

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
<b>Centre ID:</b>	OSV-0004579
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Ireland
<b>Provider Nominee:</b>	Una Nagle
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From: 08 March 2016 10:00 To: 08 March 2016 18:30

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 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This monitoring inspection was the first inspection of this centre carried out by the Health Information and Quality Authority (HIQA).

The centre was a two-storey house in a rural location with a separate attached one-bedroom self-contained apartment. Three residents lived in the main house and the fourth resident lived in the separate self-contained apartment. The centre provides a service for residents with an intellectual disability who require a high support residential placement with full-time supervision. Residents living in this centre have a specific risk profile.

As part of the inspection, inspectors discussed practices with the team leader who was identified as a person participating in the management of the centre and reviewed documentation such as personal plans, medical records, the incident book and staff training records.

Inspectors found some good practices by the staff team, led by the team leader. The team leader demonstrated that he knew residents well and displayed a person-centred approach to supporting residents. Inspectors briefly met with other staff at

the end of the day and observed interactions between staff and residents to be appropriate and supportive. There was an obvious good rapport between staff and residents.

However, inspectors found a high level of non-compliance on this inspection with 8 of 10 outcomes at the level of major non-compliance. It was not demonstrated that the governance and management arrangements were satisfactory as the person in charge was not involved in the operational management of the centre. The person in charge was unable to confirm how often she was in the centre and told inspectors that she was not in the centre even on a weekly basis. It was not demonstrated that the service provided was safe, effectively monitored or provided a therapeutic environment that met residents' specific needs.

The provider failed to demonstrate that residents were protected from sexual, physical, verbal and psychological abuse due to the incompatible mix of residents in this centre.

The provider was required to take immediate action to address two key failings. These related to the unauthorised use of an environmental restriction for a resident and also, it was not evidenced that safeguarding arrangements were satisfactory, particularly as they related to staffing levels. Other key failings related to arrangements in place to protect the health and safety of both residents and staff, the failure to implement recommendations following incidents of concern, lack of multi-disciplinary support to the staff team and breaches of residents' rights.

The provider nominee was invited to attend the HIQA head office the week following the inspection for feedback in relation to the inspection findings and to provide re-assurance in relation to the failings identified on this inspection. The provider nominee was issued with a warning letter at that meeting as the non-compliances identified impacted negatively on the safety and quality of life of residents. The provider nominee responded adequately to the warning letter and undertook to address the identified failings.

Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Three residents lived in the main house and the fourth resident lived in the separate self-contained apartment attached to the house. Each of the bedrooms in the house had restricted access via a 'fob' system and each resident carried a fob for their own bedroom only. Where environmental restrictions were in place, this is discussed under Outcome 8: Safeguarding and safety and in the associated action.

Inspectors saw that a resident was being monitored via single live-feed closed circuit television (CCTV). The CCTV was in place in this resident's living quarters only, not in the bathroom or bedroom. However, the resident was not aware that the CCTV was in operation and had not given their consent to its use. This had been identified by the service as a restriction on the privacy and dignity of the resident in 2014. There was evidence that this issue has been progressed since September 2015 and that members of the MDT made a recent (unsuccessful) attempt to inform the resident of the presence of the CCTV.

There was a service-wide behaviour standards committee chaired by a clinical psychologist that reviewed and approved any restrictive practices. The person in charge confirmed that restrictions on residents' lives as discussed above, including the use of CCTV, had not been approved by this committee. In addition, this approval had been sought since 2015. A referral for independent advocacy had been sent by the provider to the national advocacy service two years previously. However, the provider nominee confirmed that residents did not an independent advocate to assist decisions in relation to their care and support and any restrictions in place.

Inspectors were informed that two residents were wards of court. There was documentation available in the centre in relation to the wardship for each of the two residents and staff spoken with demonstrated a clear understanding of the extent of the wardship. There was evidence of input from the social work department where recent queries had arisen.

**Judgment:**  
Non Compliant - Major

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**  
Effective Services

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

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

**Findings:**

While an annual review of residents' healthcare needs was completed, it was not demonstrated that a comprehensive assessment of residents' personal and social care needs of each resident was carried out on an annual basis or as required to reflect changes in need and circumstances.

Each resident had a personal plan and involvement of residents into their personal plans was evident. Personal plans included information about each resident, their likes and dislikes, day service or employment that they enjoy or participate in, a summary of residents' personal goals, a current personal outcomes plan and an easy-to-read version of personal outcome measures.

The review of the personal plan was documented. For example, for one resident, their personal plan had been reviewed twice in 2015. However, the review of the personal plan was not multi-disciplinary, as required by the Regulations.

