| **Centre name:** | A designated centre for people with disabilities operated by The Irish Society for Autism |
| **Centre ID:** | OSV-0002000 |
| **Centre county:** | Wexford |
| **Type of centre:** | Health Act 2004 Section 39 Assistance |
| **Registered provider:** | The Irish Society for Autism |
| **Provider Nominee:** | Susan Alexandra (Lexi) Kennedy |
| **Lead inspector:** | Julie Pryce |
| **Support inspector(s):** | Ciara McShane, Michael Keating |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 5 |
| **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 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**

<table>
<thead>
<tr>
<th>From:</th>
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<tbody>
<tr>
<td>10 February 2016 09:30</td>
<td>10 February 2016 18:30</td>
</tr>
<tr>
<td>07 April 2016 09:00</td>
<td>07 April 2016 18:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 02: Communication</th>
<th>Outcome 05: Social Care Needs</th>
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<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
<td>Outcome 11: Healthcare Needs</td>
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<tr>
<td>Outcome 12: Medication Management</td>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
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**Summary of findings from this inspection**

Inspectors undertook four 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 over a sustained period. 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 regulatory and escalation meetings were held with the provider.

Due to the overall failure of the provider to implement effective improvements for residents, a notice of proposal to cancel and refuse the registration of the centre was issued to the provider on 20 May 2015.

In response the provider made a formal submission to HIQA outlining plans to bring the centre into compliance. HIQA carried out inspections to determine if these plans had been implemented. However, appropriate actions were not taken to address deficits and HIQA ultimately issued a notice of decision to cancel and refuse the registration of Sarshill House on 17 June 2016. 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.

This report outlines the findings of the fourth inspection of the centre. Overall, there continued to be a high level of non-compliance in all areas of care and support reviewed during this inspection, and in particular there were inadequate measures to protect residents from serious physical assault by other residents. Inspectors were particularly concerned for the safety of residents and required the provider to take immediate action to manage this risk. However, the provider and the person in charge submitted two versions of the action plan to manage the risk to residents which were inadequate. Inspectors then took the unusual measure of instructing the person in charge and the provider nominee on the action they needed to take to keep residents safe.

Inspectors contacted the centre on the day following the inspection to seek confirmation that the immediate measures put in place were effective and were being sustained. In addition the inspectors informed the Health Services Executive's Chief Officer of the level of concern.

Nine Outcomes were inspected against and eight were found to be in major non-compliance including health safety and risk management, safeguarding and protection, healthcare, workforce and governance and management.

These major non-compliances included:

- Inadequate safeguarding measures to ensure residents were protected from assault and felt safe living in the centre
- Ongoing risks to residents that were not being appropriately managed or responded to
- Poor governance and oversight leading to negative outcomes for residents
- Healthcare interventions and dietary restrictions without adequate assessment or evidence base
- Poor management of staffing resources
- Staff not adequately trained to meet the assessed needs of some residents

The reasons for these findings are explained under each outcome in the report and the breaches of regulations are included in the action plan at the end of the report.
**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):**

No actions were required from the previous inspection.

**Findings:**

Several of the residents had significant communication support needs, and inspectors were not satisfied that all of these needs were being met.

For example Lamh (a manual sign system used by people with intellectual disabilities and communication needs in Ireland) was an identified communication method in use in the centre, but none of the staff had received training in Lamh. There was no evidence of training having been planned, instead the person in charge reported that there were plans to introduce a different communication system to several residents. There was no evidence that this was based on the assessed needs of residents who already had a method of communication.

A requirement for functional communication training had been identified, but this had not been provided.

There were picture schedules available on the walls of the rooms of two residents, as outlined in their personal plans. However on the first day of the inspection these were not in use. There was also an easy read calendar available for one of the residents, but the date was set at October 2015.

Some residents’ consultation meetings had been held, but there was no evidence that residents with significant communication support needs had been supported to participate.

In addition there had been no involvement of a speech and language therapist for any of the residents, despite the high levels of communications needs.

