Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Centre 1, 2 and 3 - Aras Attracta
Centre ID:	OSV-0003321 + OSV-0004910 + OSV-0004911
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Keenan
Lead inspector:	Jude O'Neill; Lorraine Egan; Michael Keating
Support inspector(s):	Rachel McCarthy (OSV-0003321 + OSV-0004910)
Type of inspection	Unannounced
Number of residents on the date of inspection:	94
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

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

The inspection took place over the following dates and times

From:	To:
30 March 2016 09:40	30 March 2016 18:30
31 March 2016 09:00	31 March 2016 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
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

Summary of findings from this inspection

Between July 2015 and March 2016 inspectors completed a series of inspections at the designated centre and found poor outcomes which had a significant impact on the safety and the quality of life of residents. In October 2015, HIQA required the provider to conduct their own audit of the safety and quality of life of residents to identify their own deficits and develop a remedial action plan.

On the Aras Attracta campus, there are three designated centres for adults with disabilities. These are called Centres 1, 2 and 3. Each centre shares a common governance and management structure and therefore this report presents a composite overview of the inspection findings from all three centres.

Background to the inspection

This inspection was carried out to monitor compliance with the specific outcomes identified in the table above. This was the second inspection of Centres 1 and 3 and the fifth inspection of Centre 2. The last inspections took place on 12 July 2015 (Centres 1 and 3) and 18 August 2015 (Centre 2).

As part of this inspection, inspectors reviewed the actions taken by the provider to address the non-compliances identified during previous inspections. The details of

the actions taken to achieve compliance are discussed within the report. Where compliance had not been achieved, the requirement has been reiterated within the action plan at the end of the report.

How we gathered our evidence
Throughout the inspection, inspectors met with residents living in each centre. Residents consulted were complimentary in their comments about staff and the care provided. In particular, residents living in Centre 2 spoke very positively about the changes that have taken place as a consequence of the adoption of a social care model and the impact that this had made on the quality of their lives.

Inspectors also took the opportunity to meet with relatives visiting the centre during the inspection. Those consulted spoke positively about staff and the quality of care provided to residents.

Inspectors spoke with staff members, the persons in charge of Centres 1 and 2 and the Director of Service. Inspectors also observed care practices and reviewed documentation such as residents' personal plans, care records, accident and incident logs, policies, procedures and staff files.

Description of the service
The provider must produce a document called the statement of purpose that explains the service provided. Each centre's statement of purpose outlined the service provided for adults with intellectual disabilities which included; supports offered in meeting health and social care needs; activities in the centre and access to the local community. In Centres 1 and 2, inspectors found that the service being provided was as described in the statement of purpose. In Centre 3, some discussion took place with the Director of Service on the admission of a resident for respite which was not in keeping with the stated purpose of the centre. The Director of Service undertook to amend the statement of purpose for this centre to reflect this issue.

The majority of the accommodation provided in Aras Attracta did not meet the needs of residents, as it was largely institutional in nature with limited private space. However, significant improvement had been made to the accommodation in Centre 2 with the refurbishment of a number of bungalows and a reduction in the levels of occupancy in each which had led to improved outcomes for residents.

Overall judgment of our findings
Overall, inspectors were satisfied that significant improvements had been made since the date of the previous inspections. These improvements were more obvious in Centres 1 and 2 and further work was required by the provider in regards to Centre 3. Notwithstanding, the actions taken to date have resulted in improved quality of care and quality of life for residents within each centre. The improvements included the following:
• Introduction of daily, weekly and monthly safeguarding meetings
• Enhanced approach to safeguarding and safety
• Updated complaints policy and related procedures
• Changes to living environments (Centre 2)
• Introduction of social model of care (Centre 2)

Inspectors found further improvements were required in the following areas:
• Layout of physical environment and impact of this on privacy and dignity of residents (outcome 1)
• Over reliance on centralized care practices which reduced opportunity for residents to be involved in everyday activities of living (outcome 1)
• Reviews of personal plans – Centre 3 (outcome 5)
• Upgrading of fire alarm systems, equipment and practices (outcome 7)
• Use of restrictive practices - Centres 1 and 3 (outcome 8)
• Involvement of residents in buying, preparing and cooking their own meals (outcome 11)
• Management systems, staff rotas, training and supervision - Centre 3 (outcomes 14 and 17)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Overview of inspection findings for all three centres:

Since the previous inspection, the provider has updated the complaints policy and related procedures which were in compliance with the regulations. The complaints procedure was clearly displayed in an accessible format. A complaints log was maintained and the concerns expressed by residents and relatives had been appropriately responded to in a timely manner and in accordance with the regulations. The issues identified on the complaints log were discussed at staff and resident meetings and used to inform service improvement in all centres. For example, one concern recently expressed by a resident regarding portion sizes of meals (that these were too large) triggered discussion with catering staff and was resolved to the residents satisfaction.

Residents and visitors consulted were complimentary in their comments about staff and the care provided within the centre. Those consulted were familiar with the complaints procedure and knew who to speak to in the event of wishing to make a complaint. Staff consulted were also aware of the procedure and how to respond to a complaint.

Information on residents' rights and details of the local independent advocate were readily available and had been produced in a format more readily accessible by residents.

Religious rights were respected and mass was celebrated weekly on the campus.

While a policy was in place in relation to residents' property, personal finances and possessions and monies were kept safe, the approach adopted was institutional in practice in that all residents' monies were held in a centralised account instead of there being an individualised practice.

Additional findings specific to individual centres are discussed below.

Centre 1:

Since the date of the last inspection, the provider had taken steps to improve residents' privacy and dignity by screening the glass panels on shared bedroom doors and through the installation of static screens in shared bedrooms. While the work carried out to date had improved the levels of privacy and dignity for residents, further work was required by the provider to maximise this.

Observation throughout the inspection confirmed that staff knocked on doors before entering rooms and were respectful in their interactions with residents. Personal plans also reflected the need to promote respect, dignity and privacy, especially in the delivery of intimate care.

Centre 2:

There was evidence that actions taken within specific bungalows had increased the opportunities for residents to participate in decisions about their care and the organisation of each bungalow in which they lived. Institutional care practices for a group of residents living in specific bungalows (as identified in previous inspection reports) had been discontinued. Examples of these included reliance on centralized practices of meal preparation, laundry services, cleaning of homes and group activities. However, other residents remained reliant on these centralized care practices which impacted upon their ability to be involved in the everyday activities of living and to make an informed choice about the running of their home.

