

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Greenville House
Centre ID:	OSV-0002113
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cork Association For Autism
Provider Nominee:	Brian Healy
Lead inspector:	Julie Hennessy
Support inspector(s):	Geraldine Ryan
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	1

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 1 day(s).

The inspection took place over the following dates and times

From: 04 January 2017 13:30 To: 04 January 2017 18:00

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 21 and 22 October 2015, the second on the 4 and 9 May 2016 and the third on 16 November 2016. This inspection was a focused triggered inspection on foot of on-going concerns regarding the quality and safety of the service identified over recent inspections.

On 15 December 2016, the chief inspector requested reassurance from the Board of Directors of Cork Association for Autism regarding their capacity to oversee the quality and safety of care and support to residents, the effective management of the centre and to ensure that both management and staff have the knowledge, skills and ability to effectively meet residents' needs.

The Board of Directors of Cork Association for Autism responded to this request on 22 December 2016 and provided written reassurances that outlined steps being taken or already taken to address these concerns. This triggered inspection took place to identify the level of risk in the service at this point in time by following up on specific actions that related directly to the safety of the service being provided.

In addition, the Board of Directors of Cork Association for Autism were invited to attend a meeting at the office of the chief inspector of HIQA on 9 January 2017 and the findings of this inspection informed that meeting. A detailed plan outlining how governance and management failings will be satisfactorily addressed is to be submitted to HIQA by 20 January 2017.

How we gathered our evidence:

As part of the inspection, inspectors met with five residents, a member of the board, the person in charge, a person identified as participating in the management of the service and a number of staff on-duty. Inspectors reviewed the quality and safety of care being provided with those staff through discussion about and observation of practices. Inspectors also reviewed relevant documentation, including residents' files, the risk register, staff training records and residents' personal plans.

Description of the service:

The centre provides residential care specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque environment and there is also a day service and other facilities, such as horticulture and outdoor gym equipment in the grounds. The centre comprises a main house and six cottages and can accommodate 13 residents. The main house can accommodate five residents and the cottages can accommodate either one or two residents.

Overall judgment of our findings:

Inspectors found that a number of key issues identified at the previous inspection had not been satisfactorily progressed. It is acknowledged though that other actions that had been progressed may not have been inspected on this inspection if they did not form part of this focussed inspection.

Overall, failings identified under six of nine outcomes remained or were found to be at the level of major non-compliance as follows:

- an immediate action plan was issued regarding the on-going failure of the provider to ensure that comprehensive assessments of need were completed for the purposes of identifying and meeting residents' support requirements (outcome 5). The provider responded satisfactorily to the immediate action plan within the required timeframe
- the system for managing risks was not robust and involved a recent occasion whereby a resident was placed at an unacceptable level of risk to their personal safety (outcome 7)
- not all residents had an effective behaviour support plan in place, which had resulted in negative outcomes for individual residents (outcome 8)
- it was not demonstrated that residents had access to the multi-disciplinary supports that they required (outcome 11)
- systems were not in place to ensure safe storage of medicines and medicines and administration devices had been accessed by residents (outcome 12)
- the provider failed to appoint a person in charge who meets the requirements of the regulations in terms of having the skills and experience to manage the designated centre and failed to ensure there was adequate oversight regarding the safety of the service being provided (outcome 14)

Some good practice was found during the inspection. Residents who communicated

verbally told inspectors that they liked where they lived and they enjoyed their day service. Residents were encouraged to be independent in relation to self-care and carrying out daily tasks. Residents were supported in an individualized way to choose what they wanted to do and activities they wished to pursue. Staff were observed to interact with residents in a supportive and appropriate manner.

