<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Anne Sullivan Centre Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001388</td>
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<tr>
<td>Centre county:</td>
<td>Co. Dublin</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>The Anne Sullivan Centre Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>James O'Loughlin</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Helen Lindsey</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Deirdre Byrne, Gearoid Harrahill, Jim Kee</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>10</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</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: 08 July 2015 10:00  
To: 08 July 2015 18:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 09: Notification of Incidents</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

The purpose of this inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was also to determine if adequate progress was being made in relation to noncompliance identified during previous inspection carried out by the Authority.

The primary aim was to establish if residents were safe and were being provided with care and support following the regulations and national policies, specifically in relation to safeguarding, positive behaviour support, restrictive practice, notifications, medication practice and governance and management.

Four outcomes were fully monitored and aspects of three other outcomes were inspected solely in relation to safeguarding and safety.

The centre was established specifically to meet the needs of people who are deaf-blind. Some residents also have secondary needs, for example responsive behaviours or behaviours that challenge. The aim of the service is to facilitate deaf-blind people to pursue meaningful, active and fruitful lives.

Inspectors were limited in their ability to communicate with most of the residents, and so relied on the staff and family members to share their views of the residents' experiences. Records of assessments and judgments by other professionals were

Page 3 of 31
also used to offer insights on the experience of the residents.

The centre was made up of four houses and the main building, all within a cul-de-sac in a residential area. It was close to amenities such as shops, restaurants, banks and bus stops. The service can support 11 residents on a full time or respite basis.

The main building had a flat for one resident, a main kitchen, a kitchen for residents, and a range of offices and recreation rooms. There was a garden and a guided walkway around the building.

One house where three residents lived had a bedroom with en-suite, two living rooms and a kitchen diner on the ground floor. There were four bedrooms upstairs, one en-suite. One bedroom was used as the office. Two for residents and one spare room that could be used for staff if needed. There was a garden to the back of the house.

Three of the houses had been knocked through, so there was access between them. In the whole building there were two kitchen diners, two lounge areas, a separate flat for one resident with shower room and kitchenette, and six bedrooms. One of the bedrooms was en-suite. There was a garden area at the back of each house. There were also two bathrooms, and a downstairs toilet. Six residents lived in these houses.

On this inspection it was found that changes had taken place which could be seen to be improving the lives of residents. For example most bedrooms had been redecorated, and other improvements made to one apartment including the addition of a kitchenette, and improved staffing levels supported residents to move more freely within the centre and to engage with the local community. Residents were seen to be responding well to spending one to one time with staff, and were enjoying a range of activities on the day of the inspection, for example going out swimming, going to a local pub and walking outside of the centre.

Some actions from the previous inspection had been met, for example staff had completed training in a number of areas, including fire training, deaf-blind training and approved physical restraint methods.

Work had been undertaken to develop policies, teams set up to support staff in relation to positive behaviour support and restrictive practice, and documenting all the restrictions in place in the centre. Residents were not found to be at risk on the day of the inspection, however the systems in place did not assure inspectors that incidents and allegations could be managed if they occurred. There were significant areas of major non-compliance with the regulations, and national guidelines.

The governance and management systems were not sufficiently robust to support and promote the delivery of safe quality care services. The person in charge and the management team lacked the required knowledge, skills and expertise to effectively manage and operate the service. At the last inspection Outcome 8, Safeguarding and Safety, was rated as major non-compliant. That rating had not improved on this inspection.
Of the four outcomes fully assessed on this inspection, three were found to be major non-compliant with the regulations, and one was moderate non-compliant. Aspects of a further three outcomes were judged to be one major non-compliant and two moderate non-compliant in relation to safeguarding and safety.

The findings are discussed in the body of the report and all areas of non-compliance are actioned at the end of this report.

Since the inspection was carried out, meetings have been held with the provider. The action plan that is in place gives a commitment to make significant improvement within the centre, and some evidence has been received that progress is being made.
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.

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tbody>
<tr>
<td>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.</td>
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**Theme:**
Effective Services

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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</thead>
<tbody>
<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
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</table>

| Findings: |
| The only aspect of this outcome which inspectors examined was multidisciplinary review, as it relates to Safeguarding and Safety. Inspectors found that residents personal plans in relation to behaviour support and restrictive practice did not show evidence of multidisciplinary involvement. This is discussed further under Outcome 8. |

| Judgment: |
| Non Compliant - Major |

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<tbody>
<tr>
<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
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</table>

| Theme: |
| Effective Services |

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
</tr>
</tbody>
</table>

| Findings: |
| Risk and incident management, as it relates to safety, safeguarding and medication management, was reviewed under this outcome. Inspectors found the system of |
managing risk, accidents and incidents was in place but did not ensure that there was on-going management and review of risk. This issue is discussed in detail under Outcome 8 and Outcome 12. Other aspects relating to this outcome were not reviewed during this inspection.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspectors found that proper measures to protect residents from abuse were not in place, and appropriate action had not been taken in response to suspected abuse. Behaviour support arrangements and restrictive practice also needed significant improvement.