In addition, inspectors found that personal plans had not been updated following these reviews. The team leader outlined that for one resident, this was due to advice received from the head of social work that a multi-disciplinary approach was required when setting priorities for residents. Inspectors reviewed that this recommendation was outlined in a letter dated September 2014. It was not clearly demonstrated how this recommendation had been progressed.

Overall, there were significant deficits in the personal planning process. It was not demonstrated that residents' personal plans were based on a comprehensive assessment of their needs and as mentioned above, the review of the personal was not multi-disciplinary. The negative impact on residents arising from the absence of a multi-disciplinary review of their personal plans on at least an annual basis, or to reflect changes in need and circumstances was evident in a number of ways. For example, environmental restrictions were in place due to the incompatibility of residents residing either together or in close proximity with each other and this was not reviewed as part of the personal planning process. In addition, the absence of an annual review failed to provide a forum whereby issues regarding residents' rights, personal safety or concerns by family members were discussed and addressed.

Other meetings took place that considered residents' progress. For example, it was evidenced that living options were currently under review by members of the MDT for one resident. A recent house meeting held on 27/1/2016 had been attended by the heads of psychology and social work and the team leader. This meeting discussed key issues in the centre, such as the use of CCTV, restrictions, supports required in relation to financial decision-making and required protocols. However, the link between assessments, planning for residents' future needs and other parallel meetings that outlined actions required to support residents' needs was not clear.

Inspectors found that the designated centre did not meet the assessed needs of all residents due to the inappropriate mix of residents in the centre. Inspectors viewed a letter dating back to August 2010 where a relative had expressed their concerns about alleged on-going verbal abuse and threatening behaviour in the centre. While it was demonstrated that action was taken to address this issue however, there was on-going visual and verbal contact between the two residents.

**Judgment:**  
Non Compliant - Major

### **Outcome 07: Health and Safety and Risk Management**

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

**Theme:**  
Effective Services

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

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

#### **Findings:**

It was not demonstrated that the arrangements in place in relation to health, safety and risk management were adequate.

There was evidence that the team leader had completed risk assessments in relation to some key risks in the centre. For example, comprehensive individual assessments were in place in relation to fire evacuation and a detailed risk assessment had been completed that considered the risks relating to a resident attending a specific social event.

However, the risk register did not evidence a system in place to identify hazards, assess risks and monitor the effectiveness of controls specific to risks in this centre. Six risks were identified in the risk register which were relevant to safeguarding and to residents being 'angry'. While the additional control measures to manage these hazards had been identified, the dates for completion of the actions had lapsed. In addition, control measures had not been implemented. Clinical risk assessments required for residents are discussed under Outcome 8. There were no risk assessments in place for a number of readily identifiable hazards. For example, there was no risk assessment that considered the risk of assault to one resident who did not have an en-suite bathroom and had to leave his bedroom to access the bathroom at night. There was no risk assessment in the centre that demonstrated that the risk posed by residents to other vulnerable residents in the day service had been assessed. There were also no risk assessments relating to lone working or residents' outdoor smoking sheds.

An emergency folder was in place that contained contact details of emergency services, evacuation information and information for the emergency services. Arrangements were in place for staff in the event of an emergency and a personal panic alarm system was in use and connected to an external service provider. However and as discussed under Outcomes 8 and 17, staffing levels required review to reflect reasonably foreseeable emergency situations and to ensure the health and safety of residents and staff at all times. In addition, it was not evidenced that possible emergency scenarios had been adequately considered, including what would happen in the event of the only staff member on-duty or on-site becoming overpowered and/or incapacitated.

Inspectors reviewed the incident reporting system from January 2015 to February 2016 and incidents included three accidents and one incident where a resident required support to manage their behaviour. All incidents had been followed up appropriately by the team leader. However, based on a discussion with staff, verbal abuse to staff was not being recorded.

In relation to fire safety, two residents had a hearing impairment and the service had invested in a warning mechanism for these residents with the use of a strobe light in each bedroom. This strobe light was interconnected with the conventional audible alarm and if one of the alarms sensed smoke, all alarms sounded and the strobe flashed.

Each resident had a personal emergency evacuation plan in place which indicated what supports, if any, residents needed to leave the building in the event of a fire. Each resident had also had an assessment in January 2016 of their response to fire alarms. This identified that the two residents with hearing impairment also required a waking device fitted to their pillow in the event of an alarm. However, these had not yet been purchased. The risk assessments further identified that fire doors were not fitted throughout the premises and there was no emergency lighting in the main house. The team leader confirmed that there was emergency lighting recently installed in the self-contained apartment. However, relevant certificates were not available in relation to

this. During this inspection the fire safety installations of fire alarm panel and fire extinguishers were all within their statutory inspection schedules.

