Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by The Irish Society for Autism
Centre ID:	OSV-0003427
Centre county:	Meath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Irish Society for Autism
Provider Nominee:	Susan Alexandra (Lexi) Kennedy
Lead inspector:	Michael Keating
Support inspector(s):	Ray Lynch
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 April 2016 14:00	25 April 2016 20:30
26 April 2016 09:00	26 April 2016 16:00

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Inspectors undertook five inspections in this centre throughout 2015 and 2016. These inspections found evidence of poor outcomes for residents and areas of risk relating to health and safety, risk management, social care needs, safeguarding and safety, governance and management, use of resources and workforce. Poor managerial oversight and governance arrangements were also a recurrent finding in this designated centre. Due to the seriousness of the concerns, HIQA issued immediate actions and warning letters. Regulatory and escalation meetings were also held with the provider.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to cancel and refuse the registration of the centre was issued to the provider on 13 January 2016.

The provider subsequently appealed the decision of the Chief Inspector to the district court and a court hearing was set to commence on the 9 May 2016. On this date, the provider applied to withdraw their appeal. In accordance with Section 64 of the Health Act the chief inspector made alternative arrangements with the Health Service Executive (HSE) to take over the running of the centre.

HIQA continue to monitor this centre to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

Background to this inspection:
This unannounced inspection was triggered following notification of significant incidents of concern leading to injuries to residents, this was the fifth inspection of this designated centre operated by the Irish Society for Autism. Following previous inspections of the centre HIQA issued a notice of decision to cancel the registration of this centre. The provider had appealed this decision to the district court.

Subsequent to the inspection and prior to the publication of this report, the district court (on request of the provider) struck out the appeal and the HSE subsequently took over the management of the centre on 09 May 2016.

How we gather our evidence:
The inspectors spent time with many residents and observed staff practice. In addition the inspectors spoke with eight different staff members. The inspectors reviewed documentation such as care plans, daily notes, accident and incident report logs, risk assessments, policies and procedures and behaviour support plans. Interviews were also carried out with the person in charge and team leaders as part of the inspection.

Description of the Service:
The service provides autism specific 24 hour residential services for adults with a primary diagnosis of Autism Spectrum Disorder as described within its statement of purpose. However, the values and ethos of the service, particularly in relation to the rights and safety of residents, did not reflect the description of the service contained in the statement of purpose. The centre comprises eight houses and six single unit apartments across a large area comprising approx 70 acres of land.

Overall Judgment of Findings:
Overall, inspectors were concerned for the safety of residents. There continued to be a high level of non-compliance in all areas of care and support reviewed during this inspection, and in particular there were inadequate measures to protect residents from serious physical assault by other residents. Given the concerns of inspectors, they contacted the deputy chief inspector prior to the completion of the inspection and subsequently required the provider to take immediate action to manage these risks. Following the inspection, the deputy chief inspector wrote to confirm that the actions had been implemented and that residents were safe.

This was a focused inspection, and four outcomes were inspected against and were found to be in major non-compliance namely health safety and risk management, safeguarding and protection, workforce and governance and management.

These major non-compliances included:
• inadequate safeguarding measures to ensure residents were protected from assault and felt safe living in the centre
• ongoing risks to residents that were not being appropriately managed or responded to
• poor governance and oversight leading to negative outcomes for residents
• poor management of staffing resources
• staff not adequately trained to meet the assessed needs of residents.

The reasons for these findings are explained under each outcome in the report and the breaches of regulations are included in the action plan at the end of the report. However, following the change of provider following the notice of decision to cancel the registration of this centre. The Irish Society for Autism was no longer required to address the actions within the action plan. The new provider had to provide more immediate reassurance to HIQA by way of weekly updates of progress in relation to all actions required.

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

Findings:
Under this outcome, the inspectors focussed on the provider's management of accidents and incidents, and the safety of residents in the centre. Overall, inspectors found that the provider was failing to keep residents safe.

Inspectors had been notified by the provider of a number of incidents that had occurred and this inspection was triggered on the basis of that information. Inspectors found that residents had experienced significant injuries as a result of incidents in the centre. In addition, inspectors found that the provider and staff were aware of specific, recurrent risks and had failed to put arrangements in place to keep residents safe.

For example, arrangements for the management of some risks had been identified but the provider had failed to implement them. As a result, residents were at increased risk of injury and inspectors saw that there had been a recent serious injury because of the failure to implement these safety arrangements.

Inspectors also saw records where staff had assessed the risk to individual residents, but had used the risk assessment tool incorrectly and had not used it to inform their arrangements to keep residents safe. Again, inspectors saw examples of residents who had experienced injury because the provider had failed to ensure that risks were identified and managed appropriately.

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

Findings:
Overall it was found that adequate measures were not being taken to protect residents from being harmed resulting in targeted incidences of assaultive peer to peer aggression. In addition appropriate actions were not taken in response to allegations of abuse. An immediate action was issued by the inspectors to reduce the risk due to the urgency of the matters identified. In addition, the deputy chief inspector also wrote to the provider during the inspection seeking additional reassurances.

Known triggers and identified behaviour had not been adequately managed to prevent repeated incidences of peer to peer verbal and physical assault. In addition, inadequate measures had been taken to review and reduce the incidences of self-harm.

Safeguarding practices were poor as incidents between residents described by staff and team leaders as historical were not addressed. Risk assessments identified particular residents who were subjected to assault on a regular basis. The provider and staff had identified actions that needed to be taken to protect these residents, but had failed to implement them. Inspectors saw evidence of repeated incidents of assault with inadequate action to protect residents, resulting in a serious injury to a resident during the most recent incident.