The Board of Directors of Cork Association of Autism has been responsive and actively working to address the failings identified at previous inspections and to address other issues by strengthening the governance and management of the centre. Reassurances received include the secondment of a senior manager from the week following the inspection (week of 9 January 2017), pending recruitment of a clinical manager. This senior manager will oversee the service and represent Cork Association of Autism in its interactions with HIQA. Also, an additional person in charge will commence the following week (week of 16 January 2017), which would result in reducing the area of responsibility of the existing person in charge. A team leader structure, recruitment of additional staff and a staff training programme were completed or in progress. A review of quality and safety of the service is planned for early 2017.

However, the provider's first action plan response submitted following this inspection was not accepted by HIQA, particularly in relation to the governance arrangements for the centre. The provider was afforded a second opportunity to submit a response; this was accepted by HIQA.

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

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

Outcome 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:

At two previous inspections, the person in charge was requested to arrange for a comprehensive assessment to be completed for all residents in the centre, and for such assessments to be completed for individual residents with complex needs as soon as possible. At this inspection, an immediate action plan was issued due to the continued failure to take adequate steps and arrange for such an assessment to be completed.

While a case conference had been held prior to the previous inspection (in August 2016) with respect to individual residents with complex needs, comprehensive assessments of need had not been completed. As a result, it was not possible to determine whether individual residents were receiving the support and input that they required. In addition, processes were not in place for assessment and review of residents with changing or increasing needs, for example, where residents continued to lose weight, display self-injurious behaviour or who were suffering from mental health symptoms.

At this inspection, inspectors found that the personal plan did not always outline how staff would support residents identified needs. Guidance was in place in relation to some areas of need, for example epilepsy management and intimate care needs. However, care plans were not in place to effectively guide staff to support other areas of need, such as impaired vision, bowel care and nutrition and hydration. This was particularly relevant given the number of new staff recently recruited to work in this centre who would not be familiar with individual resident's needs.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

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

Findings:

Overall, while parts of the centre were bright, warm and clean, it was not demonstrated that other parts of the centre met residents' current needs in terms of accessibility.

Unchanged from previous inspections, the premises did not meet all of the requirements of Schedule 6 of the regulations. There was limited communal space in one shared premises. Two residents shared a single open-plan kitchen/dining/living space. The action relating to a second living area in the shared premises has yet to be completed.

In another part of the centre, it was not demonstrated that the accommodation met the needs of any resident residing there. This failing had already been identified by the provider, who was in the process of finalising the necessary programme of works. The programme of works pertained to upgrading and renovating bathroom facilities and the living space. Also, the provider was taking steps to ensure that the accommodation was accessible. Finally, a programme was required to ensure that the premises was clean and did not pose a hazard to health.

Judgment:

Non Compliant - Moderate

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:

Overall, while the provider had progressed actions arising from the previous inspection, it was not demonstrated that the system in place for assessing and managing risks was adequate.

At the previous inspection, recording and investigation of, and learning from, potentially serious incidents or adverse events involving residents was not evidenced in full. In addition, since the previous inspection, a notification had been submitted in relation to an allegation of abuse, which related to an act of neglect or omission. This notification related to a recent occasion whereby a resident was exposed to an unacceptable level of risk to their personal safety. Inspectors reviewed the steps taken by the provider in relation to the management of such incidents or adverse events. A number of measures had been implemented, including the introduction of a new protocol and review of specific routines. However, it was not demonstrated that the system in place for assessing and managing risks was adequate. Where individual routines involved risks to residents themselves, the control measures outlined in the risk assessment had not been implemented in full. For example, where controls specified a 2:1 staffing ratio, there were times when staff had no line of sight for the supervision of residents. Also, the risk had been identified as 'low' and it was unclear the rationale for this low rating given that this activity was documented as a concern in meeting minutes two days prior to the incident occurring. Information provided by a person participating in the management of the service indicated that this risk was clearly identifiable for a period of approximately one year. Also, it was not clear why a full investigation had not been initiated following the preliminary screening of this incident.

Since the previous inspection, risk assessments had been completed for other key risks. For example, where residents went swimming, risk assessments had been completed that identified staffing supports and other considerations.