The centre had introduced a revised skill mix of staff and was in the process of reorganising the centre in line with the assessed needs of residents. This assessment enabled the prioritisation of social care supports, health care supports and also the compatibility of residents to live with one another. This had led to the opening of a number of new bungalows which resulted in reduced numbers of residents living in other bungalows. The new bungalows were also opened under a social model of care with social care workers and leaders employed to run these houses. Residents spoken to in these bungalows commented positively about significant changes to their lives including the fact that there were only four people living in each house, and how their homes were now quieter and more relaxed. Residents were also complimentary in their comments about their involvement in house meetings and in care planning.

Many residents however had yet to be provided with this opportunity, and continued to live in the traditional and more institutional models of care referred to previously.

However, it was recognised from conversations with residents, relatives, staff and the person in charge that there were specific plans in place to provide more individualized bungalows across the centre with an additional two bungalows due to open approximately six weeks post inspection. The person in charge also detailed plans to roll out a revised model for all residents in the centre during 2016.

Centre 3:

While there was some day-to-day consultation with residents, this was not meaningful in terms of the quality of life experienced within this centre. For example, residents had not been consulted on the decision to admit respite residents to their home which had a negative impact on the lives of those already living there in regards to reduced space, increased noise and disruption.

Institutional practices were evident in the centre. For example, staff entered houses without knocking and residents were unable to exercise choice over their general practitioner (GP) or pharmacist. In addition, there was reliance on centralized practices of meal preparation, laundry services, cleaning of homes and group activities which impacted on residents' ability to be involved in the everyday activities of living and to make an informed choice about the running of their home.

There was one day centre located on the grounds of the campus. Some residents declined to attend the day centre and there was no evidence that residents' needs and wishes in regard to occupation and recreation had been assessed to ensure that all preferences were facilitated and that all residents were supported to spend their day in a way that met their needs.

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

Findings:
Given the variation in the assessed needs of residents and the approach adopted within each centre, it is not possible to provide an overview of inspection findings for all three centres under this outcome. Instead, inspection findings specific to individual centres are discussed below.

Centre 1:

Through the provision of an activity programme and the intervention of activation officers, residents were supported to participate in activities of their choice within the centre, the wider campus and the local community. Ongoing discussions took place between staff, residents and where appropriate their representatives in relation to residents' activities and interests. From a review of care records, minutes of meetings and discussion with staff, it was clear that these discussions informed the weekly activation schedule. The inspector noted that the activation schedule was up to date and reflected the activities offered to residents during the course of this inspection.

From a review of a sample of four personal plans, the inspector concluded that a comprehensive assessment of the health, personal care and support needs of each individual resident had been carried out prior to admission and on an ongoing basis following admission. Personal plans were clearly laid out and evidenced that the resident or where appropriate their representatives had been involved in the planning of care. The information was personalized and reflected the assessed needs and likes and or dislikes of each resident.

Behaviour support plans were in place as required. These were subject to regular and ongoing review and included background information, the type of behaviour, triggers and or cues and how staff should respond during and after an episode of behaviour that challenged. Key low arousal approaches were also included as an appendix to the plan. The inspector noted that the actions agreed at incident review group meetings were used to inform revisions to behaviour support plans.

Action plans clearly identified residents' goals and key workers maintained records of how well such goals were being achieved. The inspector noted however a variation in the standard of record keeping. While some action plans and goals were regularly updated, others had not been. In one instance, an action plan had not been updated from June and July 2014 and goals set had not been achieved.

Centre 2:

While there was evidence that residents' health care needs were well met throughout the centre, there was little evidence of adequate social care and support needs for the majority of residents. Many residents living in the centre remained reliant upon campus-based activity with records showing minimal opportunity for getting 'off site' to pursue more meaningful activity. Residents' opportunities to get off campus in many bungalows were confined to drives and walks.

Notwithstanding, there was evidence that residents and their representatives were now actively involved in the assessment of individual needs. A comprehensive needs based assessment had been completed for all residents with external independent input. A number of these assessments were read by the inspector. These clearly identified individual support requirements in areas such as home living, community access, employment, and social needs. These assessments also considered 'compatibility' in terms of the suitability of residents to live together, while also taking account of choice. Residents and relatives were involved in these assessments and the person in charge also met with each family to discuss the findings and related actions for each resident. The inspector met with one family who had come to the centre to meet the person in charge for this feedback and they spoke positively about this process.

At the time of this inspection, it was clearly evident that the outcomes from the assessments of individual needs had been implemented and were impacting positively for some residents. For example, residents identified as requiring minimal or no ongoing medical or nursing support and who had been living in large group environments were now living in 'social care led' bungalows. There were two such bungalows operating at the time of inspection, with four residents living in each one. The inspectors met some of these residents who commented positively on their new living situation and compared it to previous environments. Residents referred to their new home(s) as 'quieter and calmer' and made reference to previous circumstances. They were also able to discuss the weekly house or 'advocacy' meetings, minutes of which were read by inspectors. Residents spoke in some detail around the development of social goals including commencement of paid employment, studying for a driver theory test, holidays, joining a football team, meal preparation, home decoration and increased family visits. In all examples referred to, goals had been achieved or were at an advanced stage since residents had moved to their new environments in the past six months.

The person in charge confirmed there was a plan in place to open another 'social care bungalow' in six weeks and to change two further bungalows from nurse led to social care led in the coming months in response to the findings of the needs based assessments.

Centre 3:

Dedicated folders were available for each resident. Each folder contained a resident's personal plan including background information, family history, photographs and other information pertinent to the resident's life.

While residents' goals had been identified, it was not evident that residents had been supported to achieve all goals. There was no documented update in some plans and some goals for 2016 were the same as goals identified in 2014. The inspector was therefore not assured that the assessments of residents' social care needs were adequately comprehensive.

Furthermore, it was not evident that the effectiveness of the plans had been assessed or that residents were receiving all required support in identifying and achieving goals

related to social care.

