<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Irish Society for Autism</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002001</td>
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<td>Centre county:</td>
<td>Meath</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>The Irish Society for Autism</td>
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<tr>
<td>Provider Nominee:</td>
<td>Susan Alexandra (Lexi) Kennedy</td>
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<tr>
<td>Lead inspector:</td>
<td>Ciara McShane</td>
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<tr>
<td>Support inspector(s):</td>
<td>Julie Pryce</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>8</td>
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<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: 19 January 2016 09:30
To: 19 January 2016 17:30
From: 20 January 2016 11:00
To: 20 January 2016 18:30

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

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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: General Welfare and Development</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection
Inspectors undertook four inspections of this centre between November 2014 and January 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 centres. 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 3 February 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 18 May 2016. Prior to 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 and was unannounced. The purpose of the inspection was to inspect against failings identified on the most recent inspections completed May and October 2015. Following these inspections due to the serious concerns which were found on inspection, the chief executive officer (Provider) and the chairman were asked to attend a meeting at the Authority's Dublin office. Subsequent to this meeting the provider made assurances the centre would make significant improvements within a period of eight weeks. This inspection took place twelve weeks later to optimise the opportunity for the provider to implement improvement.

At the time of the inspection eight residents resided at the centre. The statement of purpose for the centre describes the centre as providing autism specific services for adults with a primary diagnosis of autistic spectrum disorder. Residents had complex and varied support requirements. During the inspection the inspectors communicated with a number of the residents, reviewed documentation, made observations and spoke with staff.

Overall there continued to be significant and sustained non compliances with the Health Care Act 2007 as amended. The inspectors found that although the provider had committed to completing the actions from the previous inspection(s) to make significant improvements, this was not evident at the time of inspection. The general manager of services and the person in charge told the inspectors they were unaware of these commitments provided to HIQA by the provider. As with previous inspections major non compliances were found; fourteen outcomes were inspected against, eight of which were found to be of major non-compliances.

Overall, inspectors were not satisfied that the provider had put system in place to ensure that the regulations were being met. This resulted in poor experiences for residents in some case, the details of which are described in the report.

The inspectors found that the lack of effective governance and management systems had resulted in:
• Inappropriate guidance for the use of chemical restraint.
• Behaviour support plans not in place or not effectively guiding practice.
• Inadequate safeguarding measures to ensure residents were protected and felt safe living in the centre.
• Risks to residents were not being appropriately managed or responded to.
• A lack of continuity of care.
• Unclear management and reporting structures.
• Staff not trained to meet the assessed needs of some residents.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included at the end.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The provider committed to complete the two actions from their most recent inspection by the 25 November 2015. The actions were in relation to consultation with residents and activities which were found to be predominately group based.

The inspectors reviewed minutes of the consultation meetings held with residents. From a review of the minutes the inspectors found that the residents' meetings were conducted by the key-workers as opposed to the person in charge as outlined in their action plan response. The person in charge confirmed that she did not attend these meetings. The action plan response also stated that communication tools such as Lámh and picture exchange communication systems (PECs) would be availed of during these consultations. As outlined further in Outcome 2 this was not occurring as staff were not trained in Lámh or PECs. Therefore inspectors were not assured the consultation meetings were fully effective.

The inspectors found that although the weekly consultations looked at residents preferences for that week their preferred activities were not at all times engaged in. For example, a resident identified he/she wished to go bowling, however, they attended the cinema as this was the majority preference of the other residents.

The inspectors found that although residents’ activation levels had increased since the most recent inspection activities continued, for the most part, to be group based. One to one activities were minimal and this was attributed to the lack of resources such as transport. The centre had one vehicle and public transport, due to the remoteness of the centre, was not an available option.
**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
The provider committed to complete the three actions from their most recent inspection by 1 December 2015. The actions were in relation to a lack of available communication tools, aids and appliances that residents had access to, to communicate with.

The inspectors spoke with staff, made observations and reviewed documentation in relation to the use of communication tools. The inspectors found that since the most recent inspection one resident had purchased a tablet. At the time of inspection they were being supported by staff to use the tablet to play games. As read in documentation and as told by staff the next step, once the resident was familiar with the tablet, was to commence using computer applications that would assist with their communication. The inspectors also found a visual board in the kitchen, complete with pictures that were used to outline what the activities were for that day. The inspectors were told there was a plan to start using photographs of the residents engaging in the actual activities to further assist their pictorial understanding. The inspectors were shown the photographs that had been laminated and were ready to use. Although a visual board was being used to convey daily activities to residents, the inspectors found that these activities were not in line with the actual events occurring. For example, on the first day of inspection the activity on the board was attending the gym however, the actual activity was swimming.