**Safeguarding**

There was a policy and procedures in place for the prevention, detection and response to abuse. Following the previous inspection the policy had been reviewed and amended. However, the revised policy did not clearly set out the procedure to follow, with a lack of clarity on who’s role it was to carry out an initial screening, and then an investigation if required. There were other gaps in the document including, that it set out a range of options as to who allegations should be reported to, there was also no guidance on what action to take if an allegation was made about the person in charge or senior managers and the policy did not reference the national policy, Safeguarding Vulnerable Persons at Risk of Abuse issued by the HSE in December 2014. The action for this is made under outcome 18.

The senior managers and designated person with whom the inspectors discussed the policy and procedures did not give a response to inspectors that matched the policy, or the national policy. The managers all gave a different response to the questions asked about what action they would take, including when to contact other partner agencies,
such as the Safeguarding and Protection Team (Vulnerable Persons) or An Garda Síochána if the concern could be criminal in nature. A new flow chart was seen in all areas of the centre, but the person in charge, designated person and service managers agreed it was not a correct representation of the procedure.

It was also identified through speaking with the managers that they did not have experience of how to conduct an investigation in response to an allegation of abuse. They reported that previous experience was limited to staff performance issues. None of the team had completed training of carrying out investigations.

Training had been arranged for the person responsible for training staff in centre on the safeguarding policy, however inspectors reviewed the course content and noted that it was a course on the UK arrangements, which is significantly different from the Irish context and would not adequately equip management or staff to fulfill their obligations in relation to safeguarding vulnerable residents.

Inspectors spoke to some of the staff about their understanding of what constitutes abuse, and all were found to be knowledgeable, identifying areas such as financial, physical and emotional abuse. Staff were clear about prioritising the safety of the resident, the reporting of allegations, disclosures and suspected abuse to line managers, and the need to write information down as soon as possible. However, some staff were not clear which process to use to report the information, and none knew the designated officer to whom they should report allegations of abuse, as identified in their policy.

Through the course of the inspection it was identified that there had been an incident in the centre, involving two residents. This had been responded to, and medical assistance was provided. Records and staff confirmed a review of the supervision of residents had been carried out and safeguards were put in place, for example extra staffing. However, the incident had not been identified as abuse, in line with their policy, and therefore had not been appropriately investigated in accordance with the national policy and the regulations.

When inspectors spoke with the management team about this incident, asking if they had considered if it was an allegation of ‘peer on peer’ abuse, they said they had not considered it was that, and therefore had not managed it in that way, or provided a notification to HIQA, as required in cases of suspected or confirmed abuse. The appropriate notification has since been received by HIQA, and managers did identify that they should had identified in this way from the outset.

It should be noted that the staff on the day of the inspection were seen to be treating the residents with respect and warmth, and all involved in the centre were committed to ensuring residents received the care and support they needed. However, due to the lack of experience of those involved in writing and implementing the policy, and those with a role in responding to abuse, the risk of poor management of any further incidents was high.

Behaviour Support

Inspectors were provided with a policy on positive behaviour support as part of the
action plan update, following the previous inspection. The policy was read by inspectors who identified that it set out guidance of how to develop a behaviour support plan, but did not give an overview of the subject of behaviour support, including ways to identify and alleviate the underlying cause of behaviours. It would therefore not guide staff practice.

When asked about their knowledge of behaviours that challenge, most staff said they would like to receive further training in this area. The training they had received was seen to include practical advice, for example writing a plan, and carrying out any agreed physical restraint.

It was raised on the previous inspection that residents did not have appropriate behaviour support guidelines in place. Since then, progress had been made, and a commitment had been made to have them in place for all residents by December 2015.

Inspectors reviewed two completed support plans, and one draft. They did provide information on the residents history, and information on what practical action to take at different stages of escalation/agitation, they were person centred, and had been written specifically for the resident. However, it was noted that they referenced other documents that held key information, and so relevant information was not available together for ease of reading. An example of this was to find ‘calming methods’ in a separate document, and protocol around giving ‘as required’ (PRN) medication in another document.

It was also observed that the behaviour support plans were not dated, or signed. Therefore it was not possible to confirm they were current or who wrote them, although staff did say they were written by the behaviour support team over the last three months.

There had also been a new admission to the service. this resident had a range of needs that required staff to have very clear guidance around how to support the resident effectively. This resident did not have a behaviour support plan. Documentation available did not provide enough detail to guide staff practice effectively. There had been a number of incidents involving this resident, which provided evidence of ineffective management arrangements in place.

The team developing the behaviour support plans were led by a psychologist, who was only available to the service one day a week. The other members of the team had received limited training around the area of behaviour support, with training focusing on developing a specific type of support plan. The staff team raised concern of the lack of training of the team, lack of availability of the psychologist, and lack of behaviour support plans to guide them in supporting the residents.