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):

Findings:
Overview of inspection findings for all three centres:

A comprehensive emergency plan was in place which detailed how staff should respond to a range of emergencies. The plan included relevant contact details and the arrangements for emergency accommodation.

A health and safety management committee met monthly to develop and update relevant policies and procedures, to review the centres' risk registers and to identify future training needs. The learning from daily, weekly and monthly safeguarding meetings was also used to inform risk management approaches within each centre.

The procedures to be followed for the safe evacuation of residents and staff in the event of fire were clearly displayed in prominent locations throughout each centre. The procedure had also been developed in a format more readily accessible to residents.

There was an integrated fire alarm system in place in all centres. In addition, 'panic alarms' were held by key staff within each bungalow or unit which would alert staff in the event of an emergency. However, the use of these 'panic alarms' did not provide the immediacy or clarity of response required in the event of a fire in Centres 2 or 3.

Additional findings specific to individual centres are discussed below:

Centre 1:

Staff had attended training on fire safety and the staff who spoke to the inspector were able to appropriately describe the actions they would take to evacuate the centre in the event of fire.

The fire alarm had been serviced on a quarterly basis and fire safety equipment annually. Fire drills had been carried out on at least six monthly intervals and the

records maintained included details of fire drills, fire alarm tests and the checks carried out on fire fighting equipment. All checks had been carried out in accordance with regulations and best practice.

From the sample of four residents' records reviewed, personal evacuation plans had been completed and suitably informed staff on the particular needs of each resident in the event of having to evacuate the centre.

Staff had attended training on infection control and were observed by an inspector to put this learning into practice in terms of good hand washing, the use of alcohol gel and when opening foot operated bins.

Centre 2:

Overall it was found that the health and safety of residents, visitors and staff was promoted and protected. There were policies and procedures in place for risk management and emergency planning. However, there were not adequate fire containment measures in place throughout the centre due to an absence of appropriate fire doors.

There was evidence that previous risk-averse practices which were inhibiting residents exercising independence and autonomy within individual bungalows had been changed. Following appropriate assessment, a balance of rights versus risk was now considered in relation to residents' daily living experiences. For example, two bungalows were no longer operating waking night-staff and therefore staff were no longer going into residents' bedrooms to check on them throughout the night. These residents were now provided with the support of a staff member on 'sleepover'. In addition, many residents were now able to stay in their homes for set periods of time without staff present. For example, three of four residents in one bungalow had appropriate risk assessments in place to support them to do this.

Fire drills had been carried out regularly. A review of the records of fire drills indicated that the changed living environment for some residents had been taken into account when drills were carried out. This included night time drills which considered the safe evacuation of residents following the introduction of sleepover arrangements and where a staff member worked alone.

Centre 3:

Fire drills had taken place in the centre. However, the records showed that some residents had not taken part in a fire drill since April 2014. In addition, some staff had not taken part in fire drills in the centre.

Daily, weekly and monthly checks were taking place and records were maintained. Fire extinguishers and other fire alarm equipment were serviced as required.

Risk management procedures had been implemented and it was evident that the

response to risk was proportionate and based on assessments.

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:
Overview of inspection findings for all three centres:

From the date of the last inspection, inspectors noted a significant improvement in relation to safeguarding and safety. This was especially evident in Centres 1 and 2. All staff working in each centre had received training on adult protection and in safeguarding residents. Residents spoken with said they felt safe and staff spoken with were knowledgeable of what to do if they suspected, witnessed or received an allegation of abuse.

Since the last inspection, the provider had reviewed all arrangements for the management of restrictive practices and behaviours that challenge to better safeguard residents. While the inspectors found revised arrangements had been implemented in terms of restrictive procedures improvements were required.

All incidents, allegations or suspicions of abuse were recorded within each centre and appropriately investigated and responded to in line with the centre's policy, national guidance and legislation.

Meetings involving persons participating in the management of all centres took place, where necessary, to review any incidents that occurred in the preceding 24 hours and to determine what, if any action was required, including submitting a notification to HIQA. Weekly safeguarding meetings took place to review any incidents that may have happened in the previous week and where appropriate to agree any actions. Monthly safeguarding meetings provided an opportunity for senior staff to review and where necessary, revise behaviour support plans for those residents who have had incidents in

the preceding month. Weekly and monthly meetings are attended by the Director of Service, the designated safeguarding officer, persons in charge and clinical nurse specialists in behaviour management. Minutes of recent meetings reviewed by inspectors confirmed that the actions agreed at the meetings were implemented in practice.

Policies, procedures and individual guidelines were in place to guide staff in the provision of intimate care, respecting autonomy and promoting independence.

Additional findings specific to individual centres are discussed below.

Centre 1:

The arrangements in place for the management of behaviour that challenges did not always safeguard the rights of residents in this centre. In one example discussed with the Person in Charge and Director of Service during the inspection, the restrictive interventions used were not implemented for the shortest duration possible nor were they in accordance with evidence based practice. While the inspector recognised the progress made in addressing this matter from the date of the last inspection, some interventions utilised in this centre were found to be highly restrictive and adversely impacted on the privacy and dignity of the resident involved.

Centre 2:

Since the date of the last inspection, significant changes had been made to the living environments in response to past safeguarding concerns. These changes had reduced the levels of incidents taking place and created a more positive approach to residents who had presented with difficult behaviours within group environments. For example, three residents had been moved to separate apartments. Behaviours and escalation levels had been assessed as significantly reduced for these residents. Furthermore, incidences of physical restraint had reduced from an almost daily occurrence to an average of once every two weeks. This had been attributed to a low arousal environment and the fact that staff are directed to disengage from behaviour by leaving the bungalow and observing from outside. This was not possible within the group situation as staff had to intervene to protect other residents.

Centre 3 :

Short term measures had been implemented to ensure residents were safeguarded against the risk of peer-to-peer abuse. However, a specific medium and long term plan needed to be put in place to ensure measures implemented were not restricting the rights of residents.

There were no behaviour support plans in place for residents who required support with their behaviours that challenge and no written guidelines for the administration of p.r.n medicines (a medicine only taken as the need arises) which were prescribed for

'agitation'. It was therefore not evident that all alternative measures were considered before these restrictive measures were used and that the administration of p.r.n medicines was the least restrictive measure for the shortest duration necessary.