On the previous inspection it was found that residents who wished to avail of the computer or internet could not access the office to do so. The inspectors were told by staff the office was now being left open for residents to use the computer should they wish.

As reported in the previous inspection, a speech and language therapist, May 2015, completed a communication assessment for each of the nine residents. A report was produced for each resident outlining recommendations as to how they could be assisted to communicate. Recommendations were outlined in relation to accessing assistive technology, aids and appliances. Whilst the inspectors acknowledge that work had commenced on this, the totality of the recommendations had not been implemented sufficiently to ensure there was effective two way communication between residents and
staff members. The person in charge had received training in Lámh November 2015; however, no other staff received Lámh training although the training need had been identified. This is further outlined in Outcome 17.

**Judgment:**
Non Compliant - Major

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**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
The provider committed to complete the action from their most recent inspection by the 01 December 2015. The action related to the lack of links and integration that residents had with their local community. The provider responded stating they had a comprehensive plan to increase links with the wider community and the plan had been compiled in consultation with the residents.

The inspectors found, there was no comprehensive plan regarding links and integration into the community available for the inspectors to review. While the inspectors acknowledge activity levels had somewhat increased since the most recent inspection they continued to be predominantly group based. Residents were attending a new activity; seven residents, once a week, visited a gym in a nearby town. No other additional activities had commenced to foster links with their local community. During the two day inspection residents were observed going swimming on the first day and some residents were observed assisting with household chores. On the second day of inspection a number of residents were observed walking outside, around the centre, assisting with household chores such as preparing vegetables for dinner and a group of residents went to the hairdressers together and stopped off in the grocery shop.

**Judgment:**
Substantially Compliant
**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

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

**Findings:**
The provider committed to complete the action from their most recent inspection by the 02 November 2015. The action related to the residents contract of care.

The inspectors reviewed a sample of residents' contract of care and found that an additional two pages had been placed behind the original contract of care which was signed and dated by their representatives. It was not evident, that the additional pages had been reviewed as these were attached at a later date. The inspectors also found that additional costs such as arts and crafts and attending a masseuse were also not outlined in the contract of care.

The inspectors recognised that contract of care was made more accessible for one resident using pictures. However, this residents' accessible version was signed by their representative.

**Judgment:**
Non Compliant - Moderate

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**Outcome 05: Social Care Needs**

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The provider committed to complete four actions from their most recent inspection by 1 December 2015. The actions related to a lack of evaluation of residents' personal plans, personal plans were not at all times updated to reflect changes in residents' needs, care plans were not in place to support residents' with their needs, a multi-disciplinary approach was not evident and personal plans were also not in an accessible format for residents.

The inspectors reviewed a sample of residents' personal plans and also spoke with staff regarding the needs of residents'. Since the recent inspection, the person in charge had completed an audit of the residents' personal plan. From a review of this audit it was evident that gaps were still present in the personal plans. The person in charge had tasked the residents' key workers to update the information where deficits were identified. The person in charge had also dedicated a meeting in December 2015 to looking at personal plans and offer support to staff to complete them.

From the review of residents' personal plans it was evident that attempts had been made since the recent inspection to capture changes in circumstances to residents' needs. For example, a resident had been diagnosed as having an illness and a care plan had been developed to guide staff on how their needs should be met. However, this care plan had been archived but the inspectors read in an appointment log, from a recent doctors' appointment and heard from staff, that this was a live issue. The inspectors read and were told that they were still experiencing pain from the illness and had been prescribed pain relief for same. Staff also told the inspectors the resident was 'out of sorts' due to the illness. None of which was evident from a review of their current needs. The inspectors found further attempts where staff had endeavoured to update residents' care plans to reflect their needs as seen in a care plan titled 'antibiotics'. However, this was in fact related to a wound which the resident had received. However, the use of antibiotics were not outlined in the wound care management plan which staff had titled 'dressing care plan'.

A number of personal plans were not reflective of residents’ specific needs. For example, the inspectors saw from a review of residents' blood tests, appointment log and notes written that a number of residents' had high cholesterol. This need was not outlined in a care plan and when the inspectors spoke to staff they were vague regarding the residents' cholesterol levels. One staff member spoken with was unaware of the status of some residents' cholesterol as they were not their key-worker. This staff member worked in the centre with the resident and prepared their meals. However, when spoken with they were unsure what the dietary guidelines were for residents' whom had high cholesterol levels. In addition, residents had been identified as being overweight and rated as being high risk. Yet when speaking with staff there was no guidance re meal planning nor was a food log maintained. The inspectors saw written in residents' personal plans they were to 'cut down on fry's and snacks'. Despite this concern being described as 'high risk' for one resident there was no care plan in place. A referral had been made to a dietician in October 2015 however; there was no follow up to this.
The inspectors found that the management of residents’ pain was unclear. For example, the inspectors found documented in a resident’s personal plan notes outlining a resident’s demeanour during an illness. However, there was no pain management plan in place for this resident nor was there a comprehensive pain assessment which captured observations to guide staff as to what might indicate pain for the residents. The inspectors acknowledge staff were using a pain scale tool however, it was not informing a pain management plan.

Since the recent inspection, residents' intimate care plans had been reviewed and updated, the inspectors reviewed a sample of these. There was a new format in place that was reflective of residents’ needs and attempts had been made to make them accessible with pictorial formats.

**Judgment:**
Non Compliant - Major

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**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:**
The provider committed to complete three actions from their most recent inspection by the 07 October 2015. The actions related to risk management and learning from serious incidents and accidents.

From conversations with staff the inspectors learned there had been a number of recent incidents at the centre that potentially compromised the safety of residents. These incidents were seen documented on incident reports forms. The inspectors reviewed the risk register which failed to outline the additional safety risks nor had it been updated since May 2015. The inspectors were told that as a control measure to mitigate the risk an electric gate had been requested. The response received was to ask a parent of a resident to pay for it to which the general manger was not happy to do. There was no further update regarding this therefore the likelihood of the incidents reoccurring had not decreased.

The inspectors also found individual risk assessments were lacking for residents where areas of risk had been identified. For example, a resident had recently left the premises unknown to staff. A risk assessment had not been completed for this nor had their missing persons profile been updated to state they were at risk of absconding. The kitchen door in one of the units was locked from 20:00 hours to 08:00 hours however;
there was also no risk assessment in place to support this.

Since the most recent inspection a new incident report form had been developed and was soon going to be used in the centre. The person in charge and general manager of services told the inspectors this would enable them to trend and analyse information regarding incidents and accidents. It was evident from a review of staff meeting minutes that incidents and accidents were being discussed and some areas for learning had been identified however, these had not been followed through on. For example, the inspectors read in staff meeting minutes for November that a resident had a number of incidents. Staff eluded this may relate to their lack of sleep and an action was identified to maintain a sleep log. The inspectors spoke with staff and were unaware of a sleep log, there was also no sleep log in their personal plan. So whilst learning's were being identified they were not being implemented. The inspectors found that clinical risks continued not to be highlighted or mitigated as required. A sample of clinical risk identified on the inspection included weight gain, high cholesterol levels, head injury and the potential negative effects associated with the use of psychotropic medication (benzodiazepine) in large volumes and post injury.

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:
The provider committed to complete three actions from the previous inspection by 18 December 2015. The actions related to restrictive practices, behaviours that challenge and protecting residents from abuse. The inspectors found that although some improvements had taken place the actions had not been fully completed or addressed.

The inspectors found that a behavioural support therapist had been engaged with the centre post inspection October 2015. The behaviour support therapist worked with one resident and developed a positive behavioural support plan for the resident January 2016. The behavioural support therapist engaged with staff through a number of
workshops during this process. The inspectors reviewed the positive behaviour support plan and found for the most part it outlined the residents' behaviours and how staff could best support them. From conversations with staff it was evident that all staff, whom worked directly with the resident, had not read the behaviour support plan. The behaviour support plan was therefore not being fully implemented.

It also remained that reactive strategies and control measures were not outlined in the behavioural support plan. For example, there continued to be no guidance regarding the use of chemical restraint. Residents had at times received large doses of psychotropic medication and staff spoken with by the inspectors stated they decided amongst themselves when to give the medication and how often. The inspectors read in the resident's medication administration records they received 10mg of benzodiazepine one hour and twenty minutes apart. When the staff were asked as to how this practice was guided they stated they consulted with another staff member. As outlined in Outcome 17 staff had also not received training on the use of psychotropic medication and were unaware of the side effects that should be observed. Staff were making significant decisions about significant doses of psychotropic medication in the absence of training, appropriate skill set or guidance. The inspectors reviewed a medication administration record which outlined high doses of benzodiazepine being administered in one day (42mgs) in the absence of any adequate guidance or monitoring for side effects. Staff also stated that often the use of the medication had little to no effect on the resident. It remained that chemical restraint was not been administered in line with best practice and there continued to be an absence of a robust protocol.