At the previous inspection, it was not demonstrated that the arrangements in place for evacuating residents in the event of a fire had been demonstrated to be satisfactory. Fire drill records did not consider all likely scenarios or staffing levels at different times. Since the previous inspection, fire drills had been held to simulate different scenarios in all parts of the centre. Where a timely evacuation had not taken place, the provider was actively taking steps with the input of a behaviour support therapist to support residents and improve evacuation times.

At this inspection, training records indicated that while some staff had received training in infection control and hand hygiene, a significant number of staff had not. This was relevant given the identifiable infection control risks in a part of parts of the centre.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Overall and as also identified on the previous inspection, it was not demonstrated that residents had an effective behaviour support plan in place.

At the previous inspection, where a behaviour support plan was not proving effective, a process was not in place to allow for on-going or further review by professionals involved in those residents' care and support. At this inspection, this finding was unchanged. As a result, it was not demonstrated that residents were receiving the supports that they required to ensure that they had an effective behaviour support plan in place. It was also not adequately demonstrated that the reason behind behaviours that may challenge had been adequately explored. This gap has resulted in identifiable negative outcomes for individual residents including self-injurious behaviour and routines that involve risks to resident's own health, safety and welfare.

At the previous inspection, training records indicated gaps in relation to the safeguarding of vulnerable adults and positive behaviour support. At this inspection, inspectors reviewed training as it related to safeguarding of vulnerable adults and positive behaviour support. In accordance with the action plan submitted following the previous inspection, training was being rolled out across the service. At the time of this inspection, while some staff still required training in the safeguarding of vulnerable adults and positive behaviour support, the timeframe for completion of this action submitted following the previous inspection had not yet passed and was on target for completion.

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:

As was the finding at the previous inspection, it was not demonstrated that when a resident required services provided by allied health professionals, that such access would be provided. Inspectors found that overall the arrangements in place were ad hoc with some residents accessing services privately, no system for follow up or review of residents' progress or deterioration and little evidence of clinical oversight and coordination of the care being provided.

Residents had access to a general practitioner (G.P.) of their choice and an out of hours G.P. service. Residents also had access to medical consultants as required and records of referrals and reports were kept on file.

However, it was not demonstrated that residents had access to allied health professionals where required. The lack of a multi-disciplinary team to residents in this service was highlighted both at two previous inspections and again at this inspection. At this inspection, this failing was again reiterated to a board member, a person participating in the management of the service and the person in charge. The impact of this lack of access to supports required to assess and review residents' support needs was evidenced under outcomes 5, 7 and 8.

In addition, where it had been identified that supports were required, these recommendations had not always been completed. For example, where access to a dietician had been recommended by a clinical professional in 2015, this recommendation had yet to be adequately addressed.

Inspectors also found that remedies, products and treatments had been recommended or commenced by staff and management. For example, specific diets and products (such as bulking agents) had been commenced or considered without adequate clinical supervision and referrals were sought for conditions not diagnosed by a medical practitioner.

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:

Aspects of this outcome were included as a number of notifications had been received in relation to the safe administration of medication since the previous inspection.

Inspectors reviewed the management of medication errors in the centre. While investigations were underway in relation to three errors, it was not clear from information submitted that an investigation is planned in relation to the fourth error. That error involved unsafe storage of emergency medicines (an authorised schedule 4 controlled drug), which was accessed by the resident. Medical attention was sought when staff had discovered the medicines had been accessed and the administration devices shattered. However, staff were unsure what time the medicines had been accessed or whether parts of the shattered administration device had been ingested. Further information was requested from the person in charge following this inspection, including whether an investigation was pending to determine the root cause of the incident.

Other measures recently implemented included staff training in medication management and medication management audits were being completed on a weekly basis.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Overall, the provider had progressed a number of actions since the previous inspection. However, the provider had failed to appoint a person in charge who meets the requirements of the regulations in terms of having the skills and experience to manage

the designated centre and failed to ensure there was adequate oversight regarding the safety of the service being provided.

