

**Health Information and Quality Authority
Regulation Directorate**

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



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:	Ciara McShane
Support inspector(s):	Raymond Lynch (Day 1 only), Jim Kee (Day 2 only)
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 receipt of unsolicited information. 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:
17 November 2015 09:50	17 November 2015 17:20
19 November 2015 10:30	19 November 2015 16:30

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

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 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.

Findings from this inspection:

This was the centres sixth inspection in 16 months. The inspection was unannounced and took place as a result of unsolicited information received by the Authority. The Authority has received six pieces of unsolicited information relating to this centre in the past eleven months.

From a review of two pieces of separate unsolicited information the inspectors carried out a focused inspection primarily looking at medication management, risk management in particular relating to incidents and accidents, safe guarding and safety. Inspectors also focused on how staff were supported to raise concerns regarding the quality and safety of care. The inspectors also reviewed the assessed needs of residents, staffing levels, governance and management and the notifications of incidents as a result of the primary areas that were focused on during the two day inspection.

The inspectors found that of the eight outcomes reviewed six were of major non compliance whilst two were found to be of moderate non compliance. The inspectors found that elements of the unsolicited information, received by the Authority, were substantiated. Practice relating to medication management as outlined in Outcome 12 required significant improvement to ensure safe and consistent administration. Training for staff in relation to administration of medication also required improvement. Staff working at the centre did not have training in the use of as required medication for the management of epileptic seizures or in the administration of adrenaline.

The inspectors found that staff were not supported at all times to raise concerns regarding the quality and safety of care. Management of risk and incidents and accidents was poor. All risks had not been identified and where multiple incidents occurred of a similar nature, such as self injurious behaviour or peer to peer abuse, these were not adequately reviewed to mitigate them reoccurring or appropriate measures put in place to safeguard residents.

Inspectors also found that the assessed needs of residents were not being met; this is further outlined in Outcome 5 and 11. Examples of this include a resident who had high blood pressure and high cholesterol was not been monitored for same and there were no care plans in place to guide staff in supporting the resident. In addition staff spoken with were unaware of how to manage these needs. Management of pain was also found to be weak and inconsistent. Staff were reliant on knowing the resident well as an indicator whether a resident was in pain. As outlined in Outcome 5 numerous residents had assessed needs which caused pain however, the support for this was inadequate, inconsistent and not outlined in their care plans. Pain measurement tools or aids were also not used.

Staffing levels, as found on previous inspections, remained insufficient. Eleven staff were on duty during the day to meet the needs of 34 residents. Two of these staff were allocated to a resident each, therefore nine staff were left to meet the needs of 32 residents. On average there was one staff for every 3.5 resident. The residents at this centre had complex needs in line with their primary diagnosis of autism. Continuity of care was also found to be an issue. Numerous staff worked across multiple units and inconsistency in care was identified throughout the inspection. This was furthermore reinforced by the lack of care plans in place to meet residents' needs.

Governance and management required significant improvement. Management systems were not in place to ensure the service was safe, appropriate to residents' needs, consistent and effectively monitored. The person in charge had also recently resigned. This post was vacant at the time of inspection. The provider nominee, who was also recently employed, was actively seeking a new person in charge.

The centre required significant and sustained improvements to comply with the Regulations ensuring the care, welfare and support of residents was appropriate to their needs and that residents were safe. These findings, amongst others, are outlined in the body of the report and in the action plan at the end. The Authority could not agree some of the action plan responses provided by the provider. The Authority has taken the decision not to publish their response where this was applicable.

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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 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

Findings:

As part of the inspection, residents' personal plans and assessment of needs were reviewed. From this the inspectors found that improvements were required to ensure that all needs were thoroughly assessed and plans of care were in place to guide staff in meeting residents' needs.

The inspectors reviewed a sample of residents' personal plans and found that some improvements had occurred since the most recent inspection. However, there continued to be significant gaps in personal plans to ensure each residents' needs were clearly identified and met. For example, the inspectors learned from a review of a residents' plan that they had high cholesterol. Within their personal plan there was a generic guide on how to lower cholesterol levels. There was no specific care plan developed to meet the individual needs of the resident, nor was there information regarding their actual cholesterol level or evidence to indicate they had recent blood tests to monitor their cholesterol levels. Staff spoken with had limited knowledge regarding the resident's specific plan of care and were also unaware of the resident's cholesterol level. The same resident also had no plan of care in place for their high blood pressure or information regarding a pre-existing heart condition.