Some of the information for residents was available in ‘easy read’ versions, for example the contracts of care were available in an accessible version including pictorial representation of the main points.
Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
While there was a personal plan in place for each resident they were not being fully implemented, and there were insufficient meaningful activities for residents.

Important aspects of personal plans had not been implemented. For example various activities were recommended in personal plans in relation to managing anxiety. None of these activities had been provided.

Where environmental needs had been identified for residents, these had not been provided. Requirements identified in behaviour support plans included an environment which was not shared, reduced contact with other residents, frequent one-to-one support and frequent access to off-site activities. None of these requirements had been implemented.

Goals had been identified for residents, for example going out for meals had been identified as a goal. However there were no details as to how this goal would be achieved, no steps identified, no timeframe and no staff member identified as the person responsible. In addition there was no evidence of any steps being taken to achieve this goal, no progress report and no review.

While there was an area of the house which was designated as a ‘day service’, this was not based on the assessed needs of residents. While the person in charge had arranged for several of the residents to attend a local disabilities day service for an hour a week, attendance for some was sporadic. Some residents attended a local club for people with intellectual disabilities, but there was little other evidence of residents’ involvement or participation in the local community.
There had been some improvements in aspects of the personal plans since the previous inspection, for example the person in charge had organised the personal plans so that information was stored safely and chronologically, and was instantly retrievable.

**Judgment:**
Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Effective Services

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

**Findings:**
On the first day of the inspection there were some risk assessments in place, for example in relation to self injury, road safety and the use of hot water. Some individual resident risk assessments were also in place, and the person in charge presented a comprehensive template which was being introduced in order to capture all risks for individuals. By the second day of the inspection this template had been completed for all residents.

However not all control measures identified in risk assessments had been implemented. For example the risk assessment for a resident who engaged in self injurious behaviour identified a shared living environment as a contributory factor, and yet the resident spent the majority of time in a shared environment.

There was a risk register available, however the rating of these risks did not correlate with actual the level of risk. For example one of the highest risk ratings related to epilepsy, yet there had not been a seizure for over a year, and never any negative outcomes from a seizure. Meanwhile the risk of injury from challenging behaviour was rated much lower, despite there having been significantly serious incidents on a regular basis within the centre.

Inspectors were concerned that agency staff working in the designated centre had not received fire safety training and had not been involved in a fire drill. They were not aware of whether or not there was a fire panel in the centre. In addition two of the fire doors in the centre were observed by inspector to be wedged open. These were the only aspects of fire safety examined during the course of this inspection.

While some of the infection control issues identified in previous inspections had been rectified, the designated centre was still visibly unclean. The windows could be seen from outside the building to be unclean, and this clearly had not been addressed for a
significant period of time.

There was a bathroom downstairs in which the grouting around the tiles in the shower was visibly unclean. There was a dried on urine stain on the toilet seat, and a wet mop was stored inverted in a mop bucket in this room.

Upstairs the inside of windows and window sills were unclean, there were cobwebs and debris around two of the windows in the communal areas, and cobwebs around the inside of the window in a resident's room. In addition there was debris and significant dust on the floor of the bedroom of another resident.

However, after inspectors drew attention to these issues, by the second day of the inspection these hygiene issues had all been resolved.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Safeguarding and Safety**

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe Services

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

**Findings:**
Inspectors were very concerned that there were insufficient measures in place to ensure the safeguarding of all residents.

An immediate action was issued to the provider, who was required to immediately put in place an action plan to safeguard residents. The person in charge and provider nominee submitted two inadequate action plans which failed to address the risk to residents. Inspectors then took the unusual measure of instructing the person in charge and provider as to the actions that needed to be taken to keep residents safe.

Inspectors had identified this significant risk following a review of the accident and incident records. There had been multiple incidents of challenging behaviour over the previous six months, including physical attacks on other residents, staff members and visitors, sometimes leading to injury. There was no evidence in these reports of any
changes in the management of this situation to ensure the safety of others, including other residents. 13 serious incidents were recorded between 1 December 2015 and 7 April 2016 as well as numerous ‘near miss’ incidents.

When asked by the inspectors, neither the person in charge nor the person nominated to act on behalf of the provider could explain how residents were being safeguarded, or the actions that needed to be taken to ensure the safety of all residents. Inspectors reviewed behaviour support plans and found that recommendations to appropriately support residents and keep them safe had not been implemented. These recommendations included the identification and management of triggers to challenging behaviour. Incidents of behaviour were described by staff and the person in charge as being random and without reason. However, in all incidents reviewed by inspectors there were clear triggers to the behaviour which were identified in the behaviour support plans. In addition, functional communication training had been recommended, but this had not been provided.

There had been a serious incident in April 2015 leading to a significant injury and while some measures had been taken in an attempt to reduce the likelihood of reoccurrence, these had not been effective and there had been further incidents since. One of these measures was the introduction of one to one staffing. However, inspectors found that this was inconsistently implemented and while regular staff were aware of the serious risk involved, agency staff were not. A high proportion of staff were agency staff, and they were not aware that there had been a serious injury and were not aware of specific target behaviours.

While there had been some improvements in behaviour support plans for residents since the previous inspection in July 2015, inspectors found that these were not being implemented. Residents now had access to a behaviour specialist who had developed detailed assessments and behaviour support plans. However, various aspects of these behaviour support plans had not been implemented. For example, visual schedule of events, location of bedrooms, and varied programme of activities including sports had all been recommended but none of these recommendations had been implemented.

While all regular staff had received training in the protection of vulnerable adults, agency staff engaged by the inspectors had not. The person in charge and provider nominee were not aware that agency staff had not received this training, and could not confirm that all staff working in the centre had been Garda vetted. Confirmation was submitted to HIQA following the first day of the inspection that Garda vetting was in place for all staff.

Not all restrictive practices had been identified, or reported and recorded as required. For example, access to personal storage and personal possessions was restricted but there was no risk assessment in relation to this and the practice was not recorded.

There were robust practices in place in relation to the management of residents’ finances. Residents were supported to manage their finances, and all transactions were signed for and receipts kept. Each person’s balance was checked every day, and balances checked by the inspectors were correct.
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):  
No actions were required from the previous inspection.

Findings:  
In the period of time between the two days of the inspection, the person in charge submitted to HIQA a series of notifications in relation to allegations of abuse dated from January 2016. These notifications had not been made within three days of the incidents as required by the regulations.

Additional incidents of assault leading to injury were identified during the inspection which had not been notified to HIQA.

Judgment:  
Non Compliant - Major

Outcome 11. Healthcare Needs  
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:  
Health and Development

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

Findings:  
While residents’ access to a general practitioner (GP) and to other healthcare professionals had improved since the last inspection, inspectors were not satisfied that all of residents’ healthcare needs were met. For example there were multiple references to staff querying a resident being in pain, but no pain assessment had been conducted, and there was no pain management plan in place.
Staff were implementing highly restrictive diets. There was no appropriate assessment or diagnosis to support the implementation of such diets and no evidence of the input of a dietician.

Staff reported that these strict diets were in relation to management of challenging behaviour. However, there was no recording of incidents of behaviour from which to review the effectiveness of these significant interventions. In addition there were several entries in daily records which indicated attempts by residents to take food from others, and inspectors were concerned that the highly restrictive diet could be a contributing factor for this behaviour.

There was no evidence of residents being involved in choice around their diet, or of any attempt to elicit choice from any of the residents with communication needs.

In addition, a resident had been identified in their personal plan as having difficulty in chewing food, but this risk had not been assessed by a speech and language therapist.

**Judgment:**
Non Compliant - Major

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**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 was evidence of appropriate systems and processes in place in relation to medication management, however improvements were required in the management of ‘as required’ (p.r.n.) medications, and in the guidance in the medication management policy.