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:
Overview of inspection findings for all three centres:

A sample of health care plans were reviewed within each centre. All were found to be comprehensive and reflective of the assessed needs of residents. A proactive approach to preventative healthcare had been adopted and included for example, screening, nutritional weight screening and testing for hypertension.

Residents had access to a GP and an out-of-hours service was provided at night and at weekends.

The provision of allied health professional input had improved from the date of the last inspection and staff said this had a positive impact on the care and support provided to residents.

Appropriate and respectful support was seen to be provided to residents at mealtimes and meals were provided at times which suited residents' individual needs and wishes. Residents requiring modified diets had been assessed by a Speech and Language Therapist and staff knew residents' dietary needs. Menus also included pictures to support residents in making an informed choice.

Within Centre 2, menu planning and meal preparation had been recently introduced which maximized residents' independence. A six week cookery course for residents was due to start in April.

However, for residents in Centres 1 and 3 (and some residents in Centre 2), meals continued to be prepared and served from the kitchen located on the campus. Residents were not supported to buy, prepare and cook their own meals.

Judgment:
Substantially Compliant

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

Findings:
Overview of inspection findings for all three centres:

In the main, inspectors concluded that each resident was protected by the centre's policies and procedures for medicines management.

In Centres 1 and 3, staff nurses administered medicines to residents. However, in Centre 2, the policy had been recently revised to take into account the safe administration of medicines by social care staff as well as self-administration where appropriate. This was seen to be working effectively.

Appropriate practices of medication management were observed. These included the person who administered the medication wearing a red apron to indicate they were engaged in administering medication; appropriate hand hygiene and administration which took account of residents' needs and respected residents' individual wishes.

Medicine prescription sheets and administration records contained all required information. Medicines were administered at the prescribed time and had been signed contemporaneously when administered. However, in Centre 1, an inspector identified one instance in which a p.r.n. medicine (a medicine only taken as the need arises) had been administered and not signed as such within the medicine prescription administration record.

A pharmacist was directly employed to provide oversight of medicine management practices within each centre and to manage a monthly audit programme. This programme looked at a number of practices which included for example record keeping, storage of medicines, out-of-hours requests, missing medicines and availability of reference material and resident information leaflets. This was seen to have had a positive impact on care practices.

Judgment:
Substantially Compliant

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:
Overview of inspection findings for all three centres:

Since the date of the last inspection, there had been a comprehensive review of governance and management within all centres. As a consequence of the review, a dedicated person in charge was appointed for each centre. During this inspection, the person in charge for Centres 1 and 2 met with inspectors and were found to be competent and knowledgeable about the legislation, the national standards and their roles and responsibilities within their respective centres. Inspectors concluded that the persons in charge had made a positive impact on the quality of care and quality of life experienced by residents. The person in charge of Centre 3 was on leave at the time of this unannounced inspection.

The provider carried out three monthly unannounced visits to each centre. Records of each visit were reviewed by inspectors who found that any actions stated had been implemented in practice or were in the process of being actioned within Centres 1 and 2. In Centre 3, the inspector identified a number of areas for improvement that had not been implemented. The areas outstanding were discussed with the Director of Service during the feedback meeting.

In Centre 2, a social care model of support had been introduced and was seen to be working very well. Team leads (who reported to the person in charge) had been identified within individual bungalows. They had taken on additional autonomy and responsibilities such as compiling the staff duty rota to best meet the needs of residents and to reflect planned activation schedules.

In Centre 3, some residents had moved to new houses on the campus which was focussed on providing a social care model of support. On the day of inspection, psychology project workers were observed modelling best practice in supporting

residents and a number of residents had availed of 'mindfulness' sessions.

Additional findings specific to Centre 3 are discussed below.

Centre 3:

The inspector found that a number of non-compliances identified in the report of the last inspection had not been addressed. These included the following:

- A protocol for the use of p.r.n. medicines (medicines only taken as the need arises) had not been implemented
- the policy on nutrition had not been updated
- the policy on the use of restrictive practices had not been updated
- story books outlining residents' stories of their ideal day had not been compiled with residents living in the centre.

The findings outlined in outcomes 1, 5 and 8 in relation to Centre 3, raised concern that the management systems in place were not ensuring the service provided was safe, appropriate to residents' needs, consistent and effectively monitored at all times.

On reviewing Centre 3's statement of purpose, the inspector found that the provider had failed to adhere to the stated purpose of the centre in regard to the admission of respite residents. A respite resident had been admitted to part of the centre which had not been identified as providing respite care and support. This was discussed with the Director of Service who undertook to amend the statement of purpose accordingly.

Judgment:
Non Compliant - Moderate

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:
Overview of inspection findings for all three centres:

Inspectors noted that from the date of the last inspection, a significant improvement had been made in the maintenance of training records. Records were now centre-specific and reflected those staff currently employed within each centre.

A new training policy had been implemented which linked the training required by staff to the individual needs of each resident. This gap analysis approach also enabled persons in charge to capture training requirements specific to each bungalow or unit with the centres.

Staff had attended a range of mandatory and other training that included fire safety, safeguarding, moving & handling, communication, medication management, 'Trust in Care' and children first guidance. In Centre 2, dedicated training had also been provided on the role of 'Keyworker' and on the social care model. However, in Centre 3, deficits in mandatory staff training were identified. For example, 51% of staff had not been trained in fire prevention, the use of first aid fire fighting equipment and fire control techniques; 34% of staff had not received training in the management of behaviour that is challenging (including de-escalation and intervention techniques) and 11% of staff had not been trained in manual handling.

In Centres 1 and 2, inspectors concluded that staff had been employed in adequate numbers and skill mix to meet the assessed needs of the residents. This was not the case in Centre 3. From the information available in Centre 3, it was not possible to conclude that the number and skill mix of staff was reflective of residents' needs. Further, the inspector was told (by staff) that the numbers of staff on duty often reflected the availability of staff.

In Centre 3, it was not evident that the qualifications and knowledge of staff was appropriate to the number and assessed needs of the residents. Some staff working in the centre had no previous experience of working in a designated centre and were left alone with residents while more experienced staff attended to other duties or went on a break. The inspector was not satisfied there was an adequately comprehensive induction process in place for new staff working in Centre 3.