Staff explained the process of gathering information to feed into weekly meetings with the behaviour support team, that produced weekly guidelines, but it was noted that these ran to many documents, and were not summarised to provide the pertinent information to the staff in an easy to access format.

Restrictive practice
Further development had taken place in relation to the systems to approve, review and monitor restrictive practice in the centre since the last inspection, however a number of the serious concerns remained.

A policy around restrictive practice had been developed following the previous inspection. On reading the document inspectors found that it gave a very high level overview of what the procedure should be in a service, but was not specific to this centre, and so did not guide staff in the process they should follow.

It did not make reference to the HSE national policy ‘Towards a restraint free environment’. It focused on mechanical restraint, with no information on chemical and environmental restraint. It also referenced another provider that had nothing to do with the centre.

Since the last inspection, steps had been taken to complete a register of restrictive practice being used in the centre, and to set up a committee to approve and review any restrictions to ensure they were appropriate. A broad definition of restriction had been used to identify all practice in the centre, and all restrictions were recorded together to support an audit of practice. However records relating to the review of restrictions lacked detail of why decision to retain or remove restrictions had been made.

The membership of the restrictive practice committee remained unchanged since the last inspection. No training had been carried out to support their personal knowledge of expected practice in the area of restriction and deprivation of liberties. Staff spoken with confirmed they felt they needed training in this area to develop their skills. Copies of minutes of the restrictive practice committee meetings showed a number of members had questioned their role in the group.

The level of external or multidisciplinary involvement was seen to be very low. This merited a judgment of moderate non compliance under Outcome 5. There was no documentary evidence of the consulting psychologist attending the meeting. Some meetings were carried out with only three people in attendance, all internal to the centre and without training, skills or knowledge in the area of restrictive practice.

It was not possible to identify from the minutes how they were formulating a decision, what alternatives had been tried if any, and also what actions had been completed. Many of the dates against actions had expired, but there was no update. The dates for the next updates were many months away, with no risk or urgency set against achieving any of the actions.

It was noted that some of the restrictions recorded related to diet, for example to avoid sugary food, however, there was no guidance from relevant professionals, such as a dietician or speech and language therapist setting out the rationale to support the recommendation. An example was seen of a restriction being recorded as in place with the following text ‘no reason’s identified’.

Where some restrictions had been lifted, there was no rationale recorded. For example in one area of the centre, there was a locked door to restrict the resident’s movement
out of the apartment. The restriction for locking the door was removed, then imposed again, and then removed again. There was no evidence provided to the inspectors as to why these decisions had been made, and what base of knowledge was supporting the decisions.

Risk assessments completed around raising the restriction were not fully completed, and did not set out the mitigating factors. For example in the strategy section it stated ‘door currently locked’. In the effectiveness column it stated ‘leaving doors unlocked’. In notes at the bottom of the document, it set out measures to ensure the residents safety on stairs, for example only use them with staff, and to hold trailing bars. This information was not in the risk assessment, and was not used to influence the residual risk rating.

It was also noted that when visiting one of the houses, the front door was locked even though the resident with the restriction in place was not present in the house. When asked staff said it just needed to be locked when that resident was present. On leaving the house, the inspectors heard the door being locked again, but the resident was not present. Other residents who did not have the agreed restriction of a locked door were in the house.

An action plan update was submitted ahead of this inspection setting out that the date agreed to arrange training for this area would not be met, due to the failure of the person appointed to carry out what was asked of them. This is discussed further in outcome 14.

**Judgment:**
Non Compliant - Major

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### 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):**

No actions were required from the previous inspection.

**Findings:**

A record of all incidents occurring in the designated centre was seen to be maintained. It was very detailed, with staff recording any form of event on the system. Some were incidents such as residents injuring themselves, for example scratches. Others included the use of control measures to protect a resident from a dangerous position, for example using an agreed method of physical intervention to stop someone stepping out in to a road.

On the computer database reviewed by inspectors, significant numbers of the
notifications had not been followed up, and there was no information about whether any action was required to reduce the risk of the incident or accident from occurring again.

The person in charge confirmed that at the time of the inspection, no audit was taking place, and only a limited analysis, which focused on the number of events per resident, and the time of day they occurred.

During a review of incidents it was identified that there was an incident of a peer on peer assault, as discussed in outcome 8, and this was not notified to HIQA as required by regulation 31(1)(f).

**Judgment:**
Non Compliant - Major

### Outcome 12. Medication Management

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

**Theme:**
Health and Development

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

**Findings:**
There were written operational policies implemented within the centre relating to the ordering, storage and administration of medicines to residents. However, the inspector found deficiencies relating to certain medication management practices, including the information provided regarding the use of certain PRN (as required) medicines, lack of segregation of expired medicines, and procedures for receipt of medicines within the centre. The medication management policy also required review and updating.