Medications were collected weekly from the pharmacy in blister pack form, and there were robust systems for checking and recording the receipt of medications. Medication administration was observed by the inspectors, and safe practices were demonstrated.

Medication audits were conducted quarterly, and a pharmacy audit had been conducted. Medication errors were managed appropriately, they were reported and recorded and advice was sought from the GP if required.

However, directions for p.r.n. medications lacked sufficient guidance to ensure their safe administration. For example, the guidance for the administration of a rescue medication
for epilepsy was ‘for seizure activity’, with no additional information as to the type or length of seizure which would necessitate the administration. There was no information to guide any decision to administer medication for the management of recurrent constipation, and staff reported that they recognise if a resident hadn’t been to the toilet. In addition there was no direction in relation to several topical applications.

By the second day of the inspection the person in charge had developed ‘good practice guideline’ in relation to PRN medications, which included a template in which to capture all the information required in order to safely administer these medications, and gave assurances that these would be completed for all residents.

Medication prescription and administration records were examined by the inspectors. The medications on these sheets had been transcribed by the person in charge from the doctors’ prescriptions. However this practice was not in accordance with safe medication practices. There was no service provider policy which stipulated required systems in order to minimise the risk of error, for example the stipulation that the transcribed prescriptions be signed and dated by the nurse concerned.

**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):**
No actions were required from the previous inspection.

**Findings:**
While there was a management structure in place which included a board of directors, CEO, provider nominee and person in charge, the arrangements for accountability were not clear. Inspectors found that the provider nominee did not have the autonomy required to fulfil the role. The provider nominee reported that she did not have a budget relating to the running of the centre, and was unaware for example of any particular budget for a day services.

The week following the conclusion of the inspection, HIQA were informed by the provider nominee that she had resigned her post.
The person in charge described her reporting relationship as being unclear. While she reported directly to the provider nominee, she said that she also received regular direction from other managers of the service.

There was no identified staff member to deputise in the absence of the person in charge, who described herself as being always available if not present in the centre and there was no evidence of any leadership in the centre in her absence.

There was poor monitoring of the safety and quality of care and support in the centre. There had been various audits, including a medication management audit, a pharmacy audit and a health and safety audit conducted in December 2015. However, the issues found by the inspectors had not been identified, including immediate risks to residents, general management of risk, implementation of personal plans, safe recruitment processes and hygiene control.

Unannounced visits to the centre were made by members of the board which resulted in a brief report, mainly relating to maintenance issues. This report included comments under various headings, but had not resulted in an action plan, and had not identified any of the issues found during this inspection.

An annual review of the quality and safety of care and support had been developed in December 2015, and included information from unannounced visits conducted by the provider nominee. The unannounced visits had generated an action plan, but required actions had not been implemented.

**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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were not satisfied that the numbers of staff or the skill mix were adequate to meet the assessed needs of residents.
There was no evidence of a formal review of dependency levels and related staffing numbers. As detailed throughout this report behavioural and safeguarding issues were not being managed appropriately. The inspectors found that staffing resources were not being appropriately deployed to meet the assessed needs of residents, including those needs identified in behaviour support plans and personal plans.

Agency staff did not display adequate knowledge of the assessed needs of residents, or of the recommended management strategies in the personal and behaviour support plans.

Staff training records for regular staff were examined by the inspectors, and all mandatory training had been provided and was up to date. However agency staff engaged by inspectors had not received training in fire safety or in the protection of vulnerable adults, and neither the person in charge or the provider nominee could confirm that all staff working in the centre had been Garda vetted.

No staff members had received any training in supporting people with autism, despite the fact that the declared purpose of the service as outlined in their Statement of Purpose was to provide a specialist service for people with autism.

Whilst training in the management of challenging behaviour had been provided to staff, as required in the action plan of a previous inspection, there was no evidence that this had been implemented or that it had positively impacted on the management of challenging behaviour within the centre.

Staff appraisals had been introduced and conducted, and included identification of strengths and needs, and a training needs analysis. However these were not conducted with agency staff, who were a significant proportion of the staffing compliment.