At the previous inspection, it was not demonstrated that the interim arrangements in place pending recruitment of a clinical manager would ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Following the that inspection and due to on-going concerns regarding governance and management of the service, the chief inspector requested the Board of Directors of Cork Association of Autism to provide reassurances to HIQA that the service provided was a safe quality service for residents on 15 December 2016.

The chair of the board responded to this request and written reassurances were received on 21 December 2016 in relation to governance and management of the centre. Reassurances include the secondment of a senior manager from the week following the inspection (week of 9 January 2017) pending recruitment of a clinical manager. This senior manager will oversee the service and represent Cork Association of Autism in its interactions with HIQA. Also, an additional person in charge will commence the following week (week of 16 January 2017), which would result in reducing the area of responsibility of the existing person in charge. A team leader structure, recruitment of additional staff and reviews of quality and safety of the service planned for early 2017 were additional steps outlined in the provider's response.

However, it was again not demonstrated that oversight of the service being provided was adequate to ensure it was safe, appropriate to residents' needs, consistent and effectively monitored. This was evidenced in notifications over the previous six months, including recent notifications in December 2016 and January 2017. Also, an incident in October 2016 and the aforementioned incident in December 2016 indicated delays in reporting incidents to the on-call person.

Also, the provider had failed to appoint a person in charge who meets the requirements of the regulations in terms of having the skills and experience to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

In addition, the provider's response following the previous inspection was not accepted as it failed to address key gaps that related to assessment of residents' needs and the provision of multidisciplinary supports to residents', based on those assessed needs. A revised action plan is due for submission by 16 January 2017.

Other actions identified on the previous inspection had been progressed. For example, roles and responsibilities had been clarified and an unannounced visit of the service was scheduled to take place.

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:

Overall, the provider had taken steps to improve and develop human resources practices in the organisation since the previous inspection. However, the short timeframe between the introduction of those changes and this inspection meant that it was not yet possible to judge the effectiveness of those changes in full.

At the previous inspection, reassurance was required that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

The provider had taken steps to improve and develop human resources practices in the organisation since the two most recent inspections. For example, a recruitment campaign had been undertaken that focussed on ensuring that there would be adequate staffing levels and staff with the appropriate skills and experience to support residents. However, on the day of inspection in one cottage, neither staff rostered on for the afternoon and evening were familiar with that resident's current needs.

A training needs analysis had been completed and a training programme was being rolled out to all staff. Training records indicated that this programme was progressing in accordance with the action plan submitted by the provider following the previous inspection. Staffing levels required to support specific activities had been assessed and determined. However, based on conversations with staff, inspectors did not meet any staff who had received any training in relation to supporting individuals with autism, despite this service providing a service specifically for individuals with autism.

Judgment:

Non Compliant - Moderate

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:

Aspects of this outcome were added due to failings identified on the day of inspection.

Information relevant to the care and welfare of residents was not readily available on the day of inspection (including case conference minutes and action plans and psychiatry notes), although case conference notes were submitted on request the day following the inspection. The absence of care plans made it very difficult for inspectors to ascertain what support or care was to be provided in relation to specific areas. For example, it was not clear how individual resident's dietary needs were supported and information relating to specific routines was not accurate.

Judgment:

Non Compliant - Moderate

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 Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Cork Association For Autism
Centre ID:	OSV-0002113
Date of Inspection:	04 January 2017
Date of response:	08 February 2017

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

The supports required to meet residents' needs were not based on a comprehensive assessment of residents' needs, for example, in relation to multidisciplinary supports.

1. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the

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

assessed needs of each resident.

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

Review of MDT assessments and interventions and update of information – completed.
To identify required MDT interventions for annual assessment of need.
Continue to source health professionals to complete assessment of need for each resident.
CAA multi- disciplinary team to be developed to ensure quality and timely interventions.