Actual and planned staff duty rotas clearly identified the staff on duty and in which part of each centre they were allocated. Staff had been assigned to specific units and to bungalows which promoted greater continuity of care. In Centre 2, it also enabled an effective key-working system to be introduced and maintained. Continuity of staff was also greatly improved by the conversion from agency to directly employed staff. Since the date of the last inspection, 40 posts had been converted.

The staff duty rota in Centre 3 did not clearly show staff start and finish times as abbreviations were used and there was no legend provided for the abbreviations. Start and finish times for the same shift varied over the course of the week depending on whether the staff member was employed directly by the centre or an agency.

The supervision arrangements in place within all centres were informal and based on the day-to-day operation of the centre and not reflective of staff training and development requirements. The Director of Service informed inspectors that training for managers on

how to do this effectively would be provided in the coming months. Following training, a programme of formal supervision was to be introduced within all three centres.

Six records of staff employed (two in each centre) including agency staff were reviewed by an inspector. Records were found to have been maintained in accordance with the requirements of Schedule 2 of the regulations.

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:

Lorraine Egan
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004911
Date of Inspection:	30 March 2016
Date of response:	

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 screening between residents' beds in Centre 1 was inadequate to maximise the privacy and dignity of each resident

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Centre 1:
We are currently in a transitional programme of service improvement to a social model of care. As the transition progresses the aim is to imminently reduce numbers in centre 1. Standard 1.2.2 states: "Each person has their own bedroom unless they wish to share". (Ref. National Standards for Adults with Disabilities, HIQA 2013). Within this transitional plan, residents will have the privacy of their own room or be given the decision to choose if they wish to share.
In the interim, to ensure that each residents dignity and privacy is respected at all times here on site and in the centre; we will seek to install Static screens in the remaining shared areas where required and residents own rooms are now personalised and include adequate storage for personal belongings.

Centre 2:
Not applicable to Centre 2.

Centre 3:
All residents now have their own bedrooms, a spare bedroom in each of the three houses is being converted in each house to a sitting room/Visitors room to ensure that the people living there can have private visiting time. Management offices are no longer based in residents homes and have been moved to another area of the service.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents in Centre 2 and Centre 3 were reliant on centralized care practices which impacted on their ability to be involved in the everyday activities of living and to make an informed choice about the running of their home.

2. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
Centre 2:
The rollout of the Social Model of Care and Support has commenced in Centre Two in Lough Conn House, River Moy House and in Clew Bay House. The remaining units in Centre Two are moving towards this model of support and it is planned that as Social Care staff are appointed to each unit this will assist with this roll out. With the additional governance and management the freedom to exercise choice and control in all aspects of each individual's life should become more evident and reduce

institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles. Residents are getting more involved in the service transition and the running of their houses.

Centre 3:
The rollout of the Social Model of Care and Support has commenced in Centre Three The three houses in Centre Three are moving towards this model of support and it is planned that as Social Care staff are appointed to each house this will assist with this roll out. With the additional governance and management the freedom to exercise choice and control in all aspects of each individual's life should become more evident and reduce institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles. Residents are getting more involved in the service transition and the running of their houses.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents living in Centre 3 had not been consulted about the organisation of the designated centre in regard to the use of the centre as a respite service on an emergency and planned basis.

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

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Voices and chooses meetings currently take place fortnightly in Centre 3, Currently we are developing a communication pathway to all documentation within guidance folders which will be included into the unit Induction Process to all staff working in Centre 3. The transition team are now in place and they are working with individuals to develop detailed transition plans including their will and preference for where they want to live and with whom in the future and what their meaningful day will look like. In conjunction with this Community based accommodation has been purchased as is being refurbished. On site we will continue to work on actions already identified from the

Xyea Audit System in respect of residence Rights, Dignity and Consultation under the regulations. The three houses in Centre three are moving towards the social care model of support and it is planned that as Social Care staff are appointed to each unit this will assist with this roll out. With the additional governance and management the freedom to exercise choice and control in all aspects of each individual's life will become more evident and reduce institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition where respite individuals were found to be incompatible with residents living in Centre 3 alternative arrangements have been made and this is reflected in the Statement of Purpose. Respite have been identified as a priority move in the transition of the service

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that each resident in Centres 2 and 3 had the freedom to exercise choice and control in all aspects of his or her daily life as there were a number of institutional practices in the centre.

4. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
Centre 1:
As the Service is now in a transitory phase it is the planned goal of Centre 1 to reduce resident numbers by moving residents into the transitional social care houses on site as they become available, there will also be a transfer out into the community this year. Also the respite service has been prioritised for a move off site this year. It is expected that will enhance the privacy and dignity for other residents living in centre 1.

Regular reviews of the transitory phase will be conducted .Transition plans for Centre 1 are in situ, will be kept up to date and regularly reviewed. Static screens will be installed in all shared bedrooms to maximise the levels of privacy and dignity for residents where required. Individualisation of personal space with personal effects continues.

Referrals have been made to the independent advocacy services where required with documented evidence to support this , e.g independent advocacy services have been actively involved in annual reviews to promote best planned outcome of care provision and practice for the resident.

Individuals who use the service are provided with an opportunity to be actively involved in the monthly house/unit meetings to exercise choice and control in their daily lives as recorded in minutes.

Centre 2:
The rollout of the Social Model of Care and Support has commenced in Centre Two in Lough Conn House, River Moy House and in Clew Bay House. The remaining units in Centre Two are moving towards this model of support the recruitment of Social Care staff will assist with this roll out. With this additional governance and management the freedom to exercise choice and control in all aspects of each individual's life should become more evident and reduce institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end.

Centre 3:
Develop a pictorial choice board whereby individual residents social choice will displayed on a daily basis. Activity undertaken by individuals is logged on the residents file Also the centre is developing communication passports with non verbal residents with input from Speech and Language Therapist. This is being included into the unit Induction Process for staff. The remaining units in Centre Three are moving towards this model of support the recruitment of Social Care staff is assisting with this roll out. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of residents' monies in all centres is institutional in practice in that all monies are held centrally instead of individual accounts

5. Action Required:
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Please state the actions you have taken or are planning to take:
Centre 1:
The development of a local policy and procedures which address this matter is currently underway. The opening of personal bank accounts in the names of residents is also underway. Currently residents are having financial profiles completed as part of the services transitional work. This will support the practice of residents access to their personal finances.