One to one support had been introduced to provide additional support however; this additional resource was suspended at 20:00 hrs without reasonable explanation. Inspectors found that the risk to residents increased during this period as residents were in close proximity and there were reduced night-time staffing levels.

There was a policy in place for the provision of behaviour support; however this was not being implemented. Some residents had behavioural support plans which are used to guide staff on the most appropriate way to support residents. However, these were not updated as required, with the review date for many more than six months expired. In addition, there was no evidence that behaviour support plans were updated following significant incidents. Some plans included strategies to prevent behavioural issues for residents but these were either of poor quality or were not being implemented. For example, one strategy highlighted the importance of keeping a resident busy but did not

inform staff about the most appropriate way for that resident to be kept busy.

Inspectors spent most of the inspection observing the daily routine of residents, and had discussions with staff. Inspectors found that residents received minimal support to engage in activities that were of interest to them, there was no access to appropriate day services and there was only large group activities provided. In general, residents were observed to be sitting around their homes for the vast majority of the day.

The person in charge had reported an allegation of abuse to the provider and had sought guidance in the absence of a dedicated designated officer. However, the provider had not responded and this guidance had not yet been provided at the time of the inspection.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, inspectors found that there were poor management systems in place to support and promote the delivery of safe, quality care services. Examples of poor and unsafe levels of care have been highlighted elsewhere in this report.

The provider did not have adequate arrangements to ensure that there was appropriate risk management practices in place. An immediate action was also issued under this outcome during the inspection to ensure that measures were taken to ensure systems were implemented urgently to ensure that the service was safe and appropriate to residents needs.

Inspectors found that there was poor oversight of care planning and the provider had failed to identify shortcomings in the assessment of residents support needs and the implementation of support and care practices for residents. Poor implementation and poor staff knowledge about the support needs of residents had resulted in injuries to

some residents.

There had been a high turnover of management staff which was found to be negatively impacted on residents due to poor governance and oversight. A key manager who had been recruited in August 2015 and was nominated to represent the provider had recently resigned. The provider had said that they would appoint a nurse to oversee the clinical needs of residents following all of the previous inspection and had failed to do this.

A person in charge had recently been recruited in early April 2016. This person was found to be suitably skilled, qualified and experienced to take on the role. Inspectors found that the newly appointed person in charge was not being supported by the provider to fulfil the role. Inspectors read emails from the person in charge to the provider raising significant concerns about the operation of the centre and highlighting welfare issues for residents. While the provider had responded, the provider had not addressed the areas of concern and the findings from inspection validated these concerns.

The provider had consistently demonstrated an inability to implement action plans from previous inspections. Inspectors found that management in the centre and staff were not aware of the action plans of the provider and consequently, were unable to implement them. Inspectors found that plans were developed in head office and not communicated or implemented in practice.

In addition, staff assigned specific responsibilities such as assessment of risks and incident review were not trained to appropriately skilled to carry out these tasks. This had led to significant errors and oversight as identified previously in this report.

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

Findings:
Inspectors found that the provider did not have adequate staffing levels and skill mix to provide a safe and good quality service to residents.

For example, inspectors visited one unit in the centre where two residents had experienced two significant falls recently. Four residents were being supported by by one staff member for long periods of the day. This staff member was unable to support any social activity as two residents injured through recent falls were unable to adequately mobilise. Staffing levels had not been adjusted to reflect the changed needs of residents and this had a major impacted upon the quality of life of all of the residents.

Resident's outings were dependent on the availability of staff that could drive the centres transport. Residents mainly availed of group activities, on the first day of inspection approximately 20 residents had been taken for a drive and walk together. Staff members consistently refereed to residents being bored and having minimal links with the community attributing this to staffing levels.

Additionally, staff employed for activation or skill teaching such as woodwork, gardening and leisure pursuits had been reassigned general caring responsibilities within houses to make up for staffing shortages.

In general, staff were found to be well intentioned and did their best to support residents. However, many of the staff had limited experience of caring for residents with complex support requirements. Staff were not provided with training in autism despite the service identifying itself as specialist in the care and support of people with autism.

The skill mix of staff was not found to be meeting the needs of residents with limited numbers of professionally qualified staff to meet the assessed needs of residents and no nursing support to assist with the clinical oversight and implementation of many health care plans as identified in previous inspections.

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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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Irish Society for Autism
Centre ID:	OSV-0003427
Date of Inspection:	25 April 2016
Date of response:	

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 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate systems in place for the assessment, management and ongoing review of risk.

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

1. Action Required:
Under Regulation 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions as identified in support plans were not provided to residents and support plans were not updated as required.

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

Please state the actions you have taken or are planning to take:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not being adequately protected from peer to peer abuse.

3. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An investigation had not been initiated into a incident of abuse and appropriate actions had not been taken to prevent ongoing harm.

4. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

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 lines of authority and accountability were not clearly defined and appropriate supports were not provided to ensure the person in charge could carry out their role effectively.

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

Please state the actions you have taken or are planning to take:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems were not in place to ensure that the centre is safe and appropriate to residents needs.

6. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels were not maintained to meet the assessed needs of residents.

7. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The skill mix of staff was not found to be meeting the needs of residents with limited numbers of professionally qualified staff to meet the assessed needs of residents and no nursing support to assist with the clinical oversight and implementation of many health care plans as identified in previous inspections.

8. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale:

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have access to appropriate training as part of continuous professional development in areas such as providing care and support to residents living on the autistic spectrum.

9. 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:
Following the decision of the chief inspector to refuse and cancel the registration of this centre the Irish Society of Autism were no longer required to address the actions. The new provider (HSE) was requested to provide more immediate reassurances by way of weekly updates on actions taken to address the breaches of regulation.

Proposed Timescale: