**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):** Mary Moore  
**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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 16 November 2016 09:30
To: 16 November 2016 18:00

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

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Summary of findings from this inspection
Background to the inspection:
This was the third inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 21 and 22 October 2015 and the second on the 4 and 9 May 2016.

This inspection was a triggered inspection on foot of a number of concerns received by HIQA since the previous inspection. The concerns related to staffing levels, staff skills and knowledge, the management of complaints, communication and consultation with residents' representatives, access to multi-disciplinary supports, activities, access to transport and activities, the management of behaviours that may challenge and the completion of person-centred plans.

The provider had been requested to complete an investigation into one multi-factorial concern. However, the receipt of four further concerns by HIQA since that investigation indicated that the learning from that investigation has yet to be implemented in an effective manner.
This inspection also followed up on the progress being made since the previous inspection, particularly as they related to the governance and management of the centre.

Description of the service:
The centre provides a service specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque and calm environment. The centre comprises a main house and six cottages and can accommodate 13 residents.

As part of the inspection, inspectors met seven residents, a member of the board, the person in charge, a person identified as participating in the management of the service and staff on-duty.

Overall judgment of our findings:
Residents who communicated verbally told inspectors that they liked their house. Residents were supported by staff to make choices and to communicate their emotions, for example, what they would like to have for their meals, where they wished to go that day and when they were in pain. Residents were encouraged to be independent in relation to self-care and carrying out daily tasks. Staff were observed to interact with residents in a supportive and appropriate manner.

The Board of Cork Association of Autism has been responsive and actively working to address the failings identified at the previous inspection and to address other issues by strengthening the governance and management of the centre. Steps taken included a review of the governance and management structure in the centre, recent and on-going recruitment of management and staff with the required skills and experience to support residents, development of a new complaints policy and a full-time HR (human resources) post was now in place. However, while acknowledging the steps taken by the provider since the previous inspection, the timeframe was too short to determine the true effectiveness of the measures taken.

As a result, six outcomes remained or were found to be at the level of major non-compliance as follows:
- the effectiveness of the complaints procedure had yet to be demonstrated (outcome 1)
- comprehensive assessments of need had not been completed for all residents to ensure that residents' support requirements would be clearly identified and met (outcome 5)
- improvements were required to ensure all residents could be evacuated from the centre in a timely manner and that risks were being adequately assessed, monitored and reviewed (outcome 7)
- it was not demonstrated that residents had access to the multi-disciplinary supports that they required (outcome 11)
- it was not demonstrated that the interim governance arrangements would ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored (outcome 14)
- reassurance was required that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents and the size and
layout of the designated centre. In addition, a significant number of staff required training to support residents' needs (outcome 17)

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, while the provider had taken steps to ensure that residents would be supported to make complaints and complaints would be effectively managed, further improvement was required.

At this inspection, the management of complaints was reviewed. As mentioned in the summary, a number of concerns had been submitted to HIQA since the previous inspection that indicated residents' representatives were not satisfied with how complaints were being managed by the service. In addition, the five concerns that had been submitted to HIQA since the previous inspection had not been made to the complaints officer or human resources manager (as appropriate).

Following receipt of one concern, the provider was requested to complete an investigation into the nature of the issues raised. That concern raised issues related to staffing levels, staff skills and knowledge, the management of complaints, communication and consultation with residents' representatives, access to multi-disciplinary supports, activities, access to transport and activities, the management of behaviours that may challenge and the completion of person-centred plans. While the provider had completed an investigation, the receipt of four further concerns by HIQA since that investigation indicated that the learning from the investigation had yet to be implemented in an effective manner.

An inspector also met with the complaints officer and spoke with the HR (human resources) manager, a board member, the person in charge, staff and the residential
services manager in relation to how complaints were being managed by the service. Management representatives spoken with were aware of the extent of improvement required in relation to the management of complaints.

The complaints officer had received training in relation to the management of complaints since the previous inspection. A new complaints policy was in final draft. However, the policy did not meet all of the requirements of the regulations as a second person had not been nominated to oversee the complaints process.

At the previous inspection, inspectors found that the practice of seeking consent from residents in relation to social and healthcare interventions was not in line with national guidance applicable to community and residential settings (such as the national consent policy 2014 published by the Health Service Executive).

Since the previous inspection, the organisation had reviewed a number of policies in light of the HSE National Consent Policy 2014. This included policies in relation to medication management, personal and intimate care, risk management, restrictive practices, the protection of vulnerable adults and health and safety. Staff provided examples whereby they had worked with individual residents to increase their capacity for choice and consent and knowledge of their rights and entitlements.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Overall, staff were observed to assist residents to communicate their choices, preferences and emotions in different ways. However, improvements were required in relation to how recommendations from external professionals were being implemented and in seeking access to supports where required.

At this inspection, an inspector reviewed how the communication needs were being met for a number of residents with communication needs. Residents had received an assessment by a speech and language therapist and a communication passport had been developed where recommended. Staff articulated and demonstrated how they supported residents to communicate, including by using communication passports,
communication dictionaries, visual schedules, daily planners and by reading non-verbal signs and using picture exchange communication systems (PECS).

However, staff had identified the need for further input for some residents, including for example in relation to how individual residents might communicate pain. Also, inspectors found that as a number of residents did not have a comprehensive assessment of their needs, it could not be identified who might benefit from or require input from relevant professionals (such as a speech and language therapist). This will also be addressed under outcomes 5 and 11 in the context of assessment of needs and access to multidisciplinary supports.

At the previous inspection, the follow-through of multidisciplinary recommendations as they related to communication required review as not all recommendations were being implemented. At this inspection, an example was found whereby recommendations from a speech and language therapist that related to communication were not being implemented. In addition, there was no process that allowed for follow up of such recommendations and that facilitated review of the effectiveness or otherwise of recommendations that had been trialled.

At this inspection, it was found that where residents used LAMH (an Irish manual sign system) or it was planned to develop the use of LAMH further as a means of communication, not all staff supporting those resident(s) had received this training. This will be addressed under Outcome 17: Workforce.

**Judgment:**
Non Compliant - Moderate

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

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

**Theme:**
Effective Services

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

**Findings:**
At the previous inspection, written contracts of care were not in place for residents that outlined the services to be provided and the fees to be charged. A person participating in the management of the service told inspectors that this action had recently been further progressed, following consultation with residents' representatives. However at the time of this inspection, 10 of 12 contracts had yet to be signed and returned.
At this inspection, inspectors reviewed a sample of the contract of care. However, the contract of care did not meet all of the requirements of the regulations. For example, it was not clear how the contract of care met the requirements of regulation 6(2)(d) that requires the provider to ensure that residents have access to allied health services where required.

In addition, it was not clear that the provision of healthcare services met the requirements of regulation 6(1) or 6(2)(b). Also, the contract of care referenced another service provider on its front page.

Judgment:
Non Compliant - Moderate

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):

Findings:
Overall, the provider had taken steps to review the needs of residents' with complex support needs. However, failings previously identified in relation to completing an assessment of need for all residents and the review process were unchanged at this inspection.

At the previous inspection, 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.

While case conferences had been held since the previous inspection with respect to individual residents with complex needs, assessments had not been completed for all residents. 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 on-going review for residents who continued to lose weight, whose behaviour support plans were not effective or who were suffering from mental health symptoms.
At the previous inspection, information in health care plans would not effectively guide staff to support residents. Since the previous inspection, a sample of healthcare plans were reviewed and had been developed to support identified areas of need, such as in relation to epilepsy management, communication and intimate care.

Since the previous inspection, a concern had been raised to HIQA that not all residents had an up-to-date personal plan. A person participating in the management of the service said that the responsibility for ensuring person plans were reviewed had now been clarified. Where personal plans were due for review, a schedule was in place for this to happen. At the previous inspection, the review of the personal plan was not multi-disciplinary. This finding was unchanged at this inspection.

**Judgment:**
Non Compliant - Major

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**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:**
At the previous inspection, 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.

This finding was unchanged at this inspection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

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

Findings:
Overall, improvements were required to the assessment and management of risk to protect the health and safety of residents.

At the previous inspection, actions were required in relation to the assessment, management and on-going review of risk. Since the previous inspection, a health and safety risk assessment was completed by an external health and safety consultancy and the safety statement and risk register was updated. In addition, the system for managing medication errors was reviewed.

At this inspection, inspectors found that further improvements were required in relation to how risks to residents were being assessed and managed. Where residents went swimming, there was no risk assessment to identify what supports residents required when accessing the pool. In addition, it was not demonstrated that planned swimming trips took account of what staff supports were required for swimming trips involving both female and male residents, which necessitated staff to move between the male and female changing facilities.

Following this inspection, inspectors sought reassurance from the provider in relation to an occasion where residents were unsupervised in one part of the centre to support a resident in another part of the centre. The person in charge and provider representative responded to this request. However, the incident report and accompanying documentation did not demonstrate that the risk assessment for leaving residents unsupervised in their houses was adequate, nor did it demonstrate learning from incidents.

In addition, further improvements were required in relation to the management of medication errors. For two recent errors, there was no information on the medication error form to demonstrate that the incident had been reviewed, the learning from that error or what the follow-up was. This will also be discussed under Outcome 12: Medication Management.

At the previous inspection, the infection control policy required further development to reflect national standards for the prevention and control of healthcare associated infections and the service's own practices in relation to infection control, for example in relation to staff training, hand hygiene assessment and how/when to access infection control advice.

At this inspection, a person participating in the management of the service confirmed that this policy had been developed and was awaiting approval. Due to the progress made since the previous inspection, this action will now be addressed under Outcome 18: Records and Documentation.
At the previous inspection, personal emergency evacuation plans (PEEPs) that outlined the arrangements in place for evacuating residents in the event of a fire required review. An inspector reviewed PEEPs for the five residents residing in the main house. The PEEPs contained specific information and identified the supports each resident may require to evacuate in the event of a fire.

A recent day-time drill (carried out on 3 October 2016) indicated that no resident left or got up to leave without staff prompting in response to the fire alarm. This corresponded with PEEPs, that identified that all residents required support. At night-time, there was one staff member on duty in this part of the centre. However, it was not demonstrated that the arrangements in place had been demonstrated to be satisfactory. Fire drill records did not consider all likely scenarios or staffing levels at different times of the day. For example, a drill had not taken place that simulated night-time conditions or staffing levels.

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, further improvements were required in relation to positive behaviour support and in relation to the approval of restrictive practices.

At the previous inspection, the person in charge had not ensured 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.

At this inspection, it was found that a number of steps had been taken to support residents with behaviours that may challenge. For some residents, allied health professionals, medical and psychiatric support was being provided. A behaviour analyst was providing support to residents who required this support. However, 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.

A person participating in the management of the centre confirmed that a follow up review meeting had not been organised. In addition, while a number of other residents had previously had access to allied health, medical and psychiatric support to support behaviours that may challenge, others had not and there was no multi-disciplinary team available to residents in this service. As previously mentioned under outcome 5, an assessment of needs had not been completed for residents to identify what supports were required in relation to behaviours that challenge. This will be further addressed in the context of access to allied health services under Outcome 11: Healthcare needs.

At the previous inspection, training records indicated significant gaps in relation to the safeguarding of vulnerable adults and positive behaviour support. At this inspection, this finding was unchanged. However, the recent recruitment of a full-time HR manager meant that a training schedule was now in place and training dates were scheduled.

At this inspection, a sample of restrictive practices in use were reviewed. However, the process in place for approval of restrictive practices did not demonstrate the rationale behind all practices, what alternatives were considered or that the least restrictive practice was used. Also, involvement of a multi-disciplinary team was not evidenced where required.

**Judgment:**
Non Compliant - Moderate

### 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:**
Overall, it was not demonstrated that when a resident required services provided by allied health professionals, that such access would be provided.

The lack of a multi-disciplinary team to residents in this service was highlighted both at the previous inspection and at this inspection. At this inspection, this failing was 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, as part of their personal plan, was
evidenced under outcomes 5, 7 and 8.

In addition, where access to allied health services had been sought for some residents, it was not demonstrated that there was a process in place to ensure that recommendations were either implemented or reviewed. This was also a failing on the previous inspection.

**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

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

**Findings:**
Overall, improvements had been made in relation to medication safety since the previous inspection.

At the previous inspection, there was a lack of a systems based approach to medication safety. Since the previous inspection, a person participating in management of the service outlined a number of steps that had been taken. The medication policy had been reviewed, a quarterly analysis of medication errors had commenced with sharing of learning from the quarterly analysis, monthly audits of medication management were in place and there was a process whereby any medication errors categorised as serious would generate an immediate review.

However, further improvements were required in relation to the management of medication errors. For two recent errors, there was no information on the medication error form to demonstrate that the incident had been reviewed, the learning from that error or what the follow-up was. This has been captured under Outcome 7: Health, safety and risk management.

A concern had been received by HIQA since the previous inspection in relation to staff training and ensuring safe administration of medicines. The person in charge described the system in place. This involved training non-nursing staff in relation to the safe administration of medication and five competency assessments following initial training before a staff member could administer medicines alone (not including high-risk medicines).

As found on the previous inspection, there were arrangements in place for the ordering,
receipt and safe storage of medicines.

At the previous inspection, it was found that medicines were being administered that had not been prescribed. At this inspection, it was found that all medicines administered had been prescribed by a doctor.

An inspector reviewed a sample of medicines that had been administered on a PRN ("as required") basis. For that sample, a PRN protocol was in place that included ways in which an individual may communicate pain (including non-verbal cues). Staff articulated these cues to the inspector and PRN medicines were administered as prescribed.

**Judgment:**
Compliant

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**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Overall, reassurances were required to ensure that there were effective management systems in place to support and promote the delivery of safe, quality care in the centre.

At the previous inspection, a clearly defined management structure was not in place and the provider had not completed an unannounced inspection of the centre, as required by the regulations.