Centre 2:
The development of a local policy and procedures which address this matter is currently underway. The opening of personal bank accounts in the names of residents is also underway. Currently residents are having financial profiles completed as part of the

services transitional work. This will support the practice of residents access to their personal finances.

Centre 3:
Review Aras Attracta policy of residence finance. Support residents to set up their own bank accounts Currently residents are having financial profiles completed as part of the services transitional work. This will support the practice of residents access to their personal finances.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was limited choice for residents living in Centre 3 to facilities for occupation and recreation

6. Action Required:
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
Centre 1:
We have acquired a new vehicle exclusively for the use of centre 1 and we have 19.5 hrs per week transport available to us from Enable Ireland . We also have access to independent community transport to promote social inclusion.

Promotion of the Volunteer Service in Centre 1 has allowed us to match some of our residents with appropriate volunteers in the community with skills, interests and qualities to suit residents needs and to enhance social engagement.

Our dedicated Activities co-ordinator and her team work with residents to fulfil individual interests for occupation and recreation, such as those from a farming background visiting an active farm.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Transition team have been doing extensive work with individuals living in Centre three to identify their will and preferences for the future and what they would like their meaningful day to consist of and social roles. SRV/SSDL training is being provided to Staff within the Activation team. Staff who are currently undergoing SRV and SSDL training are currently working with individuals to put residents wishes into action.

Proposed Timescale: 31/10/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While an assessment of need had been carried out for residents living in Centre 2, there was little evidence that adequate social care and support had been provided to meet residents' assessed needs.

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:
Centre 1:
The introduction of Personal Outcome Measures commenced in Centre One in April 2016. It is envisaged that this will be rolled out completely within the centre by the end of the year. The rollout of the Social Model of Care and Support has commenced in centre one. It is planned that as Social Care staff are appointed to each unit this will assist with this roll out. This will support management the to exercise a greater degree of choice and control in all aspects of each individual's life and should become more evident and reduce institutionalised practices. As the first groups of individuals transition to the community smaller accommodation units will become available 0on site which will reduce the numbers of people living in the current units. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles through relationship, housing, housekeeping and housing profiles. Residents are getting more involved in the service transition and the running of their houses. This will aid in the improvement of adequate social care and support being delivered.

Centre 2:
The introduction of Personal Outcome Measures commenced in Centre Two in April 2016. It is envisaged that this will be rolled out completely within the centre by the end of the year. The rollout of the Social Model of Care and Support has commenced in Centre Two in Lough Conn House, River Moy House and in Clew Bay House. The remaining units in Centre Two are moving towards this model of support and it is planned that as Social Care staff are appointed to each unit this will assist with this roll out. With the additional governance and management the freedom to exercise choice and control in all aspects of each individual's life should become more evident and reduce institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles through relationship, housing, housekeeping and housing profiles. Residents are getting more involved in the service transition and the running of their houses. This will aid in the improvement of adequate social care and support being delivered.

Centre 3:
The rollout of the Social Model of Care and Support has commenced in Centre Three The three houses in Centre Three are moving towards this model of support and it is planned that as Social Care staff are appointed to each house this will assist with this roll out. With the additional governance and management the freedom to exercise choice and control in all aspects of each individual's life should become more evident and reduce institutionalised practices. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end with the appointment of Social Care staff. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles. In addition the transition team have commenced work with all residents around their will and preference for their future and social roles through relationship, housing, housekeeping and housing profiles. Residents are getting more involved in the service transition and the running of their houses.

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessments of the social care needs were not adequately comprehensive for all residents living in Centres 1 and 3

8. 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:
Centre 1:
A transitional profile will be prepared for each individual. It will look at housing, relationships, housekeeping and finance. A number of staff have been trained in the area of SSDL and these staff are partnering with individuals An SIS assessment has been completed, as has an activation and sampling review . In addition the PIC has liaised with the allied health professionals which includes an annual review by their GP to ensure holistic optimal social care provision and practice and engage in the promotion of optimal psycho-social well-being and fulfilment of personal goals. Residents and relatives will be involved in all of these assessments and the person in charge also met with each family and held teleconferences for those family members abroad to discuss the findings and related actions for each resident.
The SIS assessments also considered 'compatibility' in terms of the suitability of residents to live together, while also taking account of choice, but this will be further explored through the relationships transition profile.
Centre 2:
A transitional profile will be prepared for each individual. It will look at housing,

relationships, housekeeping and finance. A number of staff have been trained in the area of SSDL and these staff are partnering with individuals An SIS assessment has been completed, as has an activation and sampling review . In addition the PIC has liaised with the allied health professionals which includes an annual review by their GP to ensure holistic optimal social care provision and practice and engage in the promotion of optimal psycho-social well-being and fulfilment of personal goals. Residents and relatives will be involved in all of these assessments and the person in charge also met with each family and held teleconferences for those family members abroad to discuss the findings and related actions for each resident.
The SIS assessments also considered 'compatibility' in terms of the suitability of residents to live together, while also taking account of choice, but this will be further explored through the relationships transition profile.

Centre 3:
A transitional profile will be prepared for each individual. It will look at housing, relationships, housekeeping and finance. A number of staff have been trained in the area of SSDL and these staff are partnering with individuals An SIS assessment has been completed, as has an activation and sampling review . In addition the PIC has liaised with the allied health professionals which includes an annual review by their GP to ensure holistic optimal social care provision and practice and engage in the promotion of optimal psycho-social well-being and fulfilment of personal goals. Residents and relatives will be involved in all of these assessments and the person in charge also met with each family and held teleconferences for those family members abroad to discuss the findings and related actions for each resident.
The SIS assessments also considered 'compatibility' in terms of the suitability of residents to live together, while also taking account of choice, but this will be further explored through the relationships transition profile.

Proposed Timescale: 01/11/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews did not assess the effectiveness of each plan for residents living in Centre 3.

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

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
The introduction of Personal Outcome Measures commenced in Centre three in April 2016. It is envisaged that this will be rolled out completely within the centre by the end of the year. An evaluation of all POMs goals and personal plans is currently underway through the Xyea© auditing system and in conjunction with Key workers, the transition team and PIC to ensure residents have current and up to date goals to include a clear understanding of the importance of having socially valued roles.