Care plans were not at all times updated to reflect a change in each residents' needs. The inspectors read in another resident's personal plan, whom recently had an injury and was in hospital for thirteen weeks, had a dexa scan. The scan showed a diagnosis of osteopenia. However, there was no guidance in place outlining the support they required for this. In addition, on discharge from a lengthy stay in hospital, while recuperating from an injury, the resident was prescribed medication to manage their pain post surgery. From a review of their personal plan, it was evident there was no clear plan of care regarding their pain management. From speaking with staff the inspectors found the approach to determine their pain was not clear or consistent. At

the time of inspection the centre did not use a pain scale to determine level of pain. From a review of the residents' medication administration records it was evident the resident was receiving pain medication however; this was not consistently being administered. The staff team that worked in the unit was also not consistent. The inspectors saw in a personal plan of another resident they too suffered pain at times. For this resident it was unclear how this was managed as there was no pain management plan developed nor was there a pain scale tool used to monitor the level of pain or the effectiveness of analgesia. The resident was also prescribed multiple pain relief medications some of which had contra indicators. However, this was not clear or highlighted as further outlined in Outcome 12. Other examples where assessed needs had been identified but no plans in place included, but not limited to, gout and scoliosis. There was also no pain management plan in place to meet these needs.

Where the plan of care had changed as a result of a review with a psychiatrist the appropriate care plan had not been updated or amended to reflect the changes. For example, a resident had guidelines in place for their emotional well being. They had subsequently been reviewed by the psychiatrist on multiple occasions and changes were recommended and implemented however, the guidelines had not been update since February 2015. They were most recently seen by the psychiatrist in November 2015.

Significant improvements were required to ensure clear care plans were in place to consistently guide staff in meeting the needs of residents ensuring best possible health.

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

Findings:

As part of the inspection, inspectors focused on the management of incidents and accidents and the associated risks. While there was some elements of good practice found improvements were required to ensure that information elicited from incidents and accidents was reviewed to ensure potential risks were mitigated.

Inspectors reviewed the incident and accident log, the risk register, individual risks assessments in addition to speaking with staff and reviewing the risk management policy. From this inspectors found that incident and accidents were being recorded by staff. Staff spoken with were aware of recent incidents and accidents, triggers for same and the control measures that should be used to mitigate such risk for future purposes. A recent incident had occurred where two residents were on a bus accompanied by staff. An incident of peer to peer abuse occurred where one resident hit out at another resident. Staff spoken with whom worked in the aforementioned residents' unit were

aware of the incident, the trigger for same and what control measures should be used to mitigate the risk. Whilst the staff completed a risk assessment post incident the revised control measures as told to inspectors had not been outlined. Risk assessments did not take into account all elements such as the environment and staffing levels. For example, a seating plan while out on the bus, had not been identified on the risk assessment. For this incident the inspectors found that a risk assessment had also not been completed regarding the staffing levels on transport with residents where behaviours that challenge were present.

Although the two staff members working on the day of inspection were aware of the control measure the inspectors were not assured that all staff were familiar with same as the staff members working at the centre were not consistent and worked in other units as further outlined in Outcome 17. The inspectors also reviewed the incident and accident form along with the risk assessment both of which stated the trigger was previously known to staff and was a familiar behaviour of one of the residents. The recording and review of incidents and accidents was insufficiently robust to ensure that learning had been gained and risk was mitigated. From this the inspectors found that staff were not operating in line with their own risk management policy. The policy stated that any learning should be sought post incident and applied and records of same should be maintained. This was not found on inspection. Incidents/accidents being appropriately reviewed and analysed to ensure residents were safe.

The inspectors also found that information within incident report forms was inaccurate. For example, the inspectors read in the follow up section of an incident report form to consider a behaviour support plan for both residents. These residents at the time of the incident each had a behaviour support plan in place. Also, read in an additional incident report form was 'no medical attention required' however, part one of the incident report form stated medical attention had been received.

The inspectors also found from a review of the incident and accident log that one resident was engaging in self injurious behaviour resulting in multiple incidents, of which there were approximately 30 since June 2015. Although these incidents were being logged systematically at the centres' head office and discussed locally at team meetings they were not being thoroughly reviewed or analysed to establish trends. This is further outlined in Outcome 8.

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

Findings:

The inspectors found that behaviour support plans were in place for a number of residents whose personal plans were reviewed. Although some improvements with behaviour support plans was evident, the inspectors found behaviour support plans were not reviewed and updated in line with changes in circumstances and each resident's needs. It was also not evident that at all times the least restrictive practice was used or that it was applied in line with evidence based best practice.

The inspectors reviewed a behaviour support plan for a resident who had behaviours that challenge. Since June 2015, the resident had approximately 30 such incidents, the majority of which involved self injurious behaviour. From a review of the incidents and accidents, relating to this resident, the inspectors found that the behaviour support plan had not been amended or updated as a result of significant incidents. The incidents, as outlined in Outcome 7, were not being reviewed or analysed sufficiently to enhance their behaviour support plan ensuring care staff could support the resident with their specific needs. Appropriate assessments such as a sensory assessment, environmental assessment and functional analysis had not been completed at the time of the inspection. On the evening of the first day of inspection, the provider nominee had sourced a psychologist to commence working with the resident. The psychologist was present on the second day of inspection.

For the same resident a protective helmet was being applied to prevent the resident from serious injury when they engaged in self injurious behaviour. The use of this helmet was being recorded and consent had been obtained from the resident's representative and supported by their psychiatrist. From speaking with staff and reviewing documentation it was evidenced the resident was also receiving medication at times when they were heightened. However, this was not been recorded as a chemical restraint in line with evidenced based best practice. As outlined in Outcome 12, there was also no protocol in place to advise staff of when this medication should be used. In the absence of incidents being trended and analysed and in the absence of assessments such as environmental assessments, the inspectors were not assured the least restrictive method was being availed of.