A functional and sensory assessment including a review of their environment had been completed for one resident. Staff spoken with were aware that this had been completed however it had not been fully implemented. On the second day of the inspection the person in charge and the general manager of services was meeting with the funding body regarding elements of the recommendations resulting from the assessment.

A number of residents presenting with difficult behaviours did not have a behavioural support plan in place. The knowledge of staff, who spoke with the inspectors, varied as to how they would respond if certain behaviour was demonstrated. These varied responses were found to be having a negative impact on the resident regarding how they then spent their time. Alternative measures had not been sought or trialled to ensure that appropriate and positive redirection techniques were implemented or reviewed for their effectiveness. In some cases the inspectors found that the least restrictive alternative was also not being used as an initial response. In one of the units a kitchen door was locked from 24:00hours to 08:00hours. This was being recorded as an environmental restraint as found in the restraint log. However, there was no positive behavioural support plan in place to support the locking of the door which staff told inspectors was being completed due to tendencies of one resident. The door was locked historically and staff had not trialled leaving the door unlocked or trialled any other least restrictive options.

The inspectors reviewed impact assessments that had been completed for each resident post the previous inspection in relation to their safety in the centre. From a review of these assessments it was evident that residents were often impacted upon negatively when certain incidents were witnessed. The inspector spoke with a resident who stated
when such incidents occurred they would 'leave the room and go to their bedroom' and they would be 'shaking like a leaf'. The inspectors also read that another resident would self-injure as a result of witnessing incidents. Although staff endeavoured to protect residents while these incidents occurred it remained that residents were not safeguarded from abuse.

**Judgment:**
Non Compliant - Major

### Outcome 09: Notification of Incidents

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

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
From a review of the incident and accident log the inspectors were assured that recent incidents had been notified as required to the Authority.

**Judgment:**
Compliant

### Outcome 10. General Welfare and Development

*Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

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

**Findings:**
The provider committed to complete the action from the most recent inspection by 01 December 2015. The action related to the lack of access and opportunities for education, training and employment. The inspectors found this action remained incomplete at inspection January 2016.
The inspectors found that each key worker had completed a vocational and training assessment with each resident. One resident had attended an interview with a view to commencing a course. The general manager of service and person in charge also told the inspectors they had made contact with some services with a view to commencing a partnership to enable residents participate in education and training. However, this was not successful. The general manager and the person in charge were unclear if the residents were funded for day services as part of the residential service at the centre and stated this may be problematic in sourcing opportunities for education and training.

At the time of inspection, only one resident attended a class once a week. The remaining seven residents had no engagement in education, training and employment. The centres statement of purpose stated a range of person centred education activities were provided on site and in the wider community. The statement of purpose also stated the provider was 'committed to offering specialised autism-specific and person centred educational and training systems to enable each person maximise their potential, based upon their ability and personal desires'. As evidenced on inspection this was not reflective of the opportunities available.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were written operational policies within the centre relating to the ordering, prescribing, storage and administration of medicines to residents. The inspectors reviewed medication management in relation to the administration of as required medication.

From a review of this, 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' requiring psychotropic medications, pain relief and for a resident who may have 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.
As outlined in Outcome 8 and 12 staff were administering PRN psychotropic medication in the absence of formal guidance relating to when it should be administered, the length of time between doses and what side effects staff should observe for. From speaking with staff the inspectors found that staff were making subjective decisions regarding the administration. Once PRN psychotropic medication was administered there was insufficient evidence to detail the effectiveness of administration if any. Residents were also prescribed pain medication however, there was also no formal guidance to the safe usage of this.

The inspectors also read in documentation a resident who was prescribed buccolam midazolam for seizure activity. Staff spoken with were unaware of the administration guidance for this medication and there was also an absence of clearly defined guidance for staff.

Staff had also not received specific training in relation to the administration of psychotropic medication.

The inspectors acknowledge that on the evening of the second day of inspection some guidance had been developed regarding the use of as required medication however, this was found to insufficiently detailed.

**Judgment:**
Non Compliant - Moderate

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**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:**
The provider committed to completing two actions by 31 December 2015. The actions related to management systems ensuring the service provided was safe, appropriate to residents' needs and effectively monitored. The second action related to the annual review. In addition, on 12 October 2015, the chief executive officer and the chairman were requested to attend a meeting with the Authority. The meeting related to the consistent and sustained breaches with the Health Act 2007 as amended and the
providers’ failure to implement sufficient improvement. The provider was given an additional eight weeks to make improvements regarding the designated centre. The purpose of the inspection, completed January 2016, was to inspect for improvement as assured by the provider post the meeting and subsequent written assurances. This inspection took place twelve weeks later to optimise the opportunity for the provider to implement improvement.

The inspectors found some improvements had occurred regarding governance and management. However, sustained and repeat breaches were found throughout the two day inspection. To ensure compliance with the Health Act 2007 as amended, significant and sustained improvements regarding the overall entity and the governance and management of the centre was required.

Since the recent inspection the inspectors found that some improvements had occurred regarding management systems. The centre now had a defined audit and meeting schedule which was reviewed by the inspectors. For example, the inspectors found that audits were being conducted in relation to medication and care planning. The inspectors also found that routine meetings were occurring at the centre between all levels of staff at a local level. The person in charge and the general manager of services also met weekly with the person in charge also compiling a monthly update report for the general manager. Although audits were been completed in addition to the six monthly unannounced visits and the annual review, the inspectors found that where deficits were identified such as skill deficits or a resource issue they had not been acted on. The management system was therefore not wholly effective to ensure the service provided was safe, appropriate to residents’ needs and consistent.

The local management team consisting of a team leader, the person in charge and the general manager of services, had at the time of inspection, been working together for five months. The inspectors found they endeavoured to drive improvements with the autonomy and resources available to them. The general manager of services, also put forward to represent the provider, had responsibility for three designated centres. For this centre the general manager lacked the authority and autonomy regarding the running of the centre. The general manager did not have any oversight of the budget, was not aware or informed of the funding for each resident nor the staff or services that was allocated to residents. For example, she was unsure if residents were funded for a day service through their residential service or what the funded whole time equivalent was regarding staff. The lack of autonomy and limited oversight of the budget for the centre resulted in the general manager not being able to schedule training ensuring staff were skilled to meet the needs of residents. The inspectors saw correspondence were required resources had been identified however; these were not followed through on. For example, the identified skill deficit regarding communication training for Lámh and PECs was raised but staff remain untrained and no training was planned. The inspectors were also told that the general manager of services had limited to no autonomy regarding the issuing of memos. These had to be reviewed by the deputy executive officer before she was allowed to circulate same. The previous provider nominee was found to be unfit to participate in the management of the centre. However, the inspectors found they were still actively involved in the management of the centre. For example, the general manager of services reported directly to them. The inspectors found that the person in charge and the general manager were not aware of their own
lines of accountability as a result of limited communication from the provider. For example, on 12 October 2015, the chief executive officer and the chairman were requested to attend a meeting with the Authority. The meeting related to the consistent and sustained breaches with the Health Act 2007 and amended and the providers’ failure to implement sufficient improvement. The provider was given an additional eight weeks to make improvements regarding the designated centre. The purpose of the inspection, completed January 2016, was to inspect for improvement as assured by the provider post the meeting and subsequent written assurances. From speaking with the person in charge and the general manager of services (also the provider nominee) it became apparent that neither were informed of the assurances the provider committed to. The inspectors therefore found that although there was a local management structure it failed to identify clear lines of authority and accountability and failed to detail lines of responsibility for all areas of service provision.

**Judgment:**
Non Compliant - Major

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**Outcome 16: Use of Resources**

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

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

**Findings:**
The provider committed to completing one action from the previous inspection by 02 October 2015. The action related to the allocation of appropriate resources.

From a review of residents activities, observations and from speaking with staff it was evident that activities remained predominantly one to one. However, on inspection staffing levels were sufficient to ensure more one to ones occur. This could not be facilitated as there was only one vehicle available and due to the remoteness of the service public transport was not an available option. Two of the twelve core staff were indemnified on their own personal vehicles to carry residents however, there was no policy in place to support this and at a directive given from the provider this practice ceased.

**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:
The provider committed to completing one action from the previous inspection. The action related to ensuring residents received continuity of care. The inspectors found this action had not been completed. In addition further deficits as outlined in Outcomes throughout the report reflect the requirement for staff to receive additional training and skills development.

From a review of the roster, observations and from speaking with staff it was evident that staffing levels had increased. The most recent inspection highlighted that agency staff were being availed off to cover a small amount of additional leave and cover for annual or sick leave. On inspection January 2016 inspectors found, that on average, 156 hours of agency staff were being availed off per week. This equated to four full time staff working 39 hours a week. The centre, as told by the general manager of services, was not recruiting for additional permanent posts. From a review of the roster there was a total of eleven agency staff working with their hours varying week to week. From a review of the induction checklists the inspectors found that 17 agency staff were inducted to the centre between 30 October 2015 and 19 January 2016. The inspectors also found in October 2015 eleven new agency staff had been inducted to the centre. The person in charge also told the inspectors the resident, who required additional staffing hours for direct support, had a preference for male staff. However, out of the eleven agency staff available only two were male.

