evaluation and care planning by the multidisciplinary team involving qualified practitioners from Psychiatry, Psychology, Nursing, Occupational Therapy, Physiotherapy and Speech & Language therapy.

In the event that resident-specific concerns are identified referrals will be made to the appropriate external consultants.

The use of physical interventions is at all times done under the direct supervision of a registered nurse, all of whom have been trained to monitor the safe application of physical interventions and the associated risks involved.

The resident's clinical status will be monitored and clinical observations are recorded following the use of physical interventions by a qualified nurse, which will inform and prompt an examination by a medical doctor if necessary.

All occurrences of physical interventions is also reviewed by the multidisciplinary team.

Proposed Timescale: 30/04/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that every effort to identify and alleviate the causes of residents' behaviour was made or that alternative measures were considered before a restrictive procedure was used.
Inspectors were not assured that the least restrictive measure for the shortest duration was afforded to residents.

Environmental restrictions remained in place preventing residents from moving within or leaving the centre.

The people, environment and situation residents found themselves in increased levels of anxiety and challenging behaviour.

Episodes of challenging behaviour were often triggered by the environment and difficulties encountered between residents living in a communal unit and area that was shared by others.

10. **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 centre has an active restraint reduction plan in place and levels of restraint are showing a significant downward trend. Since August 2014, there has been a 70% reduction in the use of physical intervention required to manage behaviours that challenge. This has been achieved through the development and implementation of a comprehensive, nine point restraint reduction strategies, ongoing Professional Management of Aggression and Violence Training, and the rollout of Positive Behavioural Support Training. The Provider and PIC will oversee this process.

A programme of training in Positive Behavioural Support has been initiated and will continue until all Redwood staff has completed same. The PIC will ensure all staff receive refresher training in the didactic and practical components of the Professional Management of Aggression & Violence programme specific to their occupational role and function.

Behaviour support plans will be explicit in their description of antecedents and guiding staff in their clinical decision making.

Within these programmes, emphasis will be placed on the early identification of triggers and antecedents through the use of appropriate documentation, direct observations, feedback from staff and review of behavioural records. Behaviours will be reviewed and analysed to identify the possible functions of identified behaviours that challenge. These will then be incorporated into the individuals behavioural support plans to support staff to alleviate the underlying causes that may lead to behaviours that challenge.

Refresher training in PMAV will place special emphasis on specific instruction on the themes of behaviours that challenge, de-escalation, the use of physical containments as interventions of last resort, and the associated physical and psychological risks. The use of the least restrictive option for the shortest possible duration will also be given special emphasis. All restrictive interventions are implemented under the direct supervision of a
qualified nurse and all occurrences of the use of physical interventions are reviewed by the multidisciplinary team.

The Provider has developed a detailed plan to convert the building into self-contained Independent Living Units which will provide an enhanced living environment and diminish potential for resident to resident conflict, and implement environmental mitigation of triggers and/or escalating factors.

Proposed Timescale: 30/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels recommended for residents assessed needs were not available on the day of the inspection.

Skill mix to ensure clinical monitoring and oversight during physical and chemical intervention and involvement of incident reviews required improvement.

Staff training or guidance to inform appropriate reviews of restrictive measures in place and used was required.

A social worker had not been appointed.

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

Please state the actions you have taken or are planning to take:
The provider employs a broad multidisciplinary team involving qualified practitioners from Psychiatry, Psychology, Nursing, Occupational Therapy, Physiotherapy and Speech & Language therapy, and Healthcare Assistants with FETAC Level 5 Qualifications and above. The services of an professional social worker will be secured.

The Provider together with the PIC will ensure that there are suitable and sufficient staff numbers with the required qualifications, skills and experience necessary to support and meet the assessed needs of the residents. In the event of unplanned absences the PIC/Unit manager will address any shortfalls through redeployment of staff, and the engagement of relief staff. The On-Call Manager will be informed where staff shortages are negatively impacting on resident’s care needs and advice sought. The use of physical interventions is at all times done under the direct supervision of a registered nurse, all of whom have been trained to monitor the safe application of physical interventions and the associated risks involved.
The resident’s clinical status is monitored and clinical observations are recorded.
following the use of physical interventions by a qualified nurse, which will inform and prompt an examination by a medical doctor if necessary. The use of physical interventions will also be reviewed by the multidisciplinary team. A specific training will be provided to all staff in how to review occurrences from the perspectives of the client, the staff, and the organisation which is appropriate to their role and function.

**Proposed Timescale:** 31/07/2015