**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:

Julie Pryce
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-0002000</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 February 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>11 May 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 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not all supported to communicate in accordance with their needs.

1. 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.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
1) The Person in Charge, in consultation with a Speech and Language Assessment team has arranged appointments for June 2016 to carry out individual assessments of the communication and support needs of each resident in the designated centre.

2) Picture Exchange Communication System (PECS) training commenced for staff and residents on 19/02/2016 (Phase 1), 10/03/2016 (Phase 2), 20/04/2016(Phase 3) and Phase 4 training is scheduled for 19/05/2016.

3) In addition Lámh training will also be provided to all staff including agency staff, and this will commence on 07/06/2016.

4) Currently all residents are utilising an individualised accessible format picture board which is located in the dining room. Residents are supported by staff on a daily basis to choose their daily activities through this method which is based on the PECS system.

5) The Person in charge has sent referral forms and cover letter requesting assessments from the HSE speech and language therapy/occupational therapy and dietician departments on 29.03.16. To date, there has been no acknowledgment or response to this request. This letter has been forwarded on 11/05/2016 to HSE South Acting Disability Manager for attention to expedite these appointments.

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<th>Proposed Timescale: 30/06/2016</th>
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<td><strong>Theme:</strong> Individualised Supports and Care</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff were not trained in an identified communications system in use in the centre.

2. **Action Required:**
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

Please state the actions you have taken or are planning to take:
1) The Person in Charge, in consultation with a Speech and Language Assessment team has arranged appointments for June 2016 to carry out individual assessments of the communication and support needs of each resident in the designated centre.

2) The assessment of communication needs will be clearly recorded onto each resident’s new Assessment of Health & Social Care Needs and the outcome of the assessment, subsequent support plan and implementation of same will be communicated to all staff in a meeting with the speech and language therapist.

3) Lámh training will also be provided to all staff including agency staff, and this will commence on 07/06/2016.
4) Picture Exchange Communication System (PECS) training commenced for staff and residents on 19/02/2016 (Phase 1), 10/03/2016 (Phase 2), 20/04/2016 (Phase 3) and Phase 4 training is scheduled for 19/05/2016.

5) A schedule for monitoring and reviewing these supports plans will be developed by the assessor and implemented as part of the assessment process. The Person in Charge will ensure that the outcomes are clearly communicated and accessible to all staff including agency staff.

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

### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Arrangements were not in place to implement the personal plans of residents to meet their assessed care and support needs.

**3. Action Required:**

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

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

1) The person in charge has acquired and adapted a template for a comprehensive Assessment of Health & Social Care Needs which will be completed by relevant external clinical specialists, who have been detailed through this report; the Person in Charge and frontline staff.

   Going forward this document will be used to record all recognised needs which arise from specialist assessments and will be reviewed on an annual basis.

   This Assessment of Health & Social Care Needs will then be used to develop and/or update the personal plans of residents therefore meeting their assessed care and support needs.

2) An external consultant will provide comprehensive Care Plan training on 13/05/16 to all staff in the designated centre.

**Proposed Timescale:** 31/08/2016
**Theme: Effective Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The designated centre was not suitable to meet the needs of residents who had been assessed as requiring an environment which was not shared.

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

**Please state the actions you have taken or are planning to take:**
The residents for whom the environment was deemed not suitable will have a complete Assessment of Health & Social Care Needs carried out by a multi-disciplinary team which include an assessment of their environment and its suitability. The actions identified from this assessment will be implemented with the assistance of same multi-disciplinary team.

1 to 1 staffing is currently in place and will be continued and monitored by the multi-disciplinary team.

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**Proposed Timescale: 30/06/2016**

**Theme: Effective Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Required assessments by appropriate healthcare professionals had not all been conducted.

**5. 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:**
1) The Person in Charge has engaged a dietician to carry out assessments commencing in June 2016.