As outlined throughout the report and as a result of the identified failings it was apparent staff required additional training and skill development in the following areas:
1. Care planning.
2. Lámh training.
3. PECs training.
4. Training regarding the use of psychotropic medication.
5. Guidance for staff regarding meeting the needs of residents with high cholesterol and/or weight management.

Additional areas were also highlighted where training was required. A resident at the centre was prescribed medication to be administered in the event of seizures. However, staff at the centre were not trained in this area and when staff were spoken with
regarding what measures to take, their knowledge was vague and stated they would refer to the person in charge. As outlined in Outcome 12 there was also no clear protocol regarding the administration of same.

The centres' statement of purpose outlined the centre provided 'autism specific' care. However, no staff working at the centre had been provided with specific training in relation to autism. Out of the nine co-workers who worked at the centre, only three had social care related qualifications. In addition limited staff working at the centre had first aid training. The inspectors were told about an instance where three staff were on duty and as a result of a serious injury, a resident required first aid. However, no staff on duty, at that time had first aid training. The staff spoken with on the day of inspection showed care and support towards the residents.

A number of these deficits, as outlined in Outcome 14, had been identified by the general manager and the person in charge, however, resources were not made available in order to ensure staff were appropriately skilled.

**Judgment:**
Non Compliant - Major

### Outcome 18: Records and documentation

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**
Use of Information

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

**Findings:**
The provider committed to completing one action from the most recent inspection by 14 October 2015. The action related to the implementation of the food and nutrition policy. The inspectors found some elements of their action plan response had been completed however, further improvements were required.

The inspectors found from a review of residents' personal plans staff had completed the Malnutrition Universal Screening Tool (MUST) along with a record of weights and Body Mass Index for those residents where it was required. However, when staff were spoken
with in relation to the policy they were not clear on why they would complete a MUST nor that it should be repeated. Staff were also not provided with guidance or instruction regarding the implementation of the food and nutrition policy. The provider also stated that a dietician was engaging with the centre to assist staff, this had not occurred.

Judgment:
Substantially Compliant

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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Irish Society for Autism</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002001</td>
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<tr>
<td>Date of Inspection:</td>
<td>19 January 2016</td>
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<td>Date of response:</td>
<td>17 February 2016</td>
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Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Activities continued to be predominantly group based which did not afford residents the opportunity to exercise choice and control in his or her daily life.
1. **Action Required:**
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**
1. Since inspection one whole time permanent staff member has been recruited. 07/02/2016

2. The Person in Charge and Team Leader currently have indemnity on their insurance. Vehicle policy enacted to facilitate staff members engaging in 1:1 activities with residents. 12/02/2016

3. Two additional staff members to be indemnified to enable two additional vehicles at the service to allow for more 1:1 activities to occur. Due 09/03/2016

**Proposed Timescale:** 15/03/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Although weekly consultation meetings took place with residents. The inspectors were not assured that they were fully effective as staff were not trained to use the communication tools required by some residents.

2. **Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
Training to commence in alternative communication strategies.
1. All staff to be trained in PECS. 11th, 13th April
2. All staff to be trained Lamh. 4th, 6th April.

**Proposed Timescale:** 13/04/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents, were not supported at all times, to engage in activities of their interest and preference.

3. **Action Required:**
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.
Please state the actions you have taken or are planning to take:
1. Since inspection one whole time permanent staff member has been recruited. 07/02/2016

2. The Person in Charge and Team Leader currently have indemnity on their insurance. Vehicle policy enacted to facilitate staff members engaging in 1:1 activities with residents. 12/02/2016

3. Two additional staff members to be indemnified to enable two additional vehicles at the service to allow for more 1:1 activities to occur. Due 09/03/2016

4. Occupational Therapist to assess four residents in areas of independence and activities. 01/03/2016

Proposed Timescale: 15/03/2016

Outcome 02: Communication
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Effective communication protocols were not in place or being actively used to assist some residents communication requirements

2. The recommendations as outlined in each of the nine speech and language assessment reports had not been fully implemented or trialled.

4. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
1. All staff to be trained in PECS. 11th, 13th April
2. All staff to be trained Lamh. 4th, 6th April.

Proposed Timescale: 13/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As outlined in the body of the report a computerised tablet was purchased by one resident and a visual board was in place. However, limited recommendations made by the speech and language therapist, in relation to accessing assistive technology, aids or appliances had not been implemented.
5. **Action Required:**
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

**Please state the actions you have taken or are planning to take:**
1. Since inspection two additional Ipads have been purchased. 04/02/2016
2. Occupational Therapist to engage with service for four residents in relation to assessment of aids and appliances. 01/03/2016

**Proposed Timescale:** 01/04/2016

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**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider did not complete the action they committed to; residents continued to have limited links and integration with their local community.