Since the previous inspection, there had been changes to the management structure and management personnel in the centre. At the time of this inspection, the management structure and systems were still undergoing change. It was not clear who was representing the provider in their interactions with HIQA. However, a short-term arrangement was confirmed with inspectors following the inspection and inspectors were told that a role for a new director of nursing had been advertised. However, adequate reassurance was not provided that the interim arrangements in place (that may extend to a period of a number of months) would ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.
A new person in charge had commenced in the centre eight days prior to this inspection. As a result of this short timeframe, the effectiveness of this new arrangement could not yet be ascertained. The person in charge participated in the inspection with the support of the residential services manager and engaged positively with the process. However, a notification had not been submitted to HIQA in relation to this change within the required timeframe, in accordance with regulation 7(2)(b) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Inspectors met with a board member who identified priority areas that the organisation had been addressing in order to strengthen the management systems in place. Actions that had been completed included a recruitment campaign for staff with the required skills and experience, recruitment of a new person in charge, revised roles and responsibilities for all staff grades, the development of a new complaints policy, review of management system including the development and recruitment for four team leader posts. A key gap acknowledged by the board member related to the need for clinical oversight of the centre. In addition, the need for improved consultation with staff and relationships with residents' representatives was discussed at length by inspectors with the board member, HR manager, complaints officer, person in charge and a person participating in the management of the service (the residential services manager). However, inspectors highlighted the need for comprehensive assessments of need for all residents to ensure that residents' support requirements would be clearly identified and met. In addition, inspectors also highlighted access to multi-disciplinary supports and the follow through of any multi-disciplinary recommendations by staff.

While revised roles and responsibilities had been developed, staff told inspectors that due to the changes in management personnel and roles, they were not clear who to go to in relation to some areas of service provision. For example, staff were not clear where to report an incident to or how to request a risk assessment be completed.

At the previous inspection, it was identified that the provider had not carried out an unannounced visit to the designated centre in relation to the safety and quality of care being provided to residents in the centre. A system had to be put in place to ensure that such visits would be completed.

**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:**
Since the previous inspection, concerns had been received by HIQA relating to staffing levels, skill mix of staff and education and training provided to staff. Overall, the provider had taken steps to improve and develop HR 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 this inspection, inspectors met with the HR (human resources) manager, who outlined a number of steps that had been taken to improve and develop HR practices in the organisation. 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. A training needs analysis had been completed and inspectors were provided with an up-to-date training schedule. The training schedule identified that there were significant training gaps to be addressed in order to ensure staff could adequately support residents in this centre.

However, some further improvement was required to ensure that staff would receive training required to support residents' care and welfare. For example, not included on the training schedule was people moving and handling training, hand hygiene or infection control training or training to support residents' individual communication needs.

The HR manager provided a report that detailed staff resource requirements in this centre. The report indicated that the number of core staff required in each location had been identified and filled. In addition, the four team leader posts required in the centre had now been filled and a new person in charge had been recruited. Some of these staff had not yet commenced working in the centre. However, it was not clearly demonstrated that changes to arrangements in place had been. While a risk assessment had been completed, it had not identified a gap between the hours of 22:00 and 23:00 hrs. At the meeting at the close of this inspection, the person in charge said that they were now aware of this gap since it was brought to their attention by staff the previous day.

**Judgment:**
Non Compliant - Major

**Outcome 18: Records and documentation**
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013
are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

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

**Findings:**
At the previous inspection, the medicines management policy did not outline the management of complementary therapies, topical preparations, ear drops and suppositories which were actively prescribed or in use in the centre at the time of the inspection. In addition, the infection control policy required further development to reflect national standards for the prevention and control of healthcare associated infections and the service's own practices in relation to infection control, for example in relation to staff training, hand hygiene assessment and how/when to access infection control advice.

At this inspection, a person participation in the management of the service confirmed that both policies had been reviewed in accordance with best practice and were in final draft. A date for implementation of these policies was required.

**Judgment:**
Substantially Compliant

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Provider’s response to inspection report

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<th>Centre name:</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0002113</td>
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<tr>
<td>Date of Inspection:</td>
<td>16 November 2016</td>
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<tr>
<td>Date of response:</td>
<td>18 January 2017</td>
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Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not meet all the requirements of the regulations as a second person had not been nominated to oversee the complaints process.

1. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
Since the inspection of the 16th November 2016, the CAA Complaints Policy has been completely reviewed, updated and amended in line with all regulations. The revised policy has been rolled out to all staff across Greenville Campus on week commencing 28th November 2016. The following elements have been included into the policy to assist stakeholders in understanding the complaints process. The following tools have been introduced to assist this process on 28th November 2016:
• Diagram outlining the “Verbal Complaint Management Process”,
• Diagram outlining the “Written Complaint Process”,
• Diagram outlining the “CAA Management Structure”,
• Guidelines on “Critical elements of Managing Complaints effectively”,
• Diagram outlining “the Lifecycle of Complaints”.
The policy has been amended to meet the regulations and the nominated person required to meet the regulations is now the CAA Board of Directors Appointee.
In order to ensure effective implementation of this policy, a staff briefing has occurred week commencing 28th November 2016, along with an action plan for policies and procedures. Staff have engaged in this process and have signed that they have read and understand the new complaints policy.
All service user families of the Greenville Centre have also received a copy of the new Complaints policy by post along with their Contract of Care on 5th December 2016. The Person in Charge has made contact with families by phone and in person on 30th November 2016 and provided contact information to them to ensure clarity and understanding of the process and in line with good communication practices. The Residential Services Manager and the Person in Charge are engaged in a one to one meeting process which commenced on the 18th November 2016 with the Greenville Campus families as a communications exercise and to outline the new management structure & clarifying roles and responsibilities of management. The process is well underway and will be completed by 9th January 2017. Any outstanding parents/guardians at that date, will be written to by the PIC.