Proposed Timescale: 15/08/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of 'panic alarms' did not provide the immediacy or clarity of response required in the event of a fire in Centres 2 or 3.

There were no fire doors in Centre 2 and Centre 3.

10. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Each house has a fire alarm, the alarm alerts staff to the location of a fire within a house. In addition the fire panel is located at reception and at the night security desk, in the event of a fire staff are alerted to its location. In addition the fire alarm is integrated to the pager system in all houses, so the activation of the fire alarm is captured on the pager system. Pagers are only provided where an assessed need has been identified. Also the activation of the panic alert (in the event of an emergency for a lone worker, again panic alerts are only provided where an assessed need has been identified), in a given location is also identified on the pager. Also an external fire consultancy firm has been engaged with regarding the situation with the fire doors within the service. The costs associated with the replacing of all doors is extensive and the investment has been deemed inappropriate within a congregated setting. However it is clear that additional integrated training is required involving the services Health and Safety representative at all fire training sessions to ensure that all staff are fully versed on aspects of the precautions that are to be taken with regard the risk of fire, the completion of fire drills,fire fighting equipment etc and evacuation plans.

Centre 3:
Each house has a fire alarm, the alarm alerts staff to the location of a fire within a house. In addition the fire panel is located at reception and at the night security desk, in the event of a fire staff are alerted to its location. In addition the fire alarm is integrated to the pager system in all houses, so the activation of the fire alarm is captured on the pager system. Pagers are only provided where an assessed need has been identified. Also the activation of the panic alert (in the event of an emergency for a lone worker, again panic alerts are only provided where an assessed need has been identified), in a given location is also identified on the pager. Also an external fire consultancy firm has been engaged with regarding the situation with the fire doors within the service. The costs associated with the replacing of all doors is extensive and the investment has been deemed inappropriate within a congregated setting. However it is clear that additional integrated training is required involving the services Health and Safety representative at all fire training sessions to ensure that all staff are fully versed on aspects of the precautions that are to be taken with regard the risk of fire, the completion of fire drills, fire fighting equipment etc and evacuation plans.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents and staff had not taken part in fire drills in Centre 3.

11. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
All staff in Centre 3 will be trained in the area of fire training and on how to respond in the event of a fire.
The Health &Safety Folder is being updated to include record of fire drills, and evacuation plans In addition integrated training is will now involve the services. Health and Safety representative at all fire training sessions to ensure that all staff are fully versed on aspects of the precautions that are available and are to be taken with regard the risk of fire, the completion of fire drills bi annually, fire fighting equipment etc and evacuation plans.

Proposed Timescale: 30/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to protect the rights of residents in Centre 1 and implement evidence based practice in the management of restrictive practices, particularly relating to the use of significant and highly unusual practices.

12. 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:
Centre 1:
The rights of all residents in centre 1 are protected and management and staff ensure that all alternative measures are considered before a restrictive procedure is used.

In the event that a restrictive procedure is used, it reflects the assessed needs of the resident, is based on best evidence-based practice, is the least restrictive to support the individual for the shortest duration possible.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Not applicable to Centre 3.

Proposed Timescale: 29/06/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents living in Centre 3 did not have documented behaviour support plans which outlined the approach staff were required to adhere to when responding to behaviour that is challenging and supporting residents to manage their behaviour.

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

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

Centre 1:
In centre 1 any residents requiring a BSP have a current and updated one in place with a proactive and reactive strategy and if a resident requires any additional support there is a psychology support worker and a MHID team and referrals are made promptly.

Centre 2:
Not applicable to Centre 2.

Centre 3:
A review of all behaviour support plans proactive and reactive strategies has taken place and are available to all staff. Staff have been involved in these reviews. All behaviour support plans are now located in section 6 of personal plans. The transition team is working with residents on the further exploration of meaningful roles. This will provide opportunities for more meaningful roles and meaningful days so that residents can be supported to manage their behaviour.

Proposed Timescale: 31/05/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not evident that all alternative measures were considered before a restrictive procedure was used and the least restrictive procedure, for the shortest duration necessary, was used when supporting residents living in Centre 3 to manage their behaviours that were challenging.

14. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 2.

Centre 2:
Not applicable to Centre 2.

Centre 3:
There are now individual off duty rotas in each house to provide continuity of support and build relationships with the residents. The Centres management team are no longer based in any of the houses, respecting the privacy of the people living in these residences. All PRN medication is reviewed and PRN protocols are in place. Where a restrictive practice has been assessed and is deemed necessary a diary is used to clearly document occasions where, why, for how long and by whom the practice was required. The diary is only located in circumstances where it is necessary.

Proposed Timescale: 30/06/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures required to protect residents from abuse in Centre 3 required review to ensure that appropriate medium and long term measures were implemented.

15. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Respite is now reduced to one bed in Centre 3, compatibility issues have been addressed. The respite service has been identified as a priority to be moved off site, currently for two individuals an individualised service is being provided on alternate weekends. Safeguarding plans are in place for all residents where a concern has been identified, these are overseen by the Designated Officer and reviewed. Staff working in Centre 3 are knowledgeable about the Safeguarding Plans

Proposed Timescale: 31/12/2016

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:
Residents living in all centres were not supported to buy, prepare and cook their own meals.

16. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
Centre 1:

New Kitchen is accessible to facilitate meal preparation in Pearl House , Centre 1 .

A bespoke kitchen has now been installed; wheelchair accessible in Pearl House where the choice of design heavily involved the residents and their fundamental needs. This will enhance freedom and choice , promote and develop new and existing cookery skills and autonomy in buying , preparing and cooking of meals.
Individuals who use the service are facilitated to participate in light household duties if they so desire. Individuals who use the service will be facilitated to go grocery shopping where they so desire.
Staff will continue to support individuals to develop skills in self care including life skills training. Individuals will now have access to the kitchen in order to prepare light meals of choice at times of their choosing (unless a risk assessment indicates otherwise).

The Food Safety & Hygiene HACCP training course which takes into account all the requirements of Food Safety legislation and standards based on the Guide to Food Safety Training published by the Food Safety Authority of Ireland (FSAI) will be undertaken by all staff in the centre.