Medicines were supplied by a retail pharmacy business in individual ‘pouches’ where appropriate, and all medicines were stored securely within the centre on medication trolleys.

Staff informed inspectors that all medicines received from the pharmacy were checked by staff against the current cardex (prescription sheet), although the policy in place did not provide guidance on the procedure to be followed to ensure a consistent approach by all staff.

Inspectors noted that the prescribed dose as indicated on the cardex did not always match the labelled instructions on the pack of dispensed medicine. There was no system in place to detect these discrepancies when medicines were delivered from the pharmacy, and to ensure such discrepancies were checked with the prescriber and the
pharmacist to ensure there was no confusion regarding the dose to be administered.

Dates of opening were not consistently marked on prescribed eye drops to indicate their subsequent expiry dates. Inspectors also found that expired medicines were stored on the medication trolley with one resident’s PRN (as required) medicines, and had not been appropriately segregated to ensure that this medicine was not inadvertently administered to the resident concerned. Inspectors also found that one medicine had no expiry date indicated on the label. This medicine also should have been segregated for disposal or return to the pharmacy.

Inspectors observed that the administration of medicines to residents was in line with current best practice guidelines. The staff member spoken with was knowledgeable of residents’ individual medicines.

Staff were aware of procedures to be followed for disposal of unused and out of date medicines. All medication errors were recorded on medication error forms, and also recorded on the incident management software system. There was no consistent review of these medication errors to ensure trends could be identified and to ensure appropriate learning could occur. There was no facility on the incident management software to review medication related incidents for any given period of time.

Inspectors reviewed a number of the medication prescription (cardex) and administration sheets (MAR). One of these cardex sheets had not been signed by the prescriber, although staff members informed the inspector that there was a signed copy in the centre. A signed copy was sent to inspectors after the inspection.

There was no procedure or protocol in place to guide staff practice in these circumstances to ensure that medicines were only administered according to a signed cardex (prescription sheet), and that there was a defined protocol for emergency prescriptions to ensure the safe administration of medicines at all times. Inspectors also discussed the importance of ensuring that the times of administration as recorded on the administration sheet (MAR) corresponded with the prescribed time of administration as indicated on the cardex (prescription sheet).

The PRN medicines on a number of the prescription sheets (cardex sheets) were also reviewed and a number of deficiencies were identified including:
- The indications/conditions for use were not consistently indicated.
- The time interval between doses was not specified
- The prescribed dose of some PRN medicines as indicated on the cardex (prescription sheet) did not correspond with the doses detailed in the resident’s behaviour support plan
- The guidance documents available to staff to ensure safe administration of one medicine used in the event of epileptic seizures for one resident contained conflicting information that did not match the prescribed dose as indicated on the cardex (prescription sheet). The prescribed dose as detailed on the cardex did not indicate that a second dose could be administered.

There were no guidance documents or protocols in place to guide staff in the administration of certain PRN medicines, to ensure that these medicines were
administered as prescribed, at the correct times, ensuring the time interval between doses was clearly stated. These guidance documents/protocols should be easily accessible within the residents’ medication folder.

Inspectors also noted that on the PRN section of some residents’ cardexes (prescription sheets), there were sleeping tablets that were only prescribed for use while the resident was on home visits. The fact that these medicines were only for use while on home visits was not clearly indicated on all cardexes.

Staff received regular mandatory training on medication management. Staff had also received epilepsy awareness training. There was no system in place at the time of the inspection to assess the ongoing competency of staff to administer PRN medicines prescribed for residents in the event of an epileptic seizure.

A pharmacist from the retail pharmacy business supplying medicines to the centre visited the centre on a regular basis to conduct audits. The audits covered a number of areas including disposal, labelling, the MAR (administration sheet), the cardex (prescription sheet) and storage. There were no internal audits conducted that included observation of administration practices within the centre.

Medication reviews were also conducted within the centre, and inspectors were shown the most recent review that involved the prescriber (residents’ general practitioner), the pharmacist, the services manager and the team leaders. Residents’ medications were reviewed, including PRN (as required) medicines, any required blood tests, any changes to doses, discontinuations and any other relevant information.

The medication management policy required review and updating to ensure it provided guidance on all aspects of medication management, including prescribing, emergency prescriptions and the process for updating prescription sheets (cardexes), receipt of medicines from the pharmacy, and the use of over the counter (OTC) medicines. The relevant action plan is under Outcome 18.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):

**Findings:**
Inspectors identified that the systems in place to promote the delivery of safe care were not effective in all areas. Also that the centre was not managed by people with the necessary qualifications, skills and experience to carry on the role.

There was a clearly defined management system in place. This included a part time person in charge, who was supported in their role by two service managers. Each house had a team leader, who supervised the staff in the house, and supported them on day to day issues that arose.