6. **Action Required:**
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

**Please state the actions you have taken or are planning to take:**
1. Since inspection one whole time permanent staff member has been recruited. 07/02/2016
2. The Person in Charge and Team Leader currently have indemnity on their insurance. Vehicle policy enacted to facilitate staff members engaging in 1:1 activities with residents. 12/02/2016
3. Two additional staff members to be indemnified to enable two additional vehicles at the service to allow for more 1:1 activities to occur. Due 09/03/2016
4. Occupational Therapist to assess four residents in areas of independence and activities. 01/03/2016

**Proposed Timescale:** 01/04/2016
**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Details regarding the additional costs that residents were incurring were not outlined in the contracts of care.

**7. Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
Contracts to be revised with additional costs for arts and crafts, massage and breakdown of staffing costs for holidays to be implemented. Revised version to be sent to residents representatives.

**Proposed Timescale:** 02/03/2016

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**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:**
As outlined in the body of the report personal plans were not entirely reflective of residents needs including:

a) The lack of care plans for assessed needs.

b) Limited information regarding residents' goals and aspirations.

**8. 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:**

A)
1. Two support team leaders now in place to assist keyworkers with development and reviewing of care plans. 10/01/2016
2. P.I.C and support team leader audited care plans since inspection. 10/02/2016
3. Nurse engaging with service for development of pain management plans. Due 19/02/2016
4. Dietician to visit service to provide guidance for staff on Nutritional Tools and develop dietary care plans for assessed needs. Due 22/03/2016
Family reviews taking place as part of the person centred plan with a HSE representative, which will include goal planning. To commence 22/02/2016

**Proposed Timescale:** 22/03/2016  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Personal plans were not, at all times, reflective of changes in residents' needs and circumstances.

**9. Action Required:**  
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

**Please state the actions you have taken or are planning to take:**  
1. Two support team leaders now in place to assist keyworkers with development and reviewing of care plans. 10/01/2016  
2. Person in Charge and Support Team Leader audited care plans since inspection. 10/02/2016  
3. Nurse engaging with service for development of pain management plans. Due 19/02/2016  
4. Dietician to visit service to provide guidance for staff on Nutritional Tools and develop dietary care plans for assessed needs. Due 22/03/2016

**Proposed Timescale:** 22/03/2016

**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:**  
Where learning had been identified from incidents and accidents it had not been implemented.

**10. Action Required:**  
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**  
Any learnings identified from incidents and accidents will be action-ed and responsibility assigned through management meetings and staff meetings.
### Proposed Timescale: 19/02/2016  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
From a review of documentation including the incident and accident log and the centre's risk register it was evident:

- a) Risks were not being identified or reviewed.
- b) Where risks' had been identified these had not been assessed.

**11. 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. Person in Charge has implemented a new risk assessment format and risk assessments for residents are now in place. 05/02/2016  
2. Risk register reviewed and update by Person in Charge and Provider Nominee, risk register now reflects all current and centre specific risks. 16/02/2016

### Proposed Timescale: 16/02/2016

### Outcome 08: Safeguarding and Safety  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff working at the centre were not familiar with residents' positive behaviour support plans and the recommendations within.

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

Please state the actions you have taken or are planning to take:
Since inspection a reviewed version of the behaviour support plan has been received by the person in charge and communicated to all staff. Person in Charge and keyworker to provide oversight for implementation of plan.

### Proposed Timescale: 10/02/2016
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As outlined in the body of the report both chemical and environmental restraints were not applied in accordance with national policy and evidence based practice.

**13. 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:
1. Risk assessment completed for environmental restraint. 05/02/2016
2. Chemical restraint protocols to be reviewed at regional meeting amongst management – recommendations to follow for policy review. 18/02/2016
3. Psychiatrist reduced amount of psychotropic medication for identified resident. 16/02/2016

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

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**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
For those residents who did not have positive behaviour support plans in place every effort had not been made to identify and alleviate the cause of the residents'' behaviour.

**14. 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:
1. Psychology services identified as a future need through the National Intellectual Disability Database. December 2015
2. Review with Disability Manager regarding update on referrals for four of the eight residents. 15/02/2016
3. Private psychological service contacted regarding assessments for all residents. 17/02/2016

**Proposed Timescale:** 01/06/2016
**Theme: Safe Services**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was found that residents were negatively impacted on while witnessing incidents and were not safeguarded from abuse.