This resident also had guidelines in place for attending activities and for going home to their family for visits. However, these had not been linked to or referenced in their behavioural support plan. Their behaviour support plan was also not linked to the guidelines regarding their emotional well being.

For other residents' whose behaviour support plans were reviewed inspectors also found appropriate assessments had not been completed in line with their needs. The inspectors were told and read about two residents who lived together, one of whom targeted the other and the staff spoken with were aware of the triggers as too were management. However, an environmental review had not been completed nor had appropriate controls and supports been put in place to mitigate these incidents of peer to peer abuse. The relative behaviour support plans were also not updated to reflect the

targeting behaviour nor were the incidents reported to the Authority as required by the Regulations. This is further outlined under Outcome 9.

Significant improvements were required to ensure that residents were supported consistently to live in a safe environment, free from abuse, ensuring their emotional health and well being was prioritised.

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

Findings:
From a review of the incident and accident log, the inspectors found notifications relating to peer to peer abuse and incidents requiring medical attention had not been notified to the Authority.

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

Findings:
The inspectors found there was some adequate practice in relation to residents' healthcare needs. For example, links had been made with their general practitioner, dietician and physiotherapy where required. However, improvements were required to ensure where healthcare needs had been identified the appropriate plan of care was implemented and residents were supported to attend the appropriate health care professional.

On the first day of inspection, there was a dietician at the centre linking with staff regarding a number of residents. The inspectors also seen from residents' personal plans and daily notes they attended health professionals such as their general practitioners

and their dentist. Also outlined in a resident's file was a recent appointment which detailed their Dexa scan results.

The inspectors read in residents' personal plans assessed needs such as high cholesterol and high blood pressure. However, there were no levels recorded for either of these nor was it evidenced they had been linked to appropriate health services to have their blood pressure taken or bloods taken to monitor their cholesterol levels. Staff spoken with were also unaware of these levels.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There were written operational policies implemented within the centre relating to the ordering, prescribing, storage and administration of medicines to residents. However, the inspectors found deficiencies relating to certain medication management practices, including the information provided regarding the use of certain PRN (as required) medicines, particularly medicines to be administered in the event of residents having epileptic seizures. The practices in place relating to the administration of PRN medicines required significant improvement to ensure that these medicines were used in a consistent safe manner.

Medicines were supplied by a retail pharmacy business in blister packs where appropriate, on a four weekly basis. There was a system in place to check the medicines on receipt from the pharmacy and there was one allocated room available in the centre to store medicines. On the day of the inspection, the majority of medicines were being stored in this room in plastic storage boxes on a table in front of the window. The medicines had not been appropriately stored in a secure cupboard/cabinet where medicines would be protected from sunlight. This storage room required cleaning. There was a fridge available for storing medicines that required refrigeration, and at the time of the inspection there were no resident medicines that required refrigeration. The temperature of this fridge was not being checked and documented on a daily basis, and the fridge required cleaning. Medicines were also stored in each of the individual units within the centre to ensure staff had access to one week of each residents' blister packed medication and any prescribed PRN (as required) medication. The medicines were stored in a locked cupboard but in a number of cases the cupboard was also used

to store other items including phone chargers, residents' personal files and other paperwork. The storage of medicines in a number of the units required review to ensure that only medicines and the associated prescription and administration documentation, and any other information relating to medication was stored in these locked storage cupboards to ensure medicines were secure at all times and that there was no risk of unauthorised access. Inspectors also found that one PRN medicine, dispensed in 2013 had no expiry date indicated on the label. This medicine should have been segregated for disposal or return to the pharmacy. Dates of opening were not consistently marked on prescribed creams and liquids to indicate their subsequent expiry dates.

Staff were aware of procedures to be followed for disposal of unused and out of date medicines. All medication errors were recorded on medication error forms. The team leaders in the centre completed weekly checks of medication administration records, including spot checks on medication stock control records. However, there was no comprehensive medication management audit system in place within the centre that reviewed all aspects of medication management including prescribing, administration, storage, documentation and an analysis of all medicine related incidents including errors to facilitate identification of trends and to identify learning and any necessary changes to practice.

Inspectors reviewed a number of the medication prescription and administration booklets. In a number of instances the medicines were prescribed by their brand name on the prescription charts but the medicines had been dispensed generically, which had the potential to cause confusion to staff administering those particular medicines. The inspectors were informed that the centre planned to implement a new system of prescription and administration documentation in the near future, and on the day of the inspection the pharmacist had visited the centre to discuss this new system.

The PRN medicines on a number of the prescription sheets were also reviewed and a number of deficiencies were identified including:

- The indications for use were not consistently indicated on the prescription sheet.
- There were no guidance documents or protocols available to staff to ensure safe administration of buccal midazolam used in the event of epileptic seizures for residents. This medicine had been prescribed on a PRN basis but there was insufficient information on the prescription charts to facilitate the development of these guidelines/protocols.
- There were no guidance documents or protocols in place to guide staff in the administration of certain other PRN medicines, including medicines prescribed to relieve pain, particularly when the resident had been prescribed two or more pain relieving medicines, to ensure that these medicines were administered appropriately and safely.