A Board was in place that oversaw the governance of the centre. It was made up of a group of volunteers with a range of professional experience. They met on a regular basis, minutes for the last five Board meetings were reviewed by inspectors.

It was identified in the Board minutes for 21 April 2015 that a report had been presented to the Board, by an external specialist on safeguarding and residents' rights. The report made recommendations for an urgent review of the skills and competencies of the management team and also that some specific incidents be investigated.

The Board minutes of the following month (23 and 30th June 2015) make no reference to these concerns. In a meeting held with the provider nominee on the 10th July, inspectors asked what action had been taken in response to these concerns, and he set out it was felt they wanted a different approach taking for training purposes.

Issues of the skills and experience of the management team was raised as part of the last inspection on 10 February 2015. The action taken by the Board to address this area of non-compliance had not been effective, and no change had been made to the management arrangements in the centre. The person in charge confirmed they had attended some briefing sessions run by the HSE, but had not completed any specific training to support them in carrying out their role.

The Board had approved the submission of the action plan update. Following a review of that information and the findings of this inspection, it was found that there was still significant areas of non-compliance that had not been fully addressed since the last inspection, and dates committed to had expired.

The action plan update was submitted on the 30 June 2015. The person in charge reported that progress was being made in a range of areas, and that some actions had now been completed, for example a review of the risk policy, redecoration of residents' bedrooms and a review of residents' medication records to ensure there were no errors.

Documents were submitted with the action plan update, to provide evidence of achieving the agreed time line. However, on reviewing the information, policies were not found to be fit to guide practice, and a resident's medication record raised further concerns. Some examples of areas followed up by inspectors in relation to the action plan update are set out below.
Three of the policies submitted (safeguarding, restrictive practice and positive behaviour support) were still not fit for purpose as they did not clearly set out the process to be followed by staff. It was confirmed that policies had been developed by staff internal to the centre, and no external expertise was used in their development.

The action plan reported that the new procedures had been circulated via booklets/flyers and posters. However, as mentioned in outcome 8, the poster did not correctly set out the process in the centre, and staff were unclear of what to do if an allegation was reported to them. Training had not been provided to the staff team on restrictive practice, deprivation of liberties or Human Rights. The date submitted for this action to be complete was 30 June 2015.

The action plan also reported that an action of identifying any restrictions in place, and putting a specific plan in place for each restriction had been met. As set out in outcome 8, the minutes of meetings did not set out how the committee was assured that the least restrictive procedures were used. The team was made up of people internal to the organisation, with the exception of the consulting psychologist, who as minutes confirmed did not attend the meeting regularly, and decisions on altering restrictions were made in their absence. No training had been provided to the committee or the staff team. The date submitted for this action to be complete was 30 June 2015.

It was reported that an update of the organisational risk register had been completed, and risks had been reviewed with controls and mitigations in place. However, during the inspection inspectors found that this was not the case. Risk assessments would not guide practice in the centre, and an overall risk around specific areas was not identified. No training had been provided on completing risk assessments. The date submitted for this action to be complete was 30 June 2015.

A medication record submitted with the action plan update had a number of areas of concern, including clarity of when ‘as required’ (PRN) medication could be used. On inspection concerns were identified as set out in outcome 12. Following the inspection, a copy of a resident’s medication record was requested to ensure an action had been followed up. The action had been addressed, however a further issue relating to the dose of a paracetamol ‘as required’ (PRN) medication was still an area of concern. Some of the issues raised were ongoing from the previous inspections.

The action plan relating to the gaps in knowledge of the people covering the person in charge role committed to ‘arrange sessions with specialist engaged to provide specific training to management in relation to national policies and evidence-based best practice.’ As set out above the specialist had been engaged, but submitted a report to the board setting out their concerns of the managers skills and lack of experience to carry out their role. As set out above, it is not clear what action, if any the board has taken in relation to the concerns raised. The Board minutes show the CEO/person in charge has been tasked with sourcing the relevant training elsewhere. The date for this action to be completed was submitted as 30 June 2015.

It was raised with the provider nominee that inspectors suspected the Board membership had changed. They confirmed this was the case, and that they were
unaware of the requirement to notify HIQA. This is a breach of regulation 7(4) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 that require notification to changes to information supplied for registration processes.

At the time of the inspection, no unannounced inspections had been carried out by the provider nominee or their representative, and no annual report on the quality and safety of the centre had been produced.

Taking all of the above into consideration, it is the view of inspectors that the Board and the Person in Charge (the CEO/manager, and two service managers) have not demonstrated their fitness to undertake their roles. There is clear evidence that they have a lack of skills, qualification and experience to carry on the business of running a designated centre for persons with disabilities.

There was also clear evidence of a lack of knowledge of the requirement of the regulations on the part of the Board and the Person in charge.

The limited amount of multidisciplinary expertise used in the centre is also a matter for concern, as it is clear that internal staff do not possess the skills, training and experience to assess residents’ needs and recommend solutions in key areas of practice, for example behaviour support and restrictive practice.