The fire register recorded fire evacuation drills. There had been fire drills in August 2014, February 2015, June 2015 and December 2015. The fire register did not indicate how many residents were present for the drill or how long it took to evacuate the residents. Inspectors were not satisfied that fire drills were being carried out at suitable intervals. In particular, as the response to the fire alarm by the resident living in the self-contained apartment was not recorded. However, the team leader confirmed that practice drills to date had not identified any issues of concern. Doors and the gate that were restricted by fob access were connected to the fire alarm.

**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.*

**Theme:**

Safe Services

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

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

**Findings:**

The provider failed to provide reassurance that residents were protected from all forms of abuse in the centre, including sexual, verbal, physical and psychological abuse, as a result of an incompatible mix of residents in this centre. The incompatibility of residents was identified as an issue as far back as 2002 and again in 2014.

It was not demonstrated that the system in place for investigating incidents, allegations or suspicions of abuse was robust. Inspectors reviewed the follow-up to an incident that occurred in July 2014. Initial screening had been completed by the designated person (DP) who determined that a full investigation was not required. Three recommendations were outlined by the DP. It was not demonstrated that two of the three recommendations were adequately implemented. One recommendation was that the DP "strongly recommends" that a clinical risk assessment is undertaken so as to provide guidance on the suitability of the two residents involved in the incident residing together. At the time of inspection (one year and nine months later), clinical risk assessments for the two residents concerned had not yet commenced. A second recommendation related to protocols to guide staff when only one staff is on-site. The

protocols developed did not address this specific recommendation. A third recommendation relating to the use of Closed Circuit Television (CCTV) had been progressed.

It could not be demonstrated that where restrictive practices were in place, such procedures were applied in accordance with national policy and evidence-based practice. As mentioned in outcome 1, a resident's living space opened into an outdoor area enclosed by a fence. There was thumb lock mechanism on the inside of the patio door that the resident could lock and unlock. However, access and egress to the enclosed outdoor area was via a gate controlled by a magnetic fob. The resident was unable to leave the enclosed area independently as the resident did not have access to a fob. As a result, the resident's movements were restricted at all times when that resident was in their living space and had to phone the main house and ask staff when he wished to leave. It was evidenced that the resident presented a potential risk to the health and safety of other residents and staff. The provider told inspectors that the separate living arrangement had been approved by the multi-disciplinary team in 2009. However, at the time of the inspection, it had not been approved by the relevant restrictive practices committee. The team leader told inspectors that this resident was restricted to his apartment between 5pm and 8am the following morning every week night. At weekends, staff supported the resident to participate in community activities on a 1:1 basis. The provider was required to take immediate action to review the process in relation to the restrictive practice as described above.

In addition, it was not demonstrated that suitable alternatives had been considered to the use of seclusion. For example, a review of minutes from a team meeting attended by the heads of psychology and social work and September 2015 and discussion with the team leader indicated that suitable alternatives, such as alternative living accommodation, were possible. However, such alternatives had not been satisfactorily progressed.

It was not demonstrated that staff had been provided with required on-going support from the multi-disciplinary team that reflected residents' needs from 2002, although this support was more recently being provided (since September 2015). This lack of support was evidenced in a number of ways in the context of safeguarding and safety:

Forensic assessments that were in place for residents were dated 2002.

There were no up-to-date clinical risk assessments available in the centre to guide staff. The team leader told inspectors that updated clinical risk assessments had been requested for all residents. These clinical risk assessments had been completed for two residents but were not available as working documents in the centre at the time of inspection. The person in charge provided inspectors with a draft risk assessment prior to the close of inspection, which was dated September 2015. A date to commence the completion of clinical risk assessments for the remaining two residents had yet to be determined.

One resident had a behaviour support plan, which was described in recent minutes as being outdated and not addressing that same resident's current situation. It was not clear whether other residents may need such a support plan as clinical risk assessments

were not in place to provide guidance in relation to same. However, an incident in the day service involving another resident in September 2015 demonstrated that at least one other resident required a behaviour support plan.

Only two of four residents had safeguarding plans in place, which had been developed in June 2015 by the person in charge, team leader and a clinical psychologist. Safeguarding plans specified that the two residents "require line of sight supervision at all times" by staff. The importance of staff supervision and vigilance was also outlined in the 2002 forensic assessments. The team leader explained that staffing levels had been increased from one to two staff following an incident in July 2014. However, there were gaps in the rota and there were times that only one staff was on-duty. As a result, it was not demonstrated how staff could have line of sight supervision at all times of the two residents, as required by the aforementioned safeguarding plans. In addition, it was not demonstrated that the staffing levels in place were based on a comprehensive assessment of residents' needs, a risk assessment and considered residents' profiles and also, the layout of the centre.

There were no protocols in place that related to specific risk behaviours or any specific recording sheet for sharing of such key information. For example, any verbal abuse and intimidating behaviour was not captured or reported in incident forms or other standard formats. Practices were based on staff's understanding of past incidents and experience of supporting residents. This was also identified as a failing in the draft clinical risk assessment viewed by inspectors prior to the close of the inspection.