Proposed Timescale: All actions completed.

Proposed Timescale: 18/01/2017
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The effectiveness of the complaints procedure had yet to be demonstrated.

2. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an
appeals procedure.

**Please state the actions you have taken or are planning to take:**
Complaints management process has been re-communicated with all residents in the Greenville campus & their families/guardians.

The complaints process is now a standard item on weekly residents meeting agenda.

Easy Read Policy to be reviewed.


**Proposed Timescale:** 27/01/2017

### Outcome 02: Communication

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The follow-through of multidisciplinary recommendations as they related to communication required review as not all recommendations were being implemented. In addition, there was no process that allowed for follow up of such recommendations and that facilitated review of the effectiveness or otherwise of recommendations that had been trialled.

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

**Please state the actions you have taken or are planning to take:**
In order to assist with service user communication needs the Person in Charge has developed a bespoke Pain App in line with user centred design processes. Service Users identified will be involved in the iterative process of the apps development in order to ensure that the app meets their needs in relation to communicating “pain”. This process involves collaboration with Service Users, Staff, families and computer science professionals. Upon implementation, the Service Users will be assisted with training so that they can
1. Understand the purpose and function of the app
2. Have the ability to independently navigate the app and mobile device.

These training programmes will be developed by the on-site augmentative and alternative communication app consultant (who is also the PIC). This process has commenced week commencing 3rd December 2016 and the first iteration is being developed at present. The overall process for all identified service users will be completed.

A review of Multi-Disciplinary Team recommendations in relation to communication to be conducted by the Person in Charge to ensure that service user needs are being met
as identified and required. (Review commencing 4th January 2017).
Upon completion of the review, follow up meetings with MDT’s will be completed as required and any changes to recommendations will be implemented by the PIC,


Proposed Timescale: 21/04/2017

| Outcome 04: Admissions and Contract for the Provision of Services | Theme: Effective Services |
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| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |
| At the time of this inspection, 10 of 12 contracts had yet to be signed and returned. |

| 4. Action Required: |
| Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre. |

| Please state the actions you have taken or are planning to take: |
| Contracts of Care have been developed in consultation with Service User representatives including meeting with all parents of Greenville Service Users in September 2016. Amendments to the Contracts of Care were agreed and passed by the Board of Directors in October 2016. Contracts have been issued to all families of Service Users. All parents/Guardians have been contacted to complete the Contracts and the following is a summary of the position as of 16th December 2016: |
| • 2 of 13 families have signed the contract to date. |
| • 7 are considering the content and will revert to us. |
| • 4 families/guardians have refused to sign the Contracts at present. |
| • Those who have refused to sign have expressed their concerns to the PIC and have agreed to sign an acknowledgement letter. |
| • The concerns expressed have been submitted to the Board of Directors Appointee and the Residential Services Manager for review. The review will be completed by 4th January 2017. |
| • In light of outcome in the following section, the Contracts of Care will have to be re-written & re-issued to comply with regulations as per 6(1) & 6(2)(b)(d) |

Proposed Timescale: Contracts of Care document to revise. Completed. Revised Contracts of Care sent to all families/guardians. Completed. Request feedback and letter of acknowledgement from families/guardians that decline
**Proposed Timescale:** 31/01/2017  
**Theme:** Effective Services

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

The contract of care did not meet all of the requirements of the regulations. For example, it did not meet the requirements of regulation 6(2)(d) that requires the provider to ensure that residents have access to allied health services where required. In addition, it was not clear that the provision of healthcare services met the requirements of regulation 6(1) or 6(2)(b).

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

**Please state the actions you have taken or are planning to take:**
Contracts of Care will have to be re-written & re-issued to comply with the Regulations 6(1), 6(2)(b) & (d), also a formal response will be issued on the feedback from all parents and guardians.

Proposed Timescale: Contracts of Care document to revise. Completed. 
Revised Contracts of Care sent to all families/guardians. Completed. 
Request feedback and letter of acknowledgement from families/guardians that decline to sign – 31st January 2017

**Proposed Timescale:** 31/01/2017

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Comprehensive assessments of need had not been competed for all residents. In addition, processes were not in place for on-going review for residents who continued to lose weight, whose behaviour support plans were not effective or who were suffering from mental health symptoms.

**6. 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
The 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:

- The review of a Multi-Disciplinary capacity within the organisation has been explored and developed by management. A model of MDT service delivery has been designed and is being approved by the interim service lead.
- The plan includes the retention of sessional contractors which will cover the following disciplines:
  - Psychology; Behavioural Support; OT; Physio; SALT. Other disciplines will be engaged on a case by case basis.
- Arising from the MDT reviews an assessment of need will be completed and will feed into the healthcare plans of each individual.
- The organisation will be completing a full MDT review for all 13 service users. The criteria for scheduling the reviews is based on the priority of need, current risk assessments and any safeguarding plans.
- The organisation is reviewing its care planning processes to ensure that changing needs of the service users are identified immediately and the necessary interventions implemented in a timely manner. On completion of the assessments of need, all PCP’s will be reviewed on an annual basis or as required.