A Sensory Integration Specialist, Speech and Language Therapist and Occupational Therapist has been contacted also with a view to assessing all residents. These assessments will commence in June 2016.

The person in charge has acquired and adapted a template for a comprehensive Assessment of Health & Social Care Needs which will be completed by relevant external clinical specialists, who have been detailed through this report; the Person in Charge and frontline staff.
2) The Person in charge has sent referral forms and cover letter requesting assessments from the HSE speech and language therapy/occupational therapy and dietician departments on 29.03.16. To date, there has been no acknowledgment or response to this request. This letter has been forwarded on 11/05/2016 to HSE South Acting Disability Manager for attention to expedite these appointments.

Proposed Timescale: 31/07/2016

**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:**
There were not appropriate measures in place to mitigate identified risks to residents from episodes of challenging behaviour.

6. **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) The Person in Charge in consultation with an external professional will perform a comprehensive review of all risks on 23/05/2016 in relation to challenging behaviour and responding to emergencies.

2) The risk register will be reviewed formally on a monthly basis and more frequently where necessary. All changes will be communicated to staff at the house meetings or via the daily diary.

Proposed Timescale: 30/05/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures to maintain an appropriate level of hygiene were not in place.

7. **Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.
Please state the actions you have taken or are planning to take:
1) A deep cleaning of designated centre has been arranged for week commencing 30/05/2016.

2) A cleaning schedule is currently in place in the designated centre, however, following the observations noted in the recent HIQA inspection which highlighted failings in this, the current schedule will be revised with input from all staff at the next house meeting which will take place on 18/05/2016 in order to ensure compliance with regulation.

3) An application was made to Local Development Office for cleaner, this has been approved on 27/04/2016. Interview of person convened for week commencing 16/05/2016 and pending suitability, Garda clearance will be sought and person will commence working 19.5 hours per week.

Proposed Timescale: 31/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in fire safety, or could correctly identify all the steps to be taken in the event of an emergency.

8. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
1) The Person in Charge has carried out a centre specific basic fire training session on 18th and 20th May 2016 which included:
   Basic Fire Prevention i.e.:
   • Common causes of fire in the home.
   • Awareness of combustible items / materials in the home.
   • Awareness of electrical items, ensuring they are switched off when not in use, recording and reporting faulty sockets / appliances.
   • Ensure candles / cigarettes are fully extinguished.
   • Ensure there is a working battery in the smoke alarm

2) In addition, an external fire protection company have been engaged to carry out fire safety and use of portable fire equipment training for all agency staff. This training will be completed by 30/06/2016.
   All staff employed through the registered provider have received this training in 2015.

Other items in the onsite fire training agenda include:
   Building Layout
   Resident Evacuation Plans
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Agency staff did not have up to date knowledge relating to challenging behaviour.

9. 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:
A meeting was held with all agency staff on 12 & 14/04/2016 to discuss their need to familiarise themselves with the behaviour support plans currently in place and the subsequent implementation of same as well as their safeguarding responsibilities.

Going forward all agency staff, will have the opportunity to attend the scheduled monthly behaviour support clinics.

Minutes of these meetings including any recommendations which arise will be available in each resident’s file. Staff will be informed via the daily diary that new minutes are available. Relevant behaviour support updates will also be available on resident’s files.

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Measures to alleviate the causes of challenging behaviour were not being implemented.

10. 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.
The specific recommendations outlined in the behaviour support plans have been identified and an individualised recording method attached to each recommendation. This will be implemented by the staff and subsequently reviewed at our current monthly behaviour consultancy clinics with Behaviour Support Specialist and Person in Charge.

**Proposed Timescale:** 11/05/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider had not put sufficient arrangements in place to safeguarded residents.

**11. 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:
An extra (9am - 9pm) staff cover is being provided on an ongoing basis. There will be ongoing monitoring of challenging behaviour of individual resident in terms of positive/negative impact for learning towards future interventions in the current monthly behaviour clinic with staff & Behaviour Support Specialist. Ongoing monitoring of staff members in terms of positive/negative impact of interventions to provide opportunities to further enhance practice of staff in the current monthly behaviour clinic with staff, Person in Charge & Behaviour Support Specialist. An updated training session for staff on specific safeguarding issues to reinforce the definition of peer to peer abuse will take place on 30/05/2016.