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

Please state the actions you have taken or are planning to take:
1. Provider Nominee reviewed safeguarding assessments. 16/02/2016
2. Person in Charge and Provider Nominee met with the relevant HSE funders to discuss appropriate placements and safeguarding plans. Review of placement now occurring and future incidents and notifications to be forwarded to HSE. 19/01/2016, 15/02/2016

**Proposed Timescale:** 22/02/2016

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**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It remained that, for the most part, residents did not have access to opportunities for education, training and employment.

16. **Action Required:**
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
Meeting with disability manager to discuss training and education needs of residents and local availability.

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

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**Outcome 12. Medication Management**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The practices in place relating to PRN (as required) medicines were not sufficiently robust in that:
1. The indications for use were not consistently specified on the prescription sheet.
2. There were no guidance documents or protocols available to staff to ensure safe administration of psychotropic medication, pain relief or buccalom midazolam used in the event of epileptic seizures for residents. These medications had been prescribed on
a PRN basis but there was insufficient information on the prescription charts to facilitate the development of these guidelines/protocols.

**17. 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:**
1. Meeting with psychiatrist to discuss and review prescription sheet 16/02/16
2. Buccal Midazolam training for staff members has been sourced. Buccal Midazolam Protocol in place. 25/02/2016 & 08/03/2016
3. Pain management plans to be implemented by a Nurse. 19/02/2016
4. Use of PRNS and protocols to be reviewed at regional meeting amongst management – recommendations to follow for policy review. 18/02/2016

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

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**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:**
As outlined throughout Outcome 14 the provider failed to identify lines of authority and accountability, specific roles and detail responsibilities for all areas of service provision. For example, but not limited to, lack of autonomy regarding budget, allocation of resources, decision making and lack of communication from the provider to those in pertinent management positions.

**18. 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:**
Governance and Management systems to be reviewed by the CEO and board.

**Proposed Timescale:** 02/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Management systems, as outlined in the body of the report, were not wholly effective to ensure the service provided was safe, appropriate to residents' needs and consistent.
19. **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:**
Governance and Management systems to be reviewed by the CEO and board.

**Proposed Timescale:** 02/03/2016

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**Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Resources were not sufficient to ensure the individual needs and preferences of residents were met due to the lack of transport available to them.

20. **Action Required:**
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
1. The Person in Charge and Team Leader currently have indemnity on their insurance. Vehicle policy enacted to facilitate staff members engaging in 1:1 activities with residents. 12/02/2016
2. Two additional staff members to be indemnified to enable two additional vehicles at the service to allow for more 1:1 activities to occur. Due 09/03/2016

**Proposed Timescale:** 09/03/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further training and skill development was required to meet the needs of the residents as detailed below.
1. Care planning.
2. Lámh training.
3. PECs training.
4. Training regarding the appropriate use and administration of psychotropic medication.
5. Training regarding the administration of medication for seizure management.
6. Guidance for staff regarding meeting the needs of residents with high cholesterol and/or weight management.
7. First aid training.
8. Training in relation to autism.

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

**Please state the actions you have taken or are planning to take:**
1. All staff booked for Care Planning Training. 18th, 25th March 2016
2 & 3. Lamh and PECS obtained for all staff. 4th – 13th April.
4. Use of psychotropic medication and its associated procedures to be reviewed by management. 18/02/2016
5. Buccal Midazolam training for all staff members on 25th February and 8th March 2016
6. Dietician to visit service to provide guidance to all staff and implementation of dietary care plans. 22/03/2016
7. Occupational First Aid to be provided for all staff, 27th – 29th April, 4th – 6th May.

**Proposed Timescale:** 15/06/2016

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As outlined in Outcome 17, it remained that agency staff were being used compromising the continuity of care for residents.

22. **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:**
1. One agency staff has been recruited full time to the designated centre. 07/02/2016
2. Reduction in the numbers of agency staff being used to a group of 7 agency staff members reduced from 11 agency staff members. 07/02/2016
3. New proposal and requirements for the use of agency staff in the designated centre sent to agency from HR. 12/02/2016

**Proposed Timescale:** 12/02/2016
<table>
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<tr>
<th><strong>Outcome 18: Records and documentation</strong></th>
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<tr>
<td><strong>Theme:</strong> Use of Information</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>All elements of the food and nutrition policy were not implemented.</td>
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<td><strong>23. Action Required:</strong></td>
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<tr>
<td>Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>Dietician to provide oversight of MUST tool guidance for staff and overview of dietary care plans.</td>
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<td><strong>Proposed Timescale:</strong> 22/03/2016</td>
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