Proposed Timescale:
- MDT Proposal Review – 24th January 2017
- Creation and engagement of Sessional MDT – 17th February 2017
- Completion of MDT Assessments – 10th March 2017
- Completion of updated PCPs – 14th April 2017

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 or staffing supports.

7. 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:

- The review of a Multi-Disciplinary capacity within the organisation has been explored and developed by management. A model of MDT service delivery has been designed and is being approved by the interim service lead.
- The plan includes the retention of sessional contractors which will cover the following disciplines:
  - Psychology; OT; Physio; SALT. Other disciplines will be engaged on a case by case basis.
• Arising from the MDT reviews an assessment of need will be completed and will feed into the healthcare plans of each individual.
• The organisation will be completing a full MDT review for all 13 service users. The criteria for scheduling the reviews is based on the priority of need, current risk assessments and any safeguarding plans
• The organisation is reviewing its care planning processes to ensure that changing needs of the service users are identified immediately and the necessary interventions implemented in a timely manner. On completion of the assessments of need, all PCP’s will be reviewed on an annual basis or as required.

• A care needs assessment has been completed for all Service Users in order to assess staffing levels required. These assessments were completed by the Staff Team Leader and/or the PIC, and all assessments were completed on 24th November 2016.
• All staffing ratios are now fully in line with the service users. This will be kept under review by the Person in Charge.

Proposed Timescale:
MDT Proposal Review – 24th January 2017
Creation and engagement of Sessional MDT – 17th February 2017
Completion of MDT Assessments – 10th March 2017
Completion of updated PCPs – 14th April 2017
Care Needs Assessment re: staff numbers – completed

**Proposed Timescale: 14/04/2017**

**Theme: Effective Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The review of the personal plan did not involve multi-disciplinary input.

**8. Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
• The review of a Multi-Disciplinary capacity within the organisation has been explored and developed by management. A model of MDT service delivery has been designed and is being approved by the interim service lead.
• The plan includes the retention of sessional contractors which will cover the following disciplines:
  • Psychology; OT; Physio; SALT. Other disciplines will be engaged on a case by case basis.
• Arising from the MDT reviews an assessment of need will be completed and will feed into the healthcare plans of each individual.
• The organisation will be completing a full MDT review for all 13 service users. The criteria for scheduling the reviews is based on the priority of need, current risk assessments and any safeguarding plans
• The organisation is reviewing its care planning processes to ensure that changing needs of the service users are identified immediately and the necessary interventions implemented in a timely manner. On completion of the assessments of need, all PCP’s will be reviewed on an annual basis or as required.

Proposed Timescale: MDT Review – 24th January 2017
Creation and engagement of Sessional MDT – 17th February 2017
Completion of MDT Assessments – 10th March 2017
Completion of updated PCPs – 14th April 2017
Creation and implementation of CAA assessment and care planning process – 21st April 2017

Proposed Timescale: 21/04/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
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. This finding was unchanged at this inspection.

9. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
• A fully costed application for capital funding was submitted to the HSE in October 2016.
• Provider Nominee seeking meeting with HSE re: CAA Capital Projects
• The needs of the service users are being managed at a local level for the interim through increased staffing levels.

Proposed Timescale: HSE Response re: submissions for capital funding – 10th February 2017

Proposed Timescale: 10/02/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the processes in place in the designated centre for the assessment, management and on-going review of risk, including a system for responding to emergencies, were adequate. For example, where residents went swimming, there was no risk assessment to identify what supports residents required when accessing the pool. In addition, it was not demonstrated that the risk assessment for leaving residents unsupervised in their houses was adequate.

10. 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 assessments are managed locally and reviewed by the Person in Charge as identified by the risk.
- A Risk Assessment “Train the Trainer” Programme has been delivered to all Greenville Campus Management on 19th December 2016, by an external provider and Management. This training will be rolled out to all staff.
- An on-call system is available to all staff at all times to provide them with support and guidance.
- Individual Emergency Evacuation Plans are in place for all service users and updated as required. All plans reviewed post fire drills on 20th December 2016 by the Team Leaders.

Proposed Timescale: Roll out of Risk Management Training to all staff – 10th February 2017

Proposed Timescale: 10/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, recording and investigation of, and learning from, potentially serious incidents or adverse events involving residents was not evidenced in full.

11. 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:
• All 13 Service Users risk assessments have been reviewed by the PIC, RSM & Key Workers since the date of this visit on 16th November 2016, in particular risks associated with the participation by the Service Users in external activities and leisure interests off campus. The review has incorporated key learnings and preventative measures.