**Proposed Timescale:** 30/05/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had received training in relation to the protection of vulnerable adults.

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

Please state the actions you have taken or are planning to take:
1) All regular staff of designated centre have up to date training in relation to Safeguarding of Vulnerable Adults. To supplement this, all staff employed through the registered provider will receive an additional updated refresher training session on 30/05/2016.
2) All agency staff will be receiving Safeguarding of Vulnerable Adults training on 27/05/2016.

**Proposed Timescale:** 30/05/2016

### Outcome 09: Notification of Incidents

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notifications of allegations of abuse were not made to the Authority within three working days.

13. **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:
The Person in Charge has submitted notifications of allegations of abuse retrospectively and is fully aware of obligation regarding notifications to the authority and will ensure that full compliance with the regulations will continue.

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

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all identified healthcare issues had been addressed.

14. **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:
1) The Person in Charge has introduced a Disability Distress Assessment Tool (DISDAT) which will identify each resident's appearance and behaviours when they are content and distressed, describe these cues and subsequently a support plan will be developed.

2) The Person in Charge has engaged a dietician commencing June 2016, who will undertake a review of menu cycle, food and drinks stocked in the home, undertake an individual nutrition assessment with each individual resident, their keyworker and family
member including nutrition training for all staff and parents taking a detailed account of resident’s past and present medical history, height and weight, detailed eating patterns/habits – likes and dislikes, assessment of food/fluid charts. A written, nutrition care plan, tailored for each resident will be supplied following the assessments.

A Speech & Language therapy assessment has been sourced to commence in June 2016 to include an eating and swallowing assessment and subsequent support plan.

**Proposed Timescale:** 30/06/2016  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Residents did not have appropriate access to a dietician or speech and language therapist.

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

Please state the actions you have taken or are planning to take:  
The Person in Charge has engaged a dietician commencing June 2016, who will undertake a review of menu cycle, food and drinks stocked in the home, undertake an individual nutrition assessment with each individual resident, their keyworker and family member including nutrition training for all staff and parents taking a detailed account of resident’s past and present medical history, height and weight, detailed eating patterns/habits – likes and dislikes, assessment of food/fluid charts. A written, nutrition care plan, tailored for each resident will be supplied following the assessments.

A Speech & Language therapy assessment has been sourced to commence in June 2016 to include an eating and swallowing assessment and subsequent support plan.

**Proposed Timescale:** 30/06/2016  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Residents were put on highly restrictive diets without a validated assessment of their dietary requirements.

16. **Action Required:**  
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.
Please state the actions you have taken or are planning to take:
The Person in Charge has engaged a dietician commencing June 2016, who will undertake a review of menu cycle, food and drinks stocked in the home, undertake an individual nutrition assessment with each individual resident, their keyworker and family member including nutrition training for all staff and parents taking a detailed account of resident’s past and present medical history, height and weight, detailed eating patterns/habits – likes and dislikes, assessment of food/fluid charts.
A written, nutrition care plan, tailored for each resident will be supplied following the assessments.

Proposed Timescale: 30/06/2016
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no measures to maximise the participation of residents in decisions about their diet, and in choice at mealtimes.

17. Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
1) A picture board system has been put in place as per the Picture Exchange Communication System (PECS) to maximise the participation of each resident in choice and decisions about their diet and meals. These pictures cover a wide range of food groups, meal choices including drinks and snacks.

2) A Speech and Language Therapist has been engaged to commence in June 2016 to assess alternative methods of enabling and supporting all residents to communicate their choice in decisions regarding their daily diet and meal.

Proposed Timescale: 30/06/2016

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:
Practices in relation to 'as required' prescriptions and transcribing of prescriptions were not adequate to ensure that medication was administered as prescribed.