Inspectors acknowledge that actions had been taken to address areas of concern, but they had been ineffective in the areas raised in this report, resulting in failure to support and promote the delivery of safe, quality care services for residents.

These concerns were raised with the provider nominee on the 10th July, where he acknowledged improvement was needed and committed to making changes in the centre.

**Judgment:**
Non Compliant - Major

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**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:  
Written policies and procedures, as they relate to Safeguarding and Safety of residents were reviewed under this outcome. The policies listed below did not provide sufficient information to guide staff practice in the centre.  
1) Prevention, detection and response to abuse  
2) Behavioural Support  
3) Medication management  
Other aspects relating to this outcome were not reviewed during this inspection.

Judgment:  
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Helen Lindsey  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Anne Sullivan Centre Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001388</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>08 July 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 September 2015</td>
</tr>
</tbody>
</table>

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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents personal plans in relation to behaviour support and restrictive practice did not show evidence of multidisciplinary involvement.

1. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Multi Disciplinary recommendations in place.

GP for all residents

Replace Speech and Language Therapist (Sept) and Dietician (August) and secure the services of a Psychiatrist (November) to ensure residents receive services appropriate to their needs

Conduct Care Plan meetings for all residents with Multidisciplinary Team participation and recommendations by 21st October to ensure that the care plans are agreed and recommendations implemented

Revise existing Positive Behaviour Plans to include MDT recommendations and include in all PBS plans as they are completed.

Proposed Timescale: 21/10/2015

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of managing risk, accidents and incidents was in place but did not ensure that there was on-going management and review of risk.

2. 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:
• Review each residents risk assessment, the environmental and organisational risk register, control measures and mitigations
• Complete the risk assessment section in EPIC for each incident, identify actions that are required and update care plans to eliminate or mitigate reoccurrence
• Use the HSE matrix to classify serious incidents and prioritise incidents that require immediate action to ensure the safety of residents.
• Establish a metric to measure the types and occurrence of incidents for review at Operations meetings
• Develop a quarterly analysis of incidents to assess trends and identify emerging risks
• Arrange key staff to take HSE Incident Management course
• Review and Update the Policy to ensure incidents are reviewed for lessons learned, action items are followed up and risk assessments updated before incidents are closed

Proposed Timescale: 30/11/2015
**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Staff did not have up to date knowledge, skills or training in the management of behaviour that is challenging, including how to identify and respond to early signs of abuse, and de-escalation techniques.

**3. 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:

- Training course for Management on managing a positive behaviour support program – completed
- All permanent staff to receive training in Positive behaviour support. This training will give staff knowledge of behaviour Support and the practices to be employed by staff – scheduled for October and November
- PBS training will also ensure that staff have the up-to-date knowledge and skills to detect and respond to early signs of abuse
- As each resident’s behaviour Support plan is developed, a trained PBS person will work full time with each resident’s staff team to ensure staff are familiar and practiced in operating the Positive Behaviour interventions for the resident
- Two staff to commence a Multi-Element Behaviour Support course commencing in September 2015, to graduate in May 2016
- 2 MAPA training sessions (provided by qualified in-house trainer) to take place before December 2015 to assist staff in de-escalation and intervention techniques
- Engage an external consult to review and supervise the implementation of the behaviour program to ensure effectiveness and ensure that PBS techniques and strategies are appropriate to the complex needs of residents. – November 30th

**Proposed Timescale:** 31/12/2015

**Theme:** Safe Services

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

Not all residents had a clear up to date plans in place that identified and gave clear guidance on how to alleviate the cause of the residents behaviour.

Where plans were in place, not all pertinent information was available to access.

**4. 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:**
- Change the PBS plan format to include recommendations from Multidisciplinary Team Members and that they are consistent with Person Centred, Care and Health plans
- Increase behaviour support resource to a full-time person (from August) to develop Positive Behaviour Support Plans with an increased emphasis on; proactive strategies and positive actions to alleviate the causes of challenging behaviour. This is to ensure that behaviour support plans are developed that are effective, staff receive appropriate support.

**Proposed Timescale:** 31/12/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy on behaviour support and restrictive practice did not give enough information to guide staff practice, and the process being followed in relation to restrictive practice was not in line with the national policy and evidence based care.

5. **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:**
- Revise the behaviour support and Restrictive practice policies to provide information on staff practice in line with national policy and evidence based care - September
- Develop and implement procedures to ensure that having considered all alternatives, restrictions are the minimum necessary, evidence based, for the shortest period of time and subject to scheduled reviews - October
- Engage an external consultant to review these policies to ensure compliance - October
- External consultant to audit the procedures and implementation - November
- Training program on Restrictive Practice for all staff to be provided by an external training company, to ensure staff have information to guide practice and ensure the safety of residents and compliance with their Human Rights - September
- Select members of the Human Rights and Restrictions Group (September), provide training (October) to commence meetings and implement a rights and restrictions review process

**Proposed Timescale:** 30/11/2015
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy in place to set out the procedure for protecting residents from abuse did not give clear instruction to guide staff practice.