**Judgment:**  
Non Compliant - Major

#### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**  
Safe Services

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

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

#### **Findings:**

Notifications had been received by the Authority where indicated by the Regulations. A report was provided to the Authority at the end of each quarter with respect to notifiable incidents occurring in the centre. However, the quarterly report submitted to the Authority did not include environmental restrictions in place in the centre, such as the use of seclusion.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

While residents had access to a number of medical and allied health services, it was not demonstrated that residents had access to all required healthcare professionals and allied health services to meet their needs.

Residents had timely access to their general practitioner (GP). Staff demonstrated that they were alert to signs of deteriorating mental health and provided a detailed relevant history to the GP in such instances to inform resident's care. Residents had regular access to a consultant psychiatrist and to other medical consultants where required.

Residents had access to some allied health services, including dentistry, chiropody, podiatry, audiology and dietetics.

However, where follow-up was recommended by healthcare professionals, it was not evidenced that recommendations had been implemented in full. Access to forensic psychology was not facilitated on an annual basis, as recommended in a forensic report by a consultant psychologist in 2002 for all residents. On the day of inspection, documentation made available for review in the centre did not evidence that reviews had taken place on an annual basis following completion of the 2002 forensic assessments.

In addition, access to psychology to develop behaviour support plans and clinical risk assessments was not facilitated in a timely manner. For example and as outlined in outcome 8, the need to refer two residents to psychology for clinical risk assessments was strongly recommended by the organisation's designated person following an incident in July 2014 but these assessments had yet to be completed.

Residents were supported in terms of meal planning and meal preparation, in accordance with their wishes and abilities. On the day of the inspection, it was observed that residents chose what they would like to have for tea and residents undertook tasks independently, such as setting the table.

**Judgment:**

Non Compliant - Major

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

The organisation had a medicines management policy in place and there was also a local medicines management policy for this centre.

The policy detailed the procedures for safe ordering, prescribing, storing and disposal of medicines. The policy also outlined the procedures in place for the management of PRN (as required) medicines.

Regular medicines were ordered on a weekly basis from the pharmacy and PRN "as required" medicines were ordered on a monthly basis. A record of orders was maintained that evidenced careful checking that medicines received were as ordered.

Returns to the pharmacy were recorded. A 'biodose' system was in use in the centre. The team leader (who was a person participating in the management of the centre) articulated the steps that would be taken in the event of a medication dose being changed or withheld.

The team leader demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Training had been provided to staff in relation to medicines management. No rescue medication or controlled drugs or refrigerated medication was in use in the centre at the time of inspection.

A sample of medication prescription and administration records was reviewed by an inspector. The medication administration records identified the medications on the prescription sheet and allowed for the recording of the time and date medicines were administered. Records demonstrated that medicines were either administered as prescribed or self-administered by residents.

Residents who chose to self-administer medication had an assessment completed and this assessment was reviewed periodically.

A PRN protocol was in place for each resident, which were signed by the staff team and the psychiatrist. Protocols clearly outlined the procedure for gaining residents' consent, when PRN was to be administered and the sequence in which PRN medication was to be

administered. The maximum PRN dose was clear to staff administering the medication. From a sample of records reviewed, PRN medication was administered as prescribed.

A system was in place to identify, report and investigate medication related incidents. Any medication-related incidents were analysed by the person in charge.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The Statement of Purpose consisted of a statement of the aims of the centre and the facilities and services to be provided for residents.

The Statement of Purpose did not meet the requirements of the Regulations as it did not accurately describe the specific care and support needs that the service is intended to meet nor was the admissions criteria adequate. This was particularly relevant given the specific nature of this service. The Statement of Purpose also failed to provide adequate information so as to inform relevant others in relation to any risks present.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

There was a clearly defined management structure in place in the centre. The staff team endeavoured to support residents to live a full and active life. However, significant failings were identified in terms of governance and management of the centre.

The provider nominee on behalf of the Brothers of Charity was the director of services for the Cork area. The person in charge reported to the sector manager, who in turn reported to the provider nominee. Staff were clear in relation to lines of authority and accountability.

The person in charge was a registered nurse in intellectual disability. The person in charge was suitably qualified and experienced to discharge her role, in accordance with the Regulations. The person in charge met with the team leader on a monthly basis off-site and was available on the phone or if issues arose in the centre. The provider nominee told inspectors that the person in charge was supported in the management of the centre by two community managers. However, it was not demonstrated that the governance and management arrangements were satisfactory as the person in charge was not involved in the operational management of the centre. The person in charge had a remit for six designated centres, in addition to day services spread over two sites. The person in charge was unable to confirm how often she was in the centre and told inspectors that she visited the centre "as required". This did not amount to visiting the centre even on a weekly basis. Given the level of non-compliance identified on this inspection, these arrangements were not satisfactory.