Inspectors noted that one resident had been prescribed three medicines on a PRN basis to treat pain, two of which contained paracetamol so it was very important that guidance was in place to ensure the safe administration of these medicines. These guidance documents/protocols should be easily accessible within the residents' medication folder. There were no pain assessment tools/scales in place as part of a pain management plan particularly for residents with assessed communication needs including residents with limited verbal communication abilities to ensure medicines prescribed to relieve pain were administered appropriately and in a consistent manner by all staff as outlined in Outcome 11.

-PRN (as required) medicines prescribed as part of a behaviour management strategy had no associated guidelines or protocols in place as part of the overall behaviour support plan to ensure it was clear to all staff when these medicines were to be administered ensuring a consistent approach to the administration of these medicines.

- A number of residents had medicines prescribed on a PRN basis as a 'pre med' for medical appointments, but inspectors found that there was insufficient information/guidance available to staff relating to the time of administration of these medicines. Staff spoken to by the inspectors indicated that these medicines were not necessary for all medical appointments but this information was not documented to ensure a consistent approach to the administration of these medicines.

Staff received regular mandatory training on the safe administration of medicines, to ensure administration practices were appropriate and in accordance with current guidelines, and one staff member spoken to by the inspectors had recently attended this training.

The inspectors were not assured, at the time of the inspection, that the competencies of staff was assessed to administer PRN medicines prescribed for residents in the event of an epileptic seizure or in the event of a resident with a known severe allergy to wasp stings. The provider, post inspection, forwarded information to state that 15 staff would receive training on the administration of PRN medication for epileptic seizures. However it was unclear if these staff worked in the units where PRN medication for epileptic seizures was prescribed and if all staff working in these units would be trained in a timely manner. Multiple units on the day of inspection were found to have residents residing there who were prescribed PRN medication for epileptic seizures. This is further outlined in Outcome 17. Furthermore the provider, post inspection forwarded additional information to state eleven staff had their competencies assessed post their safe administration of medication training. However, 47 staff who worked in the centre were trained in the safe administration of medication.

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

Findings:

The inspectors found significant improvements were required in relation to governance and management to ensure management systems were in place to deliver a safe service that met the needs of all thirty four residents living at the centre, which was consistent and effectively monitored.

At the time of inspection, there were two team leaders employed at the centre. The person in charge had recently resigned and the provider nominee, who was also recently recruited as the general manager for three designated centres, was actively recruiting to fill the vacancy. The provider nominee, in addition to fulfilling their own role, was deputising as the person in charge.

The inspectors found that management systems were inadequate to ensure the service was consistently and effectively monitored. As outlined in Outcome 7 and Outcome 8 there was an absence of a robust system in place to analysis and trend information that was available as a result of multiple incidents and accidents. This was also true for the management of medication, as outlined in Outcome 12. While a medication checklist was in place and completed by team leaders, there was an absence of a robust medication audit tool that reviewed specifics. The team leaders worked from a weekly checklist that looked at areas such as finance and care planning. However, this was ineffective as it was not detailed to audit specific information. For example, the checklist did not highlight the multiple deficits in care planning as found on inspection. The centre continued to not have a live robust audit schedule.

The inspectors were not assured staff were supported to raise concerns. Staff spoken with stated they would talk to the team leaders or the new provider nominee if they had concerns. However, there were limited formal opportunities to do this. Staff also told the inspectors they felt their concerns were not at all times addressed once raised. For example, staff had raised concerns over insufficient staffing levels but no changes occurred. At the time of inspection the centre did not have a whistle-blowing policy. Revised systems were required to ensure that staff felt supported to raise concerns at all levels.

The inspectors found that the provider had not put in effective arrangements to ensure staff were exercising their professional responsibility. For example, a staff member who refused to sign a document stating they were administering medication in line with the centres policy, was continuing to administer medication to residents.

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

Findings:

Inspectors spoke with numerous staff throughout the two day inspection and found they knew the residents well and intentions were in the best interest of residents. Inspectors found that staffing levels and skill mix continued to be an area for improvement to ensure staff was appropriate to the number and assessed needs of the residents and ensuring they were safe.

From observations, speaking with staff and reviewing documentation such as personal plans and daily notes it was evident the skill mix and the number of staff were insufficient in meeting all needs of residents. Staffing levels at the designated centre were found to be, for the most part, at a minimum level to meet the basic needs of residents. For example, the inspectors observed in one unit, where five males were linked to, (two of the residents physically slept in apartments across from the unit) there was one staff member on duty to meet their varying needs. The staff member at the time of inspection was in the process of making the dinner whilst trying their best to respond to the needs of residents. This would often result in the staff member having to leave the unit, where four residents remained, to follow the fifth resident around the centre while they engaged in rituals aligned to their diagnosis of autism. Staff throughout the centre stated they were busy trying to meet the needs of residents, this was also echoed by team leaders who stated they were busy. The inspectors made observations where staff left the centre to engage in activities and all residents went with the staff as there was no other staff on duty to stay with the residents

Residents outings were dependant on the availability of drivers, a number of staff who worked on their own with five residents were not drivers therefore could not leave the centre with the residents unless arrangements were made with a staff member working in another unit who was a driver. When a staff member was asked by the inspector about residents' links with their community they stated there was none and attributed this to the staffing level.

