

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre 1 - Aras Attracta
Centre ID:	OSV-0003321
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mary Warde
Lead inspector:	Michael Keating
Support inspector(s):	Ann-Marie O'Neill; Florence Farrelly; Shane Walsh
Type of inspection	Unannounced
Number of residents on the date of inspection:	40
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 following notification of a significant incident or event. 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:
12 July 2015 18:00	12 July 2015 19:30
13 July 2015 11:00	13 July 2015 16:00

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

Outcome 08: Safeguarding and Safety
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.

Subsequent to this HIQA completed inspections in March 2016 to examine whether the actions of the provider had been effective in improving the safety and quality of life of residents. Inspectors found that significant improvements had been achieved and residents were experiencing more positive outcomes as a result. Although improvements have been made, there continues to be areas where further improvements are required and HIQA will continue to monitor compliance at the centre.

This inspection report relates to an inspection that occurred prior to HIQA requiring the provider to undertake their own audit.

This centre is one of three centres on a large campus, Centre 1, Centre 2 and Centre 3. The three centres were inspected and there are separate reports for each centre. This report refers to Centre 1.

This was a triggered inspection following the receipt of a number of notifications submitted to the Authority in relation to the safeguarding of residents.

Prior to the inspection, the provider was required to carry out a review of all notifications submitted and the investigation into two particular notifications regarding safeguarding. The provider was requested to attend a meeting with the Authority on the 29 June 2015 to discuss the three centres. At that meeting, the inspectors were not satisfied that the actions taken by the provider in response to an allegation of abuse were sufficient to safeguard residents. Following a break in the course of the meeting, the provider returned and informed inspectors that further action had been taken. Following this meeting, the provider notified the Authority of a further allegation and the Authority were satisfied that the provider had taken appropriate action to safeguard residents in that case.

In addition to that issue, inspectors also discussed specific concerns at the meeting relating to three main areas; namely governance and management, safeguarding and safety and inadequate staffing levels. During the meeting the provider and the person in charge were unable to provide adequate assurances that residents were being adequately safeguarded and protected. Subsequent to the meeting the provider was required to submit a schedule of improvement actions to the Authority by Wednesday 8 July 2015 setting out how the provider proposed to address these concerns.

In that submission, the provider identified immediate actions that they stated had been taken including the allocation of additional staff and supports around identified residents. The other actions within the plan included recruitment of staff and the appointment of additional management staff. The management posts outlined in the plan had been approved at the time the plan was submitted, however, previous commitments provided to the Authority in relation to the recruitment of management staff were not met due to an unsuccessful recruitment campaign. In addition, actions relating to staff recruitment were dependent upon approval from the Health Service Executive (HSE) at national level. This plan did not provide adequate reassurance and therefore an unannounced inspection was scheduled for 12 and 13 July 2015.

The concerns of the Authority were substantiated by the findings on inspection, and inspectors found that the provider had failed to sustain improvements that were noted during the inspection in April 2015. The inspection focused on governance and management, safeguarding and safety and staffing. The provider was found to have major non compliances in the three outcomes. The findings are discussed in the body of the report and all non compliances are actioned at the end of this report.

As a result of the findings from this, and previous inspections the Chief Inspector deemed it necessary to request the registered provider to enhance their own governance and management monitoring as a formal requirement. They were requested to carry out a programme of auditing in accordance with Regulation 23 (2). This places a legislative responsibility on the provider to carry out unannounced visits to the centre to monitor the safety and quality of care and support provided and as required, to put a plan in place to address any concerns identified during the visit.

The registered provider was also required to prepare a written governance and

management report of the visit and to make this report available to the Chief Inspector and on request to relatives and residents. The Authority provided a report template for this purpose and at the time of publication of this report, the registered provider has been requested to complete the unannounced visit and subsequent report on a quarterly basis. One such report has been provided to the chief inspector as requested on 27 October 2015. This plan provided reassurances that noncompliance identified in this report were actively being addressed.

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 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Inspectors found that there were insufficient measures to protect residents from being harmed or suffering abuse. The inspectors found that staff were not reporting suspicions of abuse in a timely manner. Staff told inspectors that they were fearful of reporting suspicions. In addition, inspectors saw records of incidents that were not reported in a timely manner. In one example, a disclosure was only made following a discussion between the staff member and the person in charge in relation to a separate issue. In the report for one allegation, inspectors read that staff were "afraid to report". Having reviewed training records, inspectors found that not all staff had received training in the prevention, detection and response to abuse.

The arrangements for managing restrictive practices and for managing behaviour that challenges did not safeguard the rights of residents. The provider was not ensuring that the least restrictive measures were being implemented for the shortest period and that all restrictive practices were in accordance with evidence based practice. Specific example(s) were provided to the provider and person in charge during the feedback meeting.