The team leader was identified as a person participating in the management of the service. The team leader had over 30 years experience supporting persons with an intellectual disability and had worked in this centre since 2002. While he had no formal qualification in health and social care, he had completed a range of training relevant to the role including the protection of vulnerable adults and the management of behaviours that may challenge. The team leader demonstrated that he knew the residents well and understood the challenges in the centre.

Monthly meetings were also held between the team leader and staff members. The most recent house meetings were attended by the head of psychology and the head of social work, indicating the recent commencement of MDT support to the staff team.

However, the provider failed to demonstrate that the service provided was safe, effectively monitored or provided a therapeutic environment that met residents' specific needs. This is evidenced by failings throughout this report in relation to safeguarding, risk management, staff levels and skills and lack of multi-disciplinary support to residents and the staff team. The cumulative impact of the failings identified on this inspection resulted in a failure to provide adequate reassurance that residents were protected from an on-going risk of sexual, physical, verbal and psychological abuse by their peers.

In addition, an understanding of what constitutes restrictive practice was not demonstrated by staff or management. The organisation's policy on restrictive practice did not reflect current agreed and accepted definitions of seclusion. Environmental restrictions had not been recognised as environmental restrictions and based on conversations with staff, verbal abuse was not recognised as such. This had implications in terms of underreporting of incidents and failure to notify HIQA of restrictive practices.

**Judgment:**  
Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**  
Responsive Workforce

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

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

**Findings:**

Given the importance of vigilance and staff supervision in managing risk in this centre and resident profiles, it was not demonstrated that staffing arrangements were adequate.

Team meetings were held every month and periodic service reviews also took place. Inspectors met with the team leader on the day of the inspection and found that he knew residents well and displayed a positive approach to supporting residents. Inspectors briefly met with other staff at the end of the day and observed interactions between staff and residents to be appropriate and supportive. There was an obvious good rapport between staff and residents. It was evidenced that residents were supported to participate in the community and pursue individual interests and hobbies.

As previously discussed under Outcomes 7 and 8, it was not demonstrated that the staffing levels in place were based on a comprehensive assessment of residents' needs, considered residents' profiles and risk in this centre and also reflected the layout of the centre. This finding was supported by the team leader who told inspectors that there were times when staffing levels were inadequate. Times of concern were described as periods of time when only one staff member was on duty, such as before residents went to bed at night. In particular, in the event of a staff member on duty being called to the separate apartment, this would leave other residents unsupervised in the main house. Re-assurance was not provided that staffing levels had considered risks to staff working alone in this centre and also, the resultant impact on vulnerable residents if a staff

working alone were to become incapacitated for any reason.

In addition, it was not demonstrated that staff had the required skills to meet residents' needs and manage risks particular to this centre.

A review of staff training records indicated that all staff had received training in relation to the protection of vulnerable adults. However, some gaps were noted. One of 14 staff required training in relation to the management of behaviours that may challenge. Two of 14 required training in relation to fire safety. However, staff had not been provided with training specific to supporting residents in this centre. For example, staff had not received support or training in terms of identifying specific indicators of risk and how and what relevant information to record. The need to up-skill staff was also highlighted in a draft clinical risk assessment for a resident viewed by inspectors towards the end of the inspection (dated September 2015).

Discussion with the team leader and a review of the staff roster indicated that core support to residents was provided by the team leader and a social care worker who worked opposite him on the rota. Support hours were provided from the day service and rotated between social care workers and a psychiatric nurse. A review of training records indicated that 12 support staff worked in the centre. The team leader told inspectors that the support staff worked in the centre on a rotational basis and consistency was provided.

**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:***

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## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
<b>Centre ID:</b>	OSV-0004579
<b>Date of Inspection:</b>	8 March 2016
<b>Date of response:</b>	14 March 2016

### Requirements

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

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

### Outcome 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:**

Where CCTV was in place in a resident's living quarters, the resident was not aware that the CCTV was in operation and had not given their consent to its use.

<sup>1</sup> 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 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The resident in the self contained apartment has been informed of the existence of the live-feed monitor to the staff room and has agreed to it remaining in place as a support to him if he requires staff assistance.

**Proposed Timescale:** 24/03/2016

**Theme:** Individualised Supports and Care

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

Due process was not followed when determining restrictions on residents' lives. Restrictions had not been approved by the relevant organisational committee.

**2. 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:**

1. Works are in progress to expand the Courtyard garden area attached to the self-contained apartment. Currently the apartment leads to a small courtyard garden which has a locked door protocol to restrict egress from the courtyard to the wider environment and to the main house. This improvement was decided on by the Team involving multidisciplinary inputs in January 2016 and the proposal was discussed with the resident. Works have been commissioned. Workers will be on site from 22nd March and the works will be completed no later than 28th March 2016.