People identified in the policy were not clear on their role, or how to carry out an investigation.

Where an incident had occurred, staff were not able to identify that it met the definition of abuse, as set out in their policy.

6. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
• Revise the policy on Protection of Vulnerable Adults to give clear instructions to guide staff practice and comply with National policy – September 30th
• Clarify reporting and investigation procedures for managing concerns relating to Managers and Person in Charge
• Provide clear guidance on their roles to staff to ensure they are aware of the signs of abuse, reporting procedures and safeguarding measures by means of a revised policy booklet – September
• External consultant to review the Policy for compliance
• External consultant to review lessons from Notifiable events and implement procedures to ensure incidents are reported, investigations undertaken, action plans developed and safeguarding plans implemented – October 31st
• Provide training from an external company for Managers and Leaders to conduct Investigations and ensure that effective safeguarding plans are developed to ensure that safety of vulnerable adults at all times - October
• Staff Training program on protection of Vulnerable Adults by an external company arranged for all staff to ensure they have the knowledge and skills to identify abuse and implement safeguarding plans

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been an incident in the centre where the person in charge had not initiated an investigation in relation to an incident of alleged abuse.

7. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.
Please state the actions you have taken or are planning to take:
• Investigation conducted and completed with outcomes advised to HIQA and HSE
• Safeguarding Plan notified to HIQA and HSE and implemented
• Risk Assessments updated and procedures in place to ensure the reduction of likelihood of future incidents occurring
• Management to review all incidents to identify incidents to be investigated and safeguarding plans implemented
• All staff to participate in Protection of Vulnerable Adults training to ensure that they have the knowledge to identify incidents of abuse and know the procedures to report such incidents to the Designated person or alternative reporting channels.
• All staff are advised of their role in protection of vulnerable adults and their duty to report incidents – August 24th

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received training that provided them with the knowledge of what steps to take should they be informed of, witness or suspect abuse.

8. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Training on steps to be taken by staff when informed of or witness abuse included in Protection of Vulnerable adults training arranged for all staff - by September 30th

All staff informed in writing of their duty to report incidents of suspected abuse

Proposed Timescale: 30/09/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
HIQA had not been notified of an allegation of abuse as required.

9. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation,
suspected or confirmed, abuse of any resident.

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

- HIQA notified of Incident on 10th July
- Incidents to be reviewed at Operations meetings to test if they are notifiable
- Management have reviewed and are familiar with the list of Notifiable events to ensure all events are notified as required

**Proposed Timescale:** 05/08/2015

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**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:

Dates of opening were not consistently marked on prescribed eye drops to indicate their subsequent expiry dates. Expired medicines were stored on the medication trolley and had not been appropriately segregated to ensure that this medicine was not inadvertently administered to the resident concerned.

**10. Action Required:**

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

- Opening dates to be marked on prescribed eye drops – labels to be provided by pharmacy to cover all medications
- Expired medicines to be segregated in specific totes for returns
- Procedures to be developed for expiry and returns
- Update policy to ensure effective and safe administration of medication in line with best practice
- Pharmacy company to review policy to ensure it complies with best practice and that audit systems are in place to effectively monitor administration of medication

**Proposed Timescale:** 31/10/2015

**Theme:** Health and Development

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

There was no system in place at the time of the inspection to assess the ongoing competency of staff to administer PRN medicines prescribed for residents in the event
of an epileptic seizure.

11. **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:**
- Training provided by Pharmacy on administration of PRN to residents in the event of an epileptic seizure for the staff team of one identified resident – completed
- Maintain list of staff who received such training
- Include epilepsy awareness training in Induction and refreshers for all staff

**Proposed Timescale:** 30/11/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The PRN (as required) medicines on a number of the prescription sheets (cardex sheets) were also reviewed and a number of deficiencies were identified including:
- The indications/conditions for use were not consistently indicated.
- The time interval between doses was not specified
- The prescribed dose of some PRN medicines as indicated on the cardex (prescription sheet) did not correspond with the doses detailed in the resident’s behaviour support plan or within the care plan in place to manage epileptic seizures for residents.
- PRN medicines prescribed for use during home visits were not clearly identified on the cardex.

There were no PRN protocols or guidelines in place in the medication folders for a number of prescribed PRN medicines to provide appropriate guidance to staff to ensure the safe administration of these medicines.