• A Risk Assessment “Train the Trainer” Programme has been delivered to all Greenville Campus Management on 19th December 2016, by an external provider and Management. This training will be rolled out to all staff.

• Incident reviews completed monthly by the PIC and identified learning to be collated by the CAA in order to inform risk management processes and training needs in the agency.

• Review of Incident Reports for 2016 to be completed as part of Quality & Safety Review.

• CAA Learning Log to be developed.

• Learnings are also being disseminated to all staff through team meetings and performance management meetings.

Roll out of Risk Management Training to all staff – 10th February 2017
Creation of incident report log for CAA – 3rd February 2017
Creation of CAA Learning Log – 3rd February 2017
Annual Incident Report Review – 24th February 2017

**Proposed Timescale:** 24/02/2017

**Theme:** Effective Services

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

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 of the day. For example, a drill had not taken place that simulated night-time conditions or staffing levels.

12. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

• Individual Emergency Evacuation Plans to be updated for all service users by the Team Leaders.

• At least one night time fire drill has been completed in all locations on 2nd Dec, 5th Dec, 6th Dec, 18th & 20th December 2016.

• Learning to be reviewed by PIC. Team Leaders & RSM from same.

• Learnings to be circulated to all teams.

Proposed Timescale: Individual Emergency Evacuation Plans update – completed
Fire drill requirements — completed.
Review of learnings from fire drill — completed
Learnings circulated to all teams - completed

**Proposed Timescale:** 18/01/2017

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**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

However, 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. As a result, it was not clear how behavioural supports or interventions were reviewed as part of the personal planning process.

13. **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:**

- CAA has retained the services of a qualified Behavioural Analyst, whose role is to review the strategies for the support of the Service Users.
- The plans are reviewed monthly by the Therapist, Staff, PIC & RSM to examine the effectiveness and amend accordingly based on evidence provided.
- Referrals to MDT supports are discussed with service user’s families/guardians when the need arises and at the annual scheduled PCP’s.
- Staff liaise with PIC to convey this information. Staff complete referral forms as appropriate and forward to the identified MDT professional.
- Weekly reviews of progress of referral are discussed weekly at team meetings, by the duty staff. Weekly minutes are sent to the PIC for dissemination and action as appropriate.
- Consent forms re: medical interventions to be circulated to service users and their representatives for completion.

Proposed Timescale: Consent forms to be sent to service users and representatives – 20th January 2017

**Proposed Timescale:** 20/01/2017

**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 the safeguarding of vulnerable adults and positive behaviour support.

14. **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:**
- Positive Behaviour Support Training will be delivered to all staff by the Behavioural Therapist.
- Crisis Prevention Intervention (CPI) MAPA Training will be delivered to all staff.
- Safeguarding Vulnerable Adults training will be delivered to remaining staff.

- Proposed Timescale: Positive Behaviour Support Training - 28th February 2017
- Safeguarding Vulnerable Adults Training – 15th February 2017

**Proposed Timescale:** 28/02/2017

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, where restrictive procedures including physical, chemical or environmental restraint were in use, they are applied in accordance with national policy and evidence based practice.

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

**Please state the actions you have taken or are planning to take:**
The Restrictive Practice Committee meet on a monthly basis and will:
- Identify all restrictive practices through information submitted to the committee. Restrictive Practices will be reviewed and alternative practices or reducing restrictions in place will be considered to ensure best practice.
- Policy and procedures regarding implementation of restrictive practices to be reviewed by the Committee.
- Restrictive Practices will be part of the standard agenda at all team meetings and PCP Reviews.

Review of Restrictive Practice P&P - 17th February 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.

16. **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:**
- Contract of Care to be amended to comply with the regulations (see Outcome 4)
- The organisation is reviewing its care planning processes to ensure that changing needs of the service users are identified immediately and the necessary interventions implemented in a timely manner. On completion of the assessments of need, all PCP’s will be reviewed on an annual basis or as required
- Referrals to external allied health professionals are completed where required with each individual service user, excluding Behavioural Support as CAA have retained services of a dedicated Behavioural Analyst.
- Each service user currently has a regular General Practitioner and avails of South Doc services when required.
- The Assessment of Need will be used to identify additional allied health professional supports that may be required by each individual.

Proposed Timescale: Contracts of Care document to revise - Completed.
Revised Contracts of Care sent to all families/guardians - Completed.
Request feedback and letter of acknowledgement from families/guardians that decline to sign – 31st January 2017
Creation and implementation of CAA assessment and care planning process – 21st April 2017

**Proposed Timescale:** 17/02/2017

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Where access to allied health services had been sought for some residents, it was not demonstrated that there was a process in place to ensure that recommendations were
either implemented or reviewed. This was also a failing on the previous inspection.