2. The locked door protocol in relation to egress from the courtyard is being written up by the local team involving multidisciplinary supports who are actively reviewing any possible restrictive practices in the Centre. The team will conclude on this and will advance the sanctioning form to the Behavioural Standards Committee (BSC). BSC will review Regulatory Notice RN02/2014 to determine the restrictions to be reported to the Authority on a quarterly basis. 23 March 2016

3. A retrospective notification to the Authority will issue on 16 March 2016 in respect of the locked Courtyard which restricts egress for safety purposes pending the outcome of the BSC review of the restrictions notifiable status.

**Proposed Timescale:** 28/03/2016

**Theme:** Individualised Supports and Care

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

The provider nominee confirmed that residents did not have access to an independent advocate.

**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:**

1. A referral has been made to the National Advocacy Service. 30th March 2016
2. Private Independent Advocate: If the NAS cannot take on referrals then a decision to engage a private Independent Advocate to be made in consultation with the residents by 8 April 2016

**Proposed Timescale:** 08/04/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

While an annual review of residents' healthcare needs was completed, it was not demonstrated that a comprehensive assessment of residents' personal and social care needs of each resident was carried out on an annual basis or as required to reflect changes in need and circumstances.

**4. 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:**

Step 1:- Complete Updated Clinical Risk Assessments:  
(completed on 25th March 2016)

Step 2:- Complete Comprehensive Assessment of Needs:-  
To be completed for each individual by 15th April 2016

**Proposed Timescale:** 15/04/2016

**Theme:** Effective Services

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

It was not demonstrated that residents' personal plans were based on a comprehensive assessment of their needs.

**5. Action Required:**

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

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

The Personal Planning Tools previously used in this Centre were deemed not appropriate and the system recommended by the multidisciplinary led Clinical Risk Assessment Process will now be introduced and plans will be updated accordingly. The Plans will be reviewed with multidisciplinary supports no later than end of May 2016 (timeframe influenced by plans for revised living arrangements)

**Proposed Timescale:** 31/05/2016

**Theme:** Effective Services

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

The link between assessments, planning for residents' future needs and other parallel meetings was not demonstrated.

**6. Action Required:**

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

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

The revised assessment of need forms will clearly identify actions to be included in Personal Plans. The Personal Plans will identify the process by which goals will be planned for implementation.

The purpose of all parallel meetings to progress identified goals will be clearly documented in the Centre.

**Proposed Timescale:** 31/05/2016

**Theme:** Effective Services

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

The review of the personal was not multi-disciplinary. The negative impact on residents arising from the absence of a multi-disciplinary review of their personal plans on at least an annual basis, or to reflect changes in need and circumstances was evident in a number of ways.

**7. Action Required:**

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

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

The Personal Plans under the revised model of support will be reviewed by the team which will have multidisciplinary input.

**Proposed Timescale:** 31/05/2016

**Theme:** Effective Services

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

Inspectors found that the designated centre did not meet the assessed needs of all residents due to the inappropriate mix of residents in the centre.

**8. Action Required:**

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

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

The updated assessment of needs, when finalised, will inform the compatibility or otherwise of individuals and their appropriateness to reside in the Centre.

**Proposed Timescale:** 15/04/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

It was not demonstrated that the arrangements in place in relation to risk assessment were adequate. While risk assessments had been completed for specific events, the risk register did not evidence a system in place to identify hazards, assess risks and monitor the effectiveness of controls specific to risks in this centre.

**9. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

The Risk Register and risk assessment process will be fully reviewed to ensure that the centre-specific risks are fully identified and the necessary controls and monitoring arrangements are in place.

**Proposed Timescale:** 15/04/2016

**Theme:** Effective Services

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

There was under-reporting of incidents in the centre. Verbal abuse was not being recorded as such.

**10. Action Required:**

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

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

1. The Night Supervisor working with the Team will identify the frequency and pattern of verbalisations by residents.
2. All staff will get an updated briefing on the necessity to report all incidents occurring in the Centre through the day/night reports and the weekly report to the Person in Charge, to enable management to invoke the necessary follow up actions.
3. Staff will be refreshed on what constitutes verbal abuse under the Services Safeguarding Policy and on the necessary reporting requirements.

**Proposed Timescale:** 15/04/2016

**Theme:** Effective Services

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

Fire drill records did not evidence that the arrangements in place for evacuating all persons in the designated centre and bringing them to safe locations were adequate.

**11. Action Required:**

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

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

The fire drill records and evacuation procedures will be fully reviewed by the Night Supervisor to ensure that they are adequate for all residents and the records are updated accordingly.