The inspectors read in the daily notes, on multiple occasions, where staff had to stay with a resident to comfort them and support them with their emotional needs. This left other residents without support until the resident felt comfortable. The inspectors also read that staff had 'to abandon giving medication' to comfort the resident. This resident had one to one support from 8am-8pm, they did not go to bed later than this. The inspector read that staff from other units had to be called in to offer support. This would result in no staff being present in the other unit whilst they assisted.

From a review of rosters inspectors found there was eleven staff on duty during the day to meet the varying and complex needs of thirty four residents. Two of these staff were allocated to a particular resident. This resulted in nine staff to meet the needs of residents during the day, which was one staff member to every 3.5 resident. Considering the complex and varying needs of the resident group, in addition to the aforementioned, staffing levels were found to be insufficient to meet all of the residents'

needs. This had previously been reported to the provider.

The skill mix of staff working at the centre also required further development. From a review of residents' personal plans, incidents and accident forms and from speaking with staff it was evident residents had on-going complex health needs. However, there was no appropriately skilled staff to fulfil this working at the centre and residents' healthcare needs as outlined in Outcome 5 and Outcome 11 were at all times not being met. A resident who repeatedly banged their head, due to self injurious behaviour, had to attend the doctor for observations as staff at the centre were not qualified to complete neurological observations. The provider nominee stated they were actively looking for a nurse at the time of inspection.

Continuity of care was found to be an area that required a review. The inspectors found that some staff worked specifically in one unit, while other staff rotated across multiple units. On review of the findings on inspection and the complex needs of residents, many of which were not documented in personal plans, the inspectors found that residents were not receiving continuity of care. This was also reflected on the staff roster where staff were moved across multiple centres on a daily basis and from speaking with staff who told the inspectors how they would support residents with the same need in different ways. For example, the protocol for administering mood stabilising medication varied across the different staff members spoken with. Staff were not at all times employed on a permanent basis, multiple staff were issued with two year relief contracts of part time hours which were renewed every two years. These staff however often worked full-time hours. The inspectors were also told that some staff were employed at the centre for significant length of time, for example, five years with no contract assigned to them.

As outlined in Outcome 12, staff were not trained in the administration of as required medication for epileptic seizures and the administration of adrenaline. It was also unclear if all staff had their competencies assessed with regards to the safe administration of medication. The inspectors reviewed the competencies for eleven staff however, 47 staff were trained in the safe administration of medication.

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:

Ciara McShane
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Irish Society for Autism
Centre ID:	OSV-0003427
Date of Inspection:	17 November 2015
Date of response:	9 December 2015

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

Supports, required by residents, were not at all times reflective of changes in needs and/or circumstances.

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 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A monthly meeting for each resident will be convened on the 1st Friday of each month. This will include the keyworker, Team Leader, Social and Health Team Leader after appointment and General Manager (interim in place of the Person In Charge). A position for Team Leader with a nursing background was advertised on a recruitment website on Thursday 17th December. The post of Manager of Services for the designated centre was offered to a candidate on Friday 18th December 2015 pending all relevant checks.

Going forward from 19.11.15, as changes in any resident's needs arise ; all recommendations from allied health professionals will be adhered to and recorded and monitored as appropriate. These recommendations will be discussed at the relevant house meetings and will be overseen by the team leaders. This is presently on the house meeting agenda.

Multidisciplinary supports and changing needs will be assessed and an action plan developed.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Personal plans were not reflective of all residents' needs. For example, there was an absence of multiple care plans as outlined in the body of the report.

2. 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:

An assessment of individual needs has been developed to assess and monitor each resident's identified needs. This process, which is overseen by the general manager of services and monitored by the keyworkers and team leaders will ensure that all existing care plans along with any new multi-disciplinary recommendations and subsequent follow-up appointments will be in each individual's personal plan.

Care plan training took place in the designated centre by an external trainer on the 8th and 9th January 2015. 18 staff attended, 16 are still employed by the ISA. This was in a classroom situation.

Care plan training also took place on the 18th June 2015. This was on a one to one basis in the houses. 10 staff were trained.

Further care plan training will take place on the 25th January 2015. We have engaged with an external trainer to schedule dates for all staff to undertake training as soon as possible.

Proposed Timescale: 31/01/2016

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:

As outlined in the body of the report there were inadequate systems in place for the assessment, management and on-going review of risk.