Proposed Timescale:

Identification of required MDT interventions for annual assessment of need – 13/2/17
(see attached update)
Sourcing required health professionals for annual assessment of need – 13/2/17 (see attached update)
Creation of CAA MDT – 31/3/17

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

As identified on previous inspections, comprehensive assessments of need had not been completed for all residents and in particular, for residents with complex needs.

In addition, processes were not in place for assessment of residents to reflect changing needs, for example, for residents who continued to lose weight, injure themselves or who were suffering from mental health symptoms.

2. 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:

Review of MDT assessments and required interventions and update of information - completed
To identify required MDT interventions for annual assessment of need.
Continue to source health professionals to complete assessment of need for each resident.
CAA multi-disciplinary team to be developed to ensure quality and timely interventions for residents.

Proposed Timescale: Identification of required MDT interventions for annual assessment of need – 13/2/17
Sourcing required health professionals for current assessment of need – 17/2/17 (see attached update)
Completion of assessments of need for all residents(See attached schedule) - 27/3/17
Creation of CAA MDT – 31/3/17

Proposed Timescale: 31/03/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

It was not demonstrated that all parts of the centre met residents' needs in terms of accessibility.

3. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

Monthly maintenance reviews and annual maintenance plan to be introduced. The maintenance plan will be held by the Property & Facilities Manager and will be a standard agenda item on the Senior Team agenda.

Proposed Timescale:

Introduction of monthly maintenance reviews and annual maintenance plan - 28/2/17

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

A programme was required to ensure that all parts of the centre were clean and did not pose a hazard to health.

4. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

Contract cleaning company to carry out a deep clean of all residential areas of the campus.

Current cleaning regimes to be reviewed and standard operating procedures to be devised and implemented.

PIC to complete weekly checklist of all residences to identify and address any issues and promote a high standard of cleanliness throughout the campus.

Proposed Timescale:

Deep clean of all residential areas – 28/2/17

Review of current cleaning regimes – 10/3/17

Introduction of standard operating procedures re: cleaning schedules – 31/3/17

PIC's to carry out weekly checks of all residences – To commence 6/2/17

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

The premises did not meet all of the requirements of Schedule 6 of the regulations.

There was limited communal space in one shared premises. Two residents shared a single open-plan kitchen/dining/living space. The action relating to a second living area in the shared premises has yet to be completed. Another part of the centre required upgrading and renovation of the bathroom facilities and the living space.

5. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

Cedar (Shared Living Area) – Programme of works agreed which will provide an additional living area. Procurement Process completed. Funding sanctioned from CAA Fundraising revenue.

Oak (re-location of bathroom and upgrade of kitchen) – Programme of works agreed. Procurement process completed. Funding sanctioned from fundraising revenue.

Proposed Timescale:

Cedar – additional living area – 30/6/17

Oak – upgrade – 31/3/17

Proposed Timescale: 30/06/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

As detailed in the findings, it was not demonstrated that the system in place for assessing and managing risks was adequate.

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:

Risk Management Review to be completed which includes unannounced external service inspection with a primary focus on safe services.

On call arrangements, have been reviewed and are currently being managed by the Services Lead until the introduction of a revised-on call procedure which will ensure that on call arrangements are sustainable, all risks are being managed effectively out of hours and emerging issues are being communicated effectively.

Current on call record will be standard item on the care review meeting agenda.

Incident report review for 2016 commenced.

Organisational database to be developed.

Findings of the annual incident report review to be communicated at quarterly staff briefing sessions.

Schedule of audits to be introduced to service which include medication audit, health and safety, fire safety, PCP's, cleaning and maintenance.

Audit training to be delivered to management.

Proposed Timescale:

Risk Management Review – 28/2/17 (Unannounced inspection re: safe services and medication management review completed)

Audit Training for management – 31/3/17

Introduction of Audit schedules – 1/4/17

Proposed Timescale: 01/04/2017

Theme: Effective Services

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

As detailed in the findings, it was not demonstrated that the processes in place for the management and investigation of, and learning from, serious incidents or adverse events involving residents were satisfactory.