12. **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:**
- Update procedures to ensure the indications and conditions for use of PRN medicines are stated and the time interval between doses is specified
- Behaviour Support and Care plans to be checked to ensure consistency with the prescribed dose of PRN medicines as indicated on the cardex (prescription sheet)
- PRN medicines prescribed for use during home visits to be discontinued
- PRN guidelines to be developed and placed in medication folders to ensure safe administration of these medicines
**Proposed Timescale:** 30/11/2015

**Theme:** Health and Development

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

The medication management policy and associated procedures require updating to ensure that:

- procedures are in place for the receipt of medicines into the centre to ensure appropriate checks with the residents’ current cardex, and that any discrepancies between the prescribed dose as indicated on the cardex and the labelled instructions are discussed with the prescriber and the pharmacist.

- the medication management policy provided guidance on all aspects of medication management, including prescribing, emergency prescriptions and the process for updating prescription sheets (cardexes), receipt of medicines from the pharmacy, and the use of over the counter (OTC) medicines.

- There was no consistent review of medication errors to ensure trends could be identified and to ensure appropriate learning could occur.

- There were no internal audits conducted that included observation of administration practices within the centre.

- Medicines were only administered according to a signed cardex (prescription sheet), and that there was a defined protocol for emergency prescriptions to ensure the safe administration of medicines at all times.

**13. Action Required:**

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

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

- The medication management policy and associated procedures will be updated to include prescribing, emergency prescriptions, the process to update prescription sheets, receipt of medicines and the use of UTC medicines.
- Medication errors will be recorded in EPIC as incidents and classified for ease for review quarterly.
- Develop audit checklists for observation of medication administration practices and to conduct audits.
- Pharmacy company to conduct quarterly audits to ensure compliance with policy and procedures and advise on best practice in medication management.

**Proposed Timescale:** 30/11/2015
### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider had not appointed a person in charge with the skills, qualifications and experience necessary to ensure the designated centre operated within the framework of the regulations.

**14. Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
- Appoint a full-time CEO with qualifications and experience necessary to operate a designated centre and be a fit person to assume the Person In Charge responsibility in the Centre.
  - Recruitment consultant appointed and seeking specialist external support to aid selection process
- As an interim engage an appropriate person to be the clinical lead to work with the Multidisciplinary team ensuring effective interventions and participate in the clinical governance of the centre – by September 30th
- Review Incidents and ensure actions taken are appropriate and in line with National Policy and Best Practice
- Supervise the Multi-disciplinary team
- Ensure that Care Plans are appropriate to each persons need and incorporate MDT recommendations
- Participate Operations meetings
- Report monthly to the Board

**Proposed Timescale:** 31/12/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
At the time of the inspection no unannounced inspections had been carried out by the registered provider.

**15. 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:
• Unannounced inspections will take place and any deficiencies identified as part of these inspections will be subject to a formal implementation plan with specific dates and all such plans will be followed up and closed off in a timely manner. Furthermore any deficiencies identified in earlier inspections will be specifically checked as part of future inspections.
• Appoint members to the Quality and Assurance Group in accordance with the Charter approved by the Board to ensure appropriate Quality and Safeguarding systems are in place and effectively monitored.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider did not ensure effective arrangements were in place to facilitate staff to raise concerns about the quality and safety of the service in that the policy, reporting procedure and training were not in place to guide staff practice in relation to:
- safeguarding vulnerable adults
- behaviour support
- restrictive practice

16. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
Revise policies and procedures to ensure staff can raise concerns in regard to:
• Safeguarding vulnerable adults
• Behaviour support
• Restrictive practice

Provide training to staff to guide staff practice on raising concerns and safeguarding actions as part of the training program arranged in September

Ensure that the policies and systems to raise concerns and identify abuse and potential abuse are communicated to all staff by means of booklets, posters and briefings

Human Resources to initiate a program of communications to embed a culture of openness and transparency, particularly related to reporting concerns of abuse and bad practice, Refocus the “Living the Values” award program to support these values

Communicate to staff in writing that they have a duty to report incidents of abuse or suspected abuse and that not doing so places a resident in danger - completed
Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to ensure the service was safe, and appropriate to residents' needs were not effective and there was no system of effective monitoring taking place.

17. 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:
• Engage a consultant to review the service and specify monitoring systems to be implemented
• Implement the Quality and Assurance Group consisting of Board Director, Family Representative, Management Staff and external people with expertise to oversee a monitoring system to ensure residents are safe and services are effective
• Appoint people to this group - October, provide training (November) and operate a Quality and Assurance program by commissioning reports and audits to ensure the service is safe and appropriate to residents needs

Proposed Timescale: 31/12/2015

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 policies listed below did not provide sufficient information to guide staff practice in the centre.
1) Prevention, detection and response to abuse
2) Behavioural Support
3) Medication management

18. 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:
Revise policies to provide information to guide staff practice in:
1) Prevention, detection and response to abuse
2) Behavioural Support
3) Medication management
Engage external review by a consultant and a pharmacy company of the above policies to ensure that they are effective and ensure staff practices are in place to provide safe services for residents

**Proposed Timescale:** 31/10/2015