- 1) A number of incident report forms reviewed were found to be inaccurate.
- 2) Incidents and accidents were not sufficiently reviewed or audited to identify trends.
- 3) Risk assessments were not sufficiently robust.
- 4) It was found that learning from incidents and accidents was not being implemented or identified at all times.
- 5) All risks were not assessed or outlined in the risk register.

3. 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:

- 1) Incident report forms are currently being revised to ensure that all reports are accurate and concise.
- 2) Going forward a monthly meeting will be held with Team Leaders to discuss incidents and accidents which have occurred and trending will be identified. This will be overseen by the general manager of services. The first of these meetings is due to occur on 11.12.15
- 3) All risk assessments will be reviewed by the general manager of services.
- 4) In the monthly meetings, learnings from incidents and accidents will be discussed and as a result behaviour support plans and / or risk assessments will be adjusted to reflect these learnings where appropriate. Any such changes will be communicated to all staff in house meetings.
- 5) Following any such meeting where new risks have been identified, the risk register will be updated to reflect these. This will be reviewed on a quarterly basis by the general manager of services to ensure that it is up to date and accurate.

Staff will have completed training in the new Incident form and Risk Assessment Training by Friday 8th January 2016 by the General Manager. This will involve one to one and group meetings to ensure staff understand the importance of completing the form accurately. This will be complemented by training in Report Writing which will be scheduled following the completion of Incident Form Training. An Improvement Team is being established to include new Support Team Leaders who will be quality champions in the designated centre and provide additional supporting framework to ensure all relevant checks and compliances are being fully integrated into service provision. All trending of incidents, accidents, risks etc. will be undertaken by this team.

Key staff currently dealing with one individual with self-injurious behaviour have attended relevant behaviour support training to complement their previous knowledge and experience.

The General Manager will chair a monthly Behaviour Support Committee to oversee any behavioural challenges in the service. The General Manager will liaise with the Psychologist in order to discuss the needs within the service and implement any measures necessary. Meetings will be held the 1st Friday of each month.

Proposed Timescale: 11/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Interventions, such as chemical restraint, were not implemented with informed consent.

4. 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:

The Authority could not agree an action plan response, for this action, with the provider and has taken the decision not to publish their response.

Proposed Timescale:

Theme: Safe Services

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

Restraint was not at all times applied in accordance with national policy and evidence based practice. For example there was no protocol in place for staff on the use of a mood stabilising medication and it was not appropriately linked to their positive behaviour support plan.

5. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The Authority could not agree an action plan response, for this action, with the provider and has taken the decision not to publish their response.

Proposed Timescale:

Theme: Safe Services

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

Every effort was not made to alleviate the cause of resident's challenging behaviour. For example a sensory or environmental assessment in addition to a functional analysis had not been completed for a resident.

6. 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:

Since 19.11.15 a behavioural psychologist has been consulted, has visited the centre and is in the process of reviewing residents' behaviour support plans.

One person is currently being reviewed by the Psychologist and plans for 4 more residents are listed for referral.

Best practice will be ensured as each case will be discussed at the monthly Behaviour Management meeting and periodic service review / trends will be viewed and acted upon with the relevant staff.

This will be a formalised structure in the designated centre and will be in place by Friday 8th January 2016.

Proposed Timescale: 08/01/2016

Theme: Safe Services

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

Residents were not at all times protected from abuse, both peer to peer and self injurious behaviour.

7. Action Required:

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

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

The Authority could not agree an action plan response, for this action, with the provider and has taken the decision not to publish their response.

Proposed Timescale:

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:

All incidents relating to injury requiring medical attention or hospital treatment were not notified to the Authority.

8. Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

This has now been rectified. An NF03 was submitted by the Manager of Services on 24.11.15 for the incident where a resident attended a hospital.

Proposed Timescale: 08/01/2016

Theme: Safe Services

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

Incidents of repeated peer to peer abuse were not notified to the Authority.

9. Action Required:

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

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

This has now been rectified. An NF06 was submitted retrospectively by the Manager of Services on 24.11.15 for the incidents where peer to peer abuse had occurred.

Proposed Timescale: 24/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

As outlined in the body of the report residents did not at all times received appropriate healthcare. For example a resident with high cholesterol and high blood pressure was not being appropriately monitored.

10. 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:

A full health and social care assessment of needs is being prepared for each resident based partially on the information gained from the dependency assessment and also from the individual's medical history.

This assessment will be completed initially by the key workers and will be overseen by the Team Leader Social and Health (CNM I). In the interim this will be overseen by agency nurses.

Any appointments with allied health professionals as identified from the individual assessment of needs will be made and follow - ups scheduled where appropriate. All residents have access to a local GP.

Proposed Timescale: 28/02/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The facilities for storing medicines in the centre were not appropriate in that:
-storage of medicines in a number of the houses required review to ensure that only medicines and the associated prescription and administration documentation, and any other information relating to medication was stored in locked storage cupboards to ensure medicines were secure at all times and that there was no risk of unauthorised access.

-medicines were being stored in plastic boxes exposed to direct sunlight. This room required cleaning.

-The fridge available to store medicines required cleaning and the temperature of this fridge was not being checked and recorded on a daily basis.

11. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

1) All houses where previously medicines had not been stored separately now have a separate locked cupboard within the shared cupboard. The installation was completed on 27.11.15. This ensures that medicines are secure at all times and that there is no risk of unauthorised access. A memo has been issued to all staff regarding the correct use of the medication storage unit.

2) The medicine room has been cleaned and painted and a new lino will be put in place on 10.12.15. A notice has been displayed reminding staff that medicines may not be stored in direct sunlight.

3) The fridge has been cleaned and going forward will be cleaned on a weekly basis and the temperature will be checked and recorded on a daily basis, when medicines are being stored within. Alternatively when not in use, the temperature of the fridge will be checked once a week. This will be overseen by the general manager of services.

Proposed Timescale: 10/12/2015

Theme: Health and Development

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

There was no comprehensive medication management audit system in place within the centre that reviewed all aspects of medication management including prescribing, administration, storage, documentation and an analysis of all medicine related incidents including errors to facilitate identification of trends and to identify learning and any necessary changes to practice.

12. Action Required:

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

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

A medication management system audit tool has now been developed and is in place. The headings include: ordering, prescription and recording of administration, scheduled controlled MDA Drugs schedule 2, storage and labelling, errors/ near misses, staff training and action plan following medication audit.

These audits commenced on 03.12.15 and will take place on a regular basis. This will be overseen by the general manager of services.

Proposed Timescale: 03/12/2015

Theme: Health and Development

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

The practices in place relating to PRN (as required) medicines were not sufficiently robust in that:

- The indications for use were not consistently specified on the prescription sheet.
- There were no guidance documents or protocols available to staff to ensure safe administration of buccal midazolam used in the event of epileptic seizures for residents. This medicine had been prescribed on a PRN basis but there was insufficient information on the prescription charts to facilitate the development of these guidelines/protocols.
- There were no guidance documents or protocols in place to guide staff in the administration of certain other PRN medicines, including medicines prescribed to relieve pain, medicines prescribed as part of a behaviour management strategy and medicines prescribed on a PRN basis as a 'pre med' for medical appointments.

13. Action Required:

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

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

All protocols regarding PRNs have been reviewed by the team leaders. This will be completed by 18.12.15

A new prescription sheet was introduced on 07.12.15.

All PRN protocols and indications for use, side effects and maximum dosage are now specified on each individual's new prescription sheet.

This commenced being used in the designated centre on 07.12.15.

Staff have received training on the new prescription sheet from the pharmacist and a team lead to ensure that they fully understand the protocols in place. This also commenced on 07.12.15

The new prescription sheets have a designated space to clearly state the purpose for administering a PRN. All staff must ensure the GP completes this section as it is an essential component.

An individualised PRN protocol to guide staff in the appropriate administration of all PRN medicines is being developed and will be completed and in each resident's care plan by 15.12.15.

Proposed Timescale: 15/12/2015

Theme: Health and Development

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

-Inspectors found that one PRN medicine, dispensed in 2013 had no expiry date indicated on the label. This medicine should have been segregated for disposal or return to the pharmacy.

-Dates of opening were not consistently marked on prescribed creams and liquids to indicate their subsequent expiry dates.

14. Action Required:

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

This has now been rectified. A memo has been issued to all staff to remind the correct procedures regarding medication.

Proposed Timescale: 08/12/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Management systems were inadequate at the centre to ensure the service was safe and appropriate to residents. Arrangements for ensuring consistency and the monitoring of the centre were ineffective. For example:

- 1) There was no audit schedule in place
- 2) Incidents and accidents were insufficiently reviewed and analysed to monitor trends and ensure improved outcomes for residents
- 3) The weekly checklist used by team leaders was ineffective
- 4) Deficits in meeting each resident's assessed needs were not identified
- 5) The checklist used to assess the management of medication was ineffective and not sufficiently detailed.

15. 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) A comprehensive Core Management System was developed in 2015 by senior management and is currently being adhered to.
- 2) Trending of incidents and accidents will be implemented to better analyse trends and identify solutions by team leaders.
- 3) The weekly checklist is currently being revised to include trending on all incidents, accidents, peer to peer incidents, medication issues and any other items of concern and will be reissued to team leaders by 22.12.15.
- 4) The assessment of needs for each resident are being prepared for their care plan following a full dependency assessment undertaken by an external consultant.
- 5) A medication audit tool has been developed and disseminated in the designated centre.

The Core Management System is a live working document and we are striving to fill all the vacant positions in order for this system to be fully effective and comprehensive.

The post of Manager of Services for the designated centre was offered to a candidate on Friday 18th December 2015 pending all relevant checks. He is currently a Person in Charge of a Residential Centre.

Five part time Support Team Leaders have been appointed who will shadow the current Team Leaders initially and will undertake group and individual training in completion of ongoing auditing and trending within the Irish Society for Autism services. This will begin on Monday 21st December. It is planned that following the initial shadowing and training , the new Support Team Leaders will complement the designated centre provision by ensuring there is a minimum of 3 Team Leaders on during the day.