**Proposed Timescale:** 15/04/2016

**Theme:** Effective Services

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

It was not evidenced that there were adequate arrangements for detecting, containing and extinguishing fires.

Fire doors were not fitted throughout the premises.

There was no emergency lighting in the main house and a certificate was not available for the emergency lighting in the apartment.

**12. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. Fire detection and control systems will be reviewed and upgraded as necessary.
2. Additional fire doors as identified as required under the risk assessment process will be fitted.
3. Emergency lighting as identified as required under the risk assessment process will be fitted throughout the premises and the relevant certification will be held in the Centre.

**Proposed Timescale:** 15/04/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

It was not demonstrated that all alternative measures are considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was used.

**13. 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 locked door protocol on egress from garden courtyard of the self contained apartment will be reviewed to ensure that it is the least restrictive measure that could be used in accordance with the approval of the Behavioural Standards Committee

**Proposed Timescale:** 27/05/2016

**Theme:** Safe Services

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

As detailed within the findings, it could not be demonstrated that where restrictive practices were in place, such procedures were applied in accordance with national policy and evidence-based practice.

**14. 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:**

The process of seeking formal sanction of restricted practices which commenced in September 2015 will be finalised by the Team and the sanction forms will be submitted for approval by the Behavioural Standards Committee (23 March 2016).

The restrictions will be reviewed within 3 months to ensure that they are the least restrictive as required as a condition of the approval.

**Proposed Timescale:** 22/06/2016

**Theme:** Safe Services

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

It was not demonstrated that staff were provided with the knowledge, skills and support that they required to support residents specific needs as they related to behaviours that may challenge and safeguarding.

Behaviour support plans were not in place for residents with behaviours that may challenge that reflected individual resident's current situation.

Clinical risk assessments were not available in the centre for all residents.

Safeguarding plans were not in place for residents who required them.

Requirements in terms of monitoring and recording of behaviours of concern were not outlined in procedures or protocols.

**15. Action Required:**

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

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

1. Each resident has been interviewed in relation to their physical and emotional wellbeing/negativity in relation to peer residents under a Risk Assessment Process or by interview at the introductory phase of this process. This was completed on 15th March 2016
2. The recommendations of the Updated Clinical Risk Assessments on staff training and skill sets required to support residents' specific needs as they related to challenging behaviours and safeguarding issues will be implemented in full.
3. The Behaviour support plans as informed by the updated Clinical Risk Assessments will form part of their personal plans and referral to Behavioural Support Services will be considered as part of multidisciplinary review of the plan.
4. All clinical risk assessments, safeguarding plans and files of meetings will be held in the centre. The PIC will ensure that all files including files of designated referrals will be reviewed to ensure that all information relevant to the care and support of individuals' resident is available to the staff team for the purpose of understanding current supervision protocols. (15 April 2016)
5. Training will be provided to staff in relation to reporting of incidents and report writing. (15th April 2016)
6. The Supervision and Staff Safety Protocols on lone working will be fully reviewed and updated (15 April 2016)
7. The Safeguarding Protocols will be reviewed/developed and additional protocols will be put in place as is necessary for monitoring and recording of behaviours of concern in the Centre

**Proposed Timescale:** 15/05/2016

**Theme:** Safe Services

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

There were inadequate safeguarding arrangements in place, including staffing arrangements, as it could not be demonstrated how residents' safety protocols could be implemented, including line of sight of residents at all times.

In addition and of particular note, it was not demonstrated that the staffing levels in place were based on a comprehensive assessment of residents' needs, considered residents' profiles and risk in this centre and also, the layout of the centre.

**16. 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:**

- 1 .Night Awake staff are rostered in the house. One of these staff is the Night Supervisor who is nominated as PIC of the centre as a temporary measure to ensure all necessary protocols and safety measures are in place and to risk assess staffing levels having regard to the layout of the centre.
2. Night Awake Staff will remain on the roster until the recommendations of the Clinical Risk Assessment process can be implemented. 22 March to 31 July 2016
3. Based on recommendations of the updated Clinical Risk Assessment a proposal to create two self contained apartments with the Centre and to relocate two residents to a separate Centre was discussed with the Executive. 29th March 2016.
4. Formal written was proposal submitted to Executive 1 April 2016.
5. Relocation plan to be implemented as soon as an identified alternative facility can be progressed through the Authorities Registration process 31st July 2016.

**Proposed Timescale:** 31/07/2016

**Theme:** Safe Services

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

The system in place for investigating incidents, allegations or suspicions of abuse was not robust. It was not demonstrated that recommendations made by the designated person following an incident in July 2014 had been implemented in full.

**17. Action Required:**

Under Regulation 08 (4) you are required to: Where the person in charge is the subject of an incident, allegation or suspicion of abuse, investigate the matter or nominate a third party who is suitable to investigate the matter.