18. 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) PRN protocols were devised and forwarded to Psychiatrist for input and ratification. These protocols were shown to HIQA Inspector on 07/04/2016 which was deemed satisfactory with one addition recommended. This recommendation has subsequently been added to the draft protocols and been ratified by the Psychiatrist. An appointment has been scheduled for week commencing 23/05/2016 for Psychiatrist to complete same.

2) The Medication Policy did include a sentence on transcribing which has now been reviewed and a new paragraph has been included as follows: "Transcribing of Drug Prescription and Administration Record should only be completed by a prescribing practitioner or Service Manager of the Designated Centre. Once transcribed, the Drug Prescription and Administration Record is checked and signed by the a prescribing practitioner i.e. GP/Psychiatrist."

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

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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:

Management and oversight arrangements were not in place to ensure quality and safety of care and support.

**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:**

1) A support team leader was appointed in the most recent absence of the Person in Charge and this practice will continue going forward.

2) A recruitment and selection process has been initiated for a support team leader structure in the designated centre.

**Proposed Timescale:** 11/05/2016
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Areas identified as requiring attention following unannounced visits by the provider had not been addressed.

**20. Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**
Going forward all actions generated from the unannounced visits and included in the annual review will be addressed and implemented by the Person in Charge and frontline staff through the reviews scheduled to take place with the multi-disciplinary team.

**Proposed Timescale:** 11/05/2016

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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:**
The numbers of staff were not appropriate to meet the needs of residents during the day. Not all staff had the skills required to meet the needs of residents.

**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) Staff compliment has been increased to four during the day which allows for 1 – 1 support for residents in need and most vulnerable.

2) The Person in Charge is initiating a review of the current staff roster in consultation with human resources and senior management, to examine the resources available to best meet the needs of the residents.

3) The designated centre has now information on site re agency staff i.e. copies of CV, Garda Vetting form, Driving/passport licence, references, qualifications and relevant training.
A meeting was held with all agency staff on 12 & 14/04/2016 to discuss their need to familiarise themselves with all support plans currently in place and the subsequent implementation of same. This will be reviewed and monitored in regular monthly staff meetings. The agenda of these meetings will be amended to incorporate a section for discussion and action surrounding all support plans.

4) The Person in Charge has carried out a centre specific basic fire training session on 18th and 20th May 2016 which included:
   Basic fire prevention as outlined in Action 8
   Building Layout
   Resident Evacuation Plans
   Escape Routes
   Fire Control Panel
   Location of First Aid / Fire Fighting Equipment
   Location of fire alarm call points
   Firebox- location and contents.

5) In addition, an external fire protection company have been engaged to carry out fire safety and use of portable fire equipment training for all agency staff. This training will be completed by 30/06/2016.
   All staff employed through the registered provider have received this training in 2015.

6) All regular staff of designated centre have up to date training in relation to Safeguarding of Vulnerable Adults. To supplement this, all staff employed through the registered provider will receive an additional updated refresher training session on 30/05/2016.
   All agency staff will be receiving Safeguarding of Vulnerable Adults training on 27/05/2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Agency staff had not received all appropriate training.

**22. 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:**
1) The Person in Charge has carried out a centre specific basic fire training session on 18th and 20th May 2016 which included:
   Basic fire prevention as outlined in Action 8
2) In addition, an external fire protection company have been engaged to carry out fire safety and use of portable fire equipment training for all agency staff. This training will be completed by 30/06/2016. All staff employed through the registered provider have received this training in 2015.

3) All regular staff of designated centre have up to date training in relation to Safeguarding of Vulnerable Adults. To supplement this, all staff employed through the registered provider will receive an additional updated refresher training session on 30/05/2016.

All agency staff will be receiving Safeguarding of Vulnerable Adults training on 27/05/2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although agency staff were employed in a regular and on-going basis, they were not subject to formal supervision.

**23. Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The Person in Charge will undertake formal supervision with agency staff going forward commencing July 2016.

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