7. 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:

Monthly reviews of incidents introduced in November 2016 – ongoing.

Incident report reviews to be standard item on agenda of the Health & Safety Committee commencing 6/2/17 and learnings circulated to staff through team meetings.

Incident reports to be standard item on the monthly care review meetings.

Incident reports sent weekly to interim services lead for review. All serious incident reports reported to interim services lead immediately.

On call arrangements, have been reviewed and are currently being managed by the Services Lead until the introduction of a revised-on call procedure which will ensure that on call arrangements are sustainable, all risks are being managed effectively out of hours and emerging issues are being communicated effectively.

Current on call record will be standard item on the care review meeting agenda.

Incident report review for 2016 commenced.

Organisational database to be developed.

Findings of the annual incident report review to be communicated at quarterly staff briefing sessions.

Proposed Timescale:

First monthly Care Review Meeting – 15/2/17

Roll out of new on call arrangements – 10/3/17

Completion of incident report review, creation of database and analysis of data – 23/2/17

Proposed Timescale: 10/03/2017**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

At this inspection, training records indicated that while some staff had received training in infection control and hand hygiene, a significant number of staff had not.

8. 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:

Infection control and hand hygiene training to be completed.

Current cleaning regimes to be reviewed and standard operating procedures to be devised and implemented.
PIC to complete weekly checklist of all residences to identify and address any issues and promote a high standard of cleanliness throughout the campus.

Proposed Timescale: Completion of infection control and hand hygiene training – 28/2/17

Deep clean of all residential areas – 28/2/17

Review of current cleaning regimes – 10/3/17

Introduction of standard operating procedures re: cleaning schedules – 31/3/17

PIC's to carry out weekly checks of all residences – To commence 6/2/17

Proposed Timescale: 31/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Unchanged from the previous inspection, where a behaviour support plan was not proving effective, a process was not in place to allow for on-going or further review by professionals involved in those residents' care and support.

9. Action Required:

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

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

Functional assessment of need completed by the Behavioural Support Analyst as part of the MDT interventions process.

Protocols regularly reviewed by behavioural support analyst as part of ongoing assessment work.

Review of all current supports to be completed by a clinician with behavioural management expertise.

MDT currently engaging with resident re: assessment and round table meeting arranged for 7/3/17.

Proposed Timescale:

Review of all current supports – 20/2/17

Proposed Timescale: 20/02/2017

Theme: Safe Services

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

Training records indicated gaps in relation to positive behaviour support.

10. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Completion of Positive Behaviour Support Training for core staff – (see attached training update)

Proposed Timescale: Completion of PBS Training for core staff – 15/2/17

Proposed Timescale: 15/02/2017

Theme: Safe Services

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

Most but not all staff had received training in relation to safeguarding residents and the prevention, detection and response to abuse.

11. 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:

Safeguarding of vulnerable adults training for core staff – see attached training update

Proposed Timescale:

Completion of all core training modules for all staff inc: relief panel – 31/3/17

Proposed Timescale: 31/03/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

It was not demonstrated that when a resident required services provided by allied health professionals, that such access would be provided.

12. 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:

Need for intervention of AHP's to be identified through MDT process.

PIC to take responsibility for advocating for the resident regarding access to AHP's.

Introduction of monthly care review meetings where any delay in referrals to AHP's can be identified and escalated.

Proposed Timescale: Introduction of monthly care review meetings – 13/2/17

Proposed Timescale: 13/02/2017

Theme: Health and Development

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

It was not demonstrated that appropriate health care was provided for residents.

Inspectors also found that remedies, products and treatments had been recommended or commenced by staff and management. For example, specific diets and products (such as bulking agents) had been commenced or considered without adequate clinical supervision and referrals were sought for conditions not diagnosed by a medical practitioner.

13. 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:

Review of un-prescribed alternative therapies/supplements and other products completed.

GP's to be contacted and prescriptions updated if needed.