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

1. The recommendations of the July 2014 alleged incident to carry out an updated Clinical Risk Assessment will be completed 25 March 2016 and was developed in to a undated safeguarding plan 29 March 2016
2. Safeguarding Plan will be implemented in full. 31 July 2016
3. The system for investigating incidents, allegations or suspicions of abuse will be reviewed to ensure referrals and resultant recommendations can be monitored to ensure timely implementation. The Designated Person and the PIC will agree the process using the Centre's Risk Register. 30 April 2016

**Proposed Timescale:** 31/07/2016

## 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:**

The quarterly report submitted to the Authority did not include all restrictions in place in the centre.

**18. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

1. A retrospective notification of restricted egress from the apartment courtyard was submitted to the Authority (16 March 2016)
2. A full review of all restriction in the Centre will be undertaken to ensure all such restrictions are reported to the Authority from Q1 2016

**Proposed Timescale:** 30/04/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

As detailed within the findings, where review was recommended by healthcare professionals, it was not evidenced that this had been facilitated in accordance with those recommendations.

**19. Action Required:**

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

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

Referrals to allied health services that were not processed and access denied will be reviewed to ensure that access will be available. Where access cannot be facilitated or delayed, alternative arrangements will be discussed with the Executive.

**Proposed Timescale:** 31/05/2016

**Theme:** Health and Development

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

As detailed within the findings, it was not demonstrated that where a resident required services provided by allied health professionals, that access to such services was provided.

**20. Action Required:**

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

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

Access to allied healthcare will be monitored and where access cannot be facilitated or delayed, alternative arrangements will be discussed with the Executive.

**Proposed Timescale:** 31/05/2016

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The Statement of Purpose did not meet the requirements of the Regulations as it did not accurately describe the specific care and support needs that the service is intended to meet nor was the admissions criteria adequate. This was particularly relevant given the specific nature of this service. The Statement of Purpose also failed to provide adequate information so as to inform relevant others in relation to the nature of risks present in this centre.

**21. Action Required:**

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

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

The Statement of Purpose will be reviewed to clarify a number of issues having regard to the revised plan for the Centre. In the interim the Statement of Purpose will clarify the Services available to the residents in the Centre.

**Proposed Timescale:** 31/07/2016

## Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

It was not demonstrated that the arrangement in place relating to the person in charge ensured the effective governance, operational management and administration of this designated centre, as evidenced by the level of non-compliance found on this inspection.

**22. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

Recommendation on the future PIC requirement, having regard to the recommendation of the Clinical Assessment Process, will be determined. 15 April 2016.

The PIC role will be advertised week commencing 25 April 2016.

Notification of changes to the arrangements of the Person in Charge will be notified to the authority. 18 April 2016.

### **Proposed Timescale:** 29/04/2016

**Theme:** Leadership, Governance and Management

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

The provider failed to demonstrate that the service provided was a safe service that provided a therapeutic environment to meet residents' specific needs and was effectively monitored.

**23. 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:**

1. An Acting Person in Charge will work on the roster to evaluate the future requirements in the Centre 22 March 2016
2. Recommendation on the future management structure to support the model of service will be determined by 15 April 2016
3. The revised model of support as identified by the updated Clinical Risk Assessment will be implemented 31 July 2016

**Proposed Timescale: 31/07/2016**

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

As detailed within the findings, it was not demonstrated that the number, qualifications and skill mix of staff was appropriate to the profile and risk in this centre and reflected the layout of the designated centre.

**24. 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:**

- 1 .From 14/15 March 2016, additional hours of cover as detailed to the Authority have been put on the staff roster until such time as the recommendation of the Clinical Risk Assessment Process can be put in place:-
2. An en suite facility will be installed in the second resident bedroom upstairs which will not require the resident to leave his room to use bathroom facilities at night.  
(13 April 2016)
3. On completion of 3 above, all residents bedrooms will be en suite and the fob alarm system will be reprogrammed to alert sleepover staff if bedroom doors are open during the night. If the alarm is activated the Person In Charge or nominee will convene a review of the incident and consider the adequacy of this measure. (13 April 2016).
4. The recommendation of the updated Clinical Risk Assessments on staff training and staff skill set required will be implemented
5. The Risk Assessment on staffing levels by the Person in Charge will inform the required the number, qualifications and skill mix of staff in the planned reconfigured service areas.

**Proposed Timescale: 31/07/2016**

**Theme:** Responsive Workforce

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

A review of staff training records indicated that gaps were present. One of 14 staff required training in relation to the management of behaviours that may challenge. Two of 14 required training in relation to fire safety.

**25. Action Required:**

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

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

All outstanding staff training will be updated

**Proposed Timescale:** 15/07/2016