The 6 monthly Review was completed in November 2015 by the Provider Nominee. All 18 outcomes were reviewed. The Annual Review is currently being undertaken by the Provider Nominee and feedback from families is being collated before completion.

Proposed Timescale: 15/01/2015

Theme: Leadership, Governance and Management

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

Staff were not performance managed at all times to ensure they exercised their professional responsibility. For example, a staff member continued to administer medication even though they refuse to sign a document they were adhering to the medication policy.

16. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

The Authority could not agree an action plan response, for this action, with the provider and has taken the decision not to publish their response.

Proposed Timescale:

Theme: Leadership, Governance and Management

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

Staff were not supported or facilitated to raise concerns about the quality and safety of the care and support provided to residents. For example:

- 1) There was no whistleblowing policy.
- 2) Staff concerns were not at all times addressed.
- 3) The Authority has received numerous pieces of information anonymously from staff working at the centre.

17. Action Required:

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

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

- 1) The organisation is developing a whistleblowing policy which will be disseminated to all services and available to all staff.
- 2) There is 6 monthly supervision / performance review in place which affords staff the opportunity to raise concerns or discuss issues.
- 3) The organisation has a grievance policy which is available to all staff, should they wish to pursue a complaint.
- 4) There is a Human Resources department as well as the locally available management at the designated centre with whom issues can be discussed if staff wish to do so.

The new Whistleblowing Policy will be delivered to staff by the General Manager during week 11th to 15th January 2016. Staff will also be made aware of the many avenues to make a complaint including the Protected Disclosures Act, the HSE and HIQA.

The General Manager is on site and staff know they can contact her as and when they require. When the General Manager visits the houses and the Training Centre she always asks informally regarding complaints/problems.

Proposed Timescale: 18/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

As outlined in the body of the report, staffing levels were insufficient to meet all aspects of residents' needs.

18. Action Required:

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

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

The Registered Provider is currently recruiting for positions within the organisation to ensure that staffing levels are sufficient. This recruitment process is ongoing.

In one particular house – 1 extra staff member has been added on the rota on a permanent basis.

In another house – a staff member will cover the 8-10pm slot in relation to the resident with self-injurious behaviour.

New staff

A new Co-worker started on 11.12.15

A new Co-worker started on 17.12.15

Two new staff members have accepted an offer of employment and will start after regulatory checks are completed.

five existing staff members will be appointed part time Support Team Leaders as part of an ongoing Improvement Plan for the designated centre. They will assume this role as required.

The Manager of Services has been offered the position to the designated centre on 18.12.15 pending regulatory checks.

An ad has been placed on an online recruitment site on 17.12.15 for a Team Leader who will be a qualified Nurse and attend to all clinical needs of the service

An ad has been placed on the same recruitment site on 17.12.15 and with 2 Agencies to assist with recruiting Co-workers.

Until a nurse is in post in the designated centre, the need for an Agency Nurse is still current.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

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

The centre did not have a nurse to meet the needs of the residents.

19. Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

The Registered Provider is currently recruiting for the position of a nurse within the organisation.

In the interim an agency nurse has commenced in the designated centre.

The position being recruited for is a Team Leader Social and Health (CNM I).

The staff member will be employed 39 hours per week and 1 whole time equivalent.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

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

Residents did not received continuity of care, due to staff working in multiple units and the deficits in care plans

20. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Deficits in the care plans are currently being addressed by key workers and team leaders. To coincide with this, more care plan training has been scheduled for staff to ensure continuity of care.

Care plan training took place in the designated centre by an external trainer on the 8th and 9th January 2015. 18 staff attended, 16 still employed by the ISA. This was in a classroom situation.

Care plan training also took place on the 18th June 2015. This was on a one to one basis in the houses. 10 staff were trained.

Further care plan training will take place on the 25th January 2015. We have engaged with an external trainer to schedule more dates for all staff to undertake training as

soon as possible.

Furthermore it is envisaged that the support Team Leaders will assist in care plan improvements and ongoing support.

The registered provider is actively recruiting for various positions within the organisation which will reduce the number of staff working in multiple units and staff will be assigned to particular units.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

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

Staff were not trained in the administration of PRN medication for epileptic seizures and adrenaline.

The inspectors were not assured that staff trained in the safe administration of medication had completed the necessary competencies assessments.

21. 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:

Epilepsy and the administration of Buccal Midazolam training has commenced on 01st December 2015. This training is being carried out by an external consultancy firm. Training sessions will be rolled out as appropriate. We have engaged with an external trainer to schedule dates for all staff to undertake training as soon as possible for Buccal Midazolam.

Training in Epipen usage will be delivered by the Pharmacist to staff working in the one identified house and all Team Leaders. We are awaiting confirmation of this date from the Pharmacist.

All staff trained in the safe administration of medication (SAM) will have one full competency test carried out by a qualified medical professional to assure that their competency assessments are up to date.

All trained staff received their two competencies by the previous Person in Charge. To ensure ongoing review we are rolling out an additional competency assessment which will be undertaken by a competent person on a monthly basis.

We are awaiting confirmation of training dates.

Proposed Timescale: 01/12/2015