Meeting arranged with pharmacist on 9/2/17 to discuss service needs regarding medication management practice. Request to label all alternative therapies/supplements is part of agenda for the meeting.

All referrals for medical consultation to be managed by the resident's GP.

Information on management of residents' health care to be included in family communications process. This communications process will include attendance at round table meetings, monthly written update on CAA and future family workshops.

Proposed Timescale: GP and pharmacy contact and change in medication management practice – 10/2/17

Proposed Timescale: 10/02/2017

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:

It was not demonstrated that systems were in place to ensure safe storage of medicines.

14. Action Required:

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

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

Storage of all medications and locations across the campus to be reviewed and any gaps identified and addressed.

Proposed Timescale:
Medication Storage Review – 10/2/17

Proposed Timescale: 10/02/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The provider had failed to appoint a person in charge who meets the requirements of the regulations in terms of having the skills and experience to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

15. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

Person in Charge 1. This employee has a third level social care qualification, 4 years' experience of working with people with intellectual disability.

Person in charge 2. This employee commenced her post on 31/1/17 and has a third level social care qualification, 10 year's experience of working with people with intellectual disability and 4 years management experience as social care lead and person in charge in a designated centre.

CAA to facilitate management training for both PIC's. (HMI Management QQI Level 6)

Proposed Timescale: Completion of Management Course – 29/6/17

Proposed Timescale: 29/06/2017

Theme: Leadership, Governance and Management

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

At the time of this inspection, it was not demonstrated that the management systems in place ensured that the service being provided was adequate to ensure it was safe, appropriate to residents' needs, consistent and effectively monitored.

16. 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:

Additional person in charge in post since 30/1/17. (see attached organisational chart)
Services have been allocated between two PIC's to ensure clear lines of accountability, effective communication and appropriate skill mix. (Management structure chart attached).

Current pilot of team leader positions under review to determine effectiveness. The intention is to maintain this level of supervision but to ensure clear lines of accountability, effective communication and appropriate skill mix.

Introduction of formal supervision process for management team.

Review of current supervision process for support workers and roll out of revised

process.

Risk Management Review to be completed which includes unannounced external service inspection and medication management review with a primary focus on safe services.

Schedule of audits to be introduced to service which include medication audit, health and safety, fire safety, PCP's, cleaning and maintenance.

Audit training to be delivered to management.

Introduction of monthly care review meetings to evaluate care delivery and identify any necessary interventions.

Review all communications throughout CAA to include:

Review of TOR's and membership of all forums.

Create new communications structure throughout organisation.

Agree interim communications pending new communications structure.

Arrange quarterly briefing sessions for staff.

Review of information management systems and documentation to be completed.

Proposed Timescale:

External Medication Management Review – completed

External unannounced service inspection - completed

Team Leader Review – 15/3/17

Organisational Structure Review – 31/3/17

Review and roll out of organisational supervision policy for support staff – 24/4/17

Audit Training for management – 31/3/17

Introduction of monthly care review meetings – 13/2/17

Completion of communications structure review – 28/2/17

Completion of information management systems and documentation review – 31/3/17

Proposed Timescale: 24/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

It was not clearly demonstrated whether staff had access to appropriate training to support individuals with autism.

17. 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:

Facilitator has been identified to deliver 'Introduction to Autism' module.

Proposed Timescale:
Roll out of 'Introduction to Autism' Training to all staff – (see attached update)

Proposed Timescale: 08/02/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

It was not demonstrated that records were accurate and up to date or easily retrievable.

18. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

Auditing and archiving of all residents' files commenced 30/1/17.

Development of resident file management protocols to ensure information is up to date, easily accessible and secure.

CAA Documentation Review to ensure standardisation across all services.

Proposed Timescale:

Completion of residents file audit – 10/2/17

Development of resident file management procedures – 28/2/17

CAA Documentation Review – 31/3/17

Proposed Timescale: 31/03/2017