Centre 2:
The rollout of the Social Model of Care and Support has commenced in Centre Two in Lough Conn House, River Moy House and in Clew Bay House. The remaining units in Centre Two are moving towards this model of support and it is planned that as Social Care staff appointed to each unit it will assist with this roll out. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end as the Social Care staff are appointed. Central to this new approach of service provision is the in home purchasing of foods, preparation and cooking of meals – all of which will be fully participated in by residents.

Centre 3:
Residents are encouraged to participate in preparing and cooking their own meals at the week end if the so wish.
An account has been set up in the local spar and resident are encouraged to participate in the shopping.
As the current model of service provide meals via a catering service the services is encouraging the residents in Centre 3 to become more evolved in food preparation while preparing for transition. Cookery classes is in place within the day service. It is planned that as Social Care staff appointed to each unit it will assist with this roll out. It is envisaged that the reliance on centralised services such as catering, cleaning and laundry services will end as the Social Care staff are appointed. Central to this new approach of service provision is the in home purchasing of foods, preparation and cooking of meals – all of which will be fully participated in by residents.

Proposed Timescale: 31/12/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A p.r.n. medicine (a medicine only taken as the need arises) had been administered and not signed as such within the medicine prescription administration record.

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

Please state the actions you have taken or are planning to take:
Centre 1:
Medication audits have been carried and are available with actions in the centre.
Medication reviews have been completed and residents participated in self - administration of medication assessments.
All appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines are monitored to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident as per the current medication management policy.

In relation to the drug error in Centre 1, where A PRN (as required) medication had been administered and not signed as such within the medication prescription administration record; the staff member has completed their medication management module and has had supervised and supported observations of practice and competency assessments in medication administration and management undertaken. All Staff are sporadically assessed for clinical competency and proficiency in the safe administration of medication as per policy.

A number of staff are now trained in the Safe Administration of Medication (SAMs) to ensure care staff manage and administer medication in a safe manner and in line with best practice as per medication management policy.

Centre 2:
The service has six staff trained as train the trainers in the SAM system and are rolling out this training in the service. The Policy has been reviewed and updated to reflect this. Regular Medication Audits will be completed in Centre Two as per the medication policy. This is being led by the pharmacist.

Centre 3:
The service has six staff trained as train the trainers in the SAM system and are rolling out this training in the service. The Policy has been reviewed and updated to reflect this. Regular Medication Audits will be completed in Centre Two as per the medication policy. This is being led by the pharmacist.

Proposed Timescale: 30/06/2016

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 management systems in place in Centre 3 had not ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored at all times.

18. 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:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
The centre has an identified PPIM on duty every day, in the absence of the PPIM the roster has an identified senior staff member on duty and managing the Centre.. The manager is available and supervises the practices of the staff on duty. All managers will engage in Support and Supervision workshops that will commence in September 2016. The purpose of this process is to educate all managers on the importance of supervision and how to provide effective supervision.The managers have moved there offices out of the homes of the residents to a different location in the complex. Seven residents within Centre 3 are part of the 1st phase of the transition to community plan, which we hope will happen by the end of the year. Safeguarding plans are in place for those residents where a concern has been identifies. Resident who remain on sight will be transfer to other bungalows as space becomes available

Proposed Timescale: 31/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident 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 Centre 3.

19. 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:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Statement of purpose and function has been to reflect the skill mix of the team. and the provision of respite contained to Áit Iontach. No 12. In addition a roster is available in each house in Centre 3 to reflect this. All of the individuals residing in this Centre have been through the SIS assessments. Support need have been identified and will be put in place for the individuals as they transition off site. There are a number of individuals living in this centre who have very different support needs. The transition team have commenced work with all residents around their will and preference for their future and social roles through relationship, housing, housekeeping and housing profiles. Support resources will be targeted in terms of what residents need to have a good life.

Proposed Timescale: 31/12/2016
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff rota in Centre 3 did not clearly show staff start and finish times as abbreviations were used and some start and finish times varied for the same identified working shifts.

20. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 2.

Centre 2:
Not applicable to Centre 2.

Centre 3:
A planned and actual staff rota is now in place and it showing staff on duty at any time during the day and night. It shows the start and the finish time of all of the staff on duty. There is an Individual Rota per House and a copy is also on view in the CNMs

office area, which is not in the residents home. This Rota is signed off on a daily basis by CMN2 or acting person.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The supervision arrangements in place within all centres were informal and based on the day to day operation of the centre and not reflective of staff training and development requirements.

It was not evident that new staff members were appropriately supervised when working in Centre 3.

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

Please state the actions you have taken or are planning to take:
Centre 1:
Formal Support and supervision education and training for management to be rolled out in Áras Attracta and is due to commence in the next few weeks .

Centre 2:
The further development of 'core teams' of staff is to take place and the formal rollout of support and supervision for each staff member is due to commence in the coming weeks. Staff training and development requirements will be reflective of the collective support needs of the residents which are provided with support and care by that core team.

Centre 3:
Off duty rota are in place in each house and a manager is identified for each day. This is to support the supervision of staff on duty. Managers will be supported with Support and Supervision training, the purpose of this is to commence formal support and supervision with all staff in the service.

All rosters now have an identified PPIM or PIC on duty every day. All staff are now identified on the roster, in the location where they are working. A more consistent team of staff are now allocated to this centre. In addition the service is rolling out Support and Supervision training for managers and staff. The purpose of this is to ensure that managers understand the purpose and the importance of supervision and that staff are very clear about what managers expect in terms of the support that is provided to individuals, their knowledge of the location where they are working and all aspects of the supports and care plans for individuals.

Proposed Timescale: 31/10/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff working in Centre 3 had not received required training. For example, training had not been provided in responding to behaviour that is challenging, including de-escalation and intervention techniques; fire prevention, first aid fire fighting equipment and fire control techniques; and manual handling.

22. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Centre 1:
Not applicable to Centre 1.

Centre 2:
Not applicable to Centre 2.

Centre 3:
Training will be provided to those staff where a record of training is not evident in Studio 3 techniques; fire prevention, first aid and manual handling. A record of training will be available within each area.

Proposed Timescale: 30/09/2016