17. **Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**
A review of Multi-Disciplinary Team recommendations to be conducted by the Person in Charge to ensure that service user needs are being met as identified and required. (Review commencing 4th January 2017).
Upon completion of the review, follow up meetings with MDT’s will be completed as required and any changes to recommendations will be implemented by the PIC.
The organisation is reviewing its care planning processes to ensure that changing needs of the service users are identified immediately and the necessary interventions implemented in a timely manner. On completion of the assessments of need, all PCP’s will be reviewed on an annual basis or as required

Creation and implementation of CAA assessment and care planning process – 21st April 2017

**Proposed Timescale: 21/04/2017**

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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:**
A notification had not been submitted to HIQA in relation to this change within the required timeframe, in accordance with regulation 7(2)(b) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

18. **Action Required:**
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The Person in Charge has completed the necessary notification and forwarded to the authority on 18th November 2016 and apologise for this organisational oversight.
Proposed Timescale: Completed

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**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 interim arrangements would ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

**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:**
- The governance & management structures of the CAA are undergoing a complete review since October 2016 and have been well documented by ongoing correspondence with HIQA.
- The Chairman has submitted a comprehensive paper and update to the HIQA Inspector manager on the progress and action taken by the Board to demonstrate the commitment by the Board to strengthen the clinical governance and qualified management needed to ensure that the service is safe, appropriate to residents needs and is operating to the regulatory standards. Our letter of 21st December 2016 to HIQA comprehensively sets out the progress made and steps taken to address this need.

Proposed Timescale: Meeting with HIQA scheduled for 9th January 2017 to review progress.

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

A system was not in place to ensure that an unannounced visit to the designated centre in relation to the safety and quality of care being provided to residents in the centre would be completed.

**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:**
- A complete schedule of unannounced inspections has been diaried for 2017 and agreed between the RSM & PIC for Greenville campus, focusing on safety & quality of care, commencing in January 2017

Proposed Timescale: Unannounced Inspection - 1st February 2017

**Proposed Timescale:** 01/02/2017

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While revised roles and responsibilities had been developed, staff told inspectors that due to the changes in management personnel and roles, they were not clear who to go to in relation to some areas of service provision.

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

**Please state the actions you have taken or are planning to take:**
- An updated Organisation Management structure was circulated to staff on week commencing 28th November 2016.
- Team Leaders for Greenville Campus attended a 3-hour briefing on organisation structure, HIQA action planning, programme of work and re-organisations underway across the campus & training and development on 13th December 2016.

- The meeting is the first of a series of scheduled meetings for Team Leaders & Greenville Campus staff.
- Updated roles and responsibilities of all CAA Staff & Management are now available to staff on the organisations shared drive. (These were circulated in hard copy format when launched in October 2016)
- An action plan has been implemented since 28th November 2016 with all staff in relation to re-briefing of all of the organisations policies and procedures. Completion of same will reinforce the management structure of the organisation for all staff.
- New and revised Induction Process to be implemented.
- New and updated Staff Handbook to be circulated.

Proposed Timescale: Staff communications memo re: recent changes in management to be circulated by the board – 20th January 2017
Schedule of staff briefings 2017 - completed
Revised Induction Packs to be developed – 30th January 2017
Staff Handbook to be revised – completed
Outcome 17: Workforce

Theme: Responsive Workforce

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

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

Please state the actions you have taken or are planning to take:
• The CAA in line with many Voluntary Bodies has resourcing challenges. The organisation’s HR Manager has identified all work locations to replenish core staff and this programme has been completed.
• We continue to recruit new staff on a weekly basis to replenish the depleted relief panel (form which many of the ultimate core staff originate from). Recruitment will continue on a weekly basis throughout 2017.
• Focus on recruitment is the identification of potential future Team Leader potential with requisite competence and professional qualifications.
• We have a number of HR programmes underway to ensure that the organisations succession needs for key roles remain a top priority including management development training programme to commence for our Team leaders in January 2017, and recruiting already competent professionals with management experience as evidenced by the recruitment of 2 new additional PIC’s & advertised for as yet unfilled CNM3 post. Our letter to HIQA of 21st December provides comprehensive details on same.
• The organisation also has a scheduled mandatory training and refresher training programme underway.

Proposed Timescale: Team Leader Training Programme commencing in January 2017 Recruitment ongoing.

Proposed Timescale: 31/01/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While a training schedule was in place, a significant number of staff required mandatory
training and other training to support residents’ needs.

23. **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:**
- Training Programme reviewed since the date of Inspection on 16th November 2016. All mandatory training modules & refresher training for Greenville Staff.
- Current training database to be reviewed and cross referenced against manual training records and new training modules included.

Proposed Timescale: Completion of Training re: safeguarding; positive behaviour; risk management - 28th February 2017
Creation of Training Database and revised training records process – 30th January 2017

**Proposed Timescale:** 28/02/2017

### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As detailed in the findings, the medication management policy and infection control policy required review in accordance with best practice and were in final draft. A date for implementation of these policies was required.

24. **Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
- Medication Management Policy to be reviewed.
- Infection Control policy to be reviewed.

Infection Control Policy – completed
Reviewed Policies made available to all staff – 3rd February 2017

**Proposed Timescale:** 03/02/2017