The rights of residents to appropriate and consistent interventions were not being safeguarded. Residents identified as having behaviours that challenge did not have an adequate management strategy prescribed or documented within their care plans. For example, this was particularly pertinent in the case of one resident who was supported on a daily basis by a 'personal assistant' employed through an external agency. Prescribed behaviour management strategies were not documented or implemented to support the resident and staff during incidents of behaviours that is challenging. This

posed a risk of inappropriate and inconsistent practices which would impact adversely on the resident. In addition, all staff had not been provided with training in the management of behaviour that challenges that would allow them to engage with the resident and provide interventions in an informed way.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors found that there were inadequate governance and management levels during the inspection. The clinical nurse manager assigned responsibility for the centre was unable to provide appropriate governance or supervision across the centre comprising two separate units due to inadequate staffing levels and her need to stay primarily within one of these units in order to provide nursing cover. She confirmed she found it extremely difficult to get into the second unit at all, she stated that this concerned her as she was responsible for the care and support being provided there and could not engage in the overall supervision of the staff in the centre. She also stated that much of her time was taken up trying to get staff to cover shifts and this also took from her ability to ensure staff were engaging in appropriate practices.

The provider and person in charge were failing to ensure staffing supports were provided in a safe and consistent fashion, as detailed within Outcome 17; Workforce. During the inspection, staff were brought into the centre from other centres including day services. Inspectors spoke with staff nurses who said they were very anxious as they had not completed a medication round in months and did not normally work in that centre. Another staff member described the medication round the previous morning as not finishing until 11:30am and also stated that residents did not receive breakfast until 11.30, due to a lack of staff to get residents up. Additionally on the morning of Day 2 inspectors witnessed a resident leaving the unit independently. This resident was subsequently described as 'absconding' and the reason given was that staff who were unfamiliar with the centre did not know he was unable to leave the centre

independently.

In general, the management systems in place were not found to be supporting and promoting the delivery of safe, quality care services.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

The provider and person in charge were not ensuring that the staffing levels and skill mix were based on the assessed needs of residents. The clinical nurse manager referred to an historical agreement for the allocation of ten nurses and five care assistants to the unit, but there had been no recent assessment or review of staffing based on the needs of residents. A previous inspection in September 2014 highlighted this issue, and the provider had committed to putting in place an assessment of need and 'protocol for staff allocation' in place by 29 May 2015. The provider had failed to implement this action within the agreed timeframe.

The quality of service provision was being impacted by a lack of continuity of care. There was a significant reliance upon agency staff members. The staff rota did not identify which staff working in the centre were agency staff and twilight staff were not listed on the rota. In addition, the common practice of moving staff between the three designated centres within the campus was not being appropriately recorded and it was difficult to identify which staff were working in which centre. As a result, the person in charge was unable to demonstrate whether adequate staffing levels were maintained at all times in the centre.

As has been discussed previously staff members were not provided with appropriate training in managing challenging behaviour and some staff had not completed safeguarding training. The training records maintained were poorly managed, for example some staff listed had retired and no longer worked in the centre, the records were campus based and not centre specific, and the reliability of the documentation was

questionable as clinical nurse managers stated that some staff members had received safeguarding training however, this was not reflected in training records.

Staff were inadequately supervised and supported; particularly at weekends as the clinical nurse manager assigned management responsibility was not supernumerary and was based in one unit for much of the weekend.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003321
Date of Inspection:	12 July 2015
Date of response:	13 August 2015

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 08: Safeguarding and Safety

Theme: Safe Services

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

Staff had not received adequate training in the management of behaviour that is challenging including de-escalation techniques and intervention techniques for residents who were presenting with difficult behaviour.

1. Action Required:

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

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

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

Since March 2015, the Service has changed its philosophy of training in the management of behaviour that challenge including de-escalation and intervention techniques to a low arousal, less restrictive approach.

Staff training in the low arousal approach has been ongoing every month since April 2015 and is planned for August 31st, 01st and 02nd of September 2015 and 15, 16th and 17th September. Further training is being planned for October, November and December 2015, dates to be confirmed. Three staff are being trained as Train the Trainers in Studio3 to deliver ongoing training and provide support in the development and implementation of behavioural support plans. Once all staff are trained, one day refresher training will be provided.

Experts in the management of challenging behaviour are onsite each month to review behavioural support plans, and to support staff and Clinical Nurse Managers in implementing the practice of the low arousal approach acquired during training. Additional support is being provided from 17th to 19th August 2015

Proposed Timescale: 31st December 2015

Proposed Timescale: 31/12/2015

Theme: Safe Services

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

The provider had not ensured that all staff had 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.

Behaviour support plans were not in place to provide guidance to staff and promote consistency for residents in relation to interventions taking place in relation to the management of difficult behaviour.

2. 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:

Behaviour support plans have been put in place to provide guidance to staff and promote consistency for residents in relation to interventions taking place in relation to the management of challenging behaviour. These are updated and reviewed with the Clinical Nurse Specialist in Behaviours that challenge and the Keyworker.

Ongoing training on a low arousal approach in the management of behaviours that challenge will provide up to date knowledge and skill to staff.

Psychology project workers are onsite to support staff in the management of challenging behaviours.

Experts in the management of challenging behaviour are onsite each month to review behavioural support plans, and to support staff and Clinical Nurse Managers in the low arousal approach. Additional support is being provided by expert practitioners from 17th to 19th August 2015. This will enhance the knowledge and skills of staff.

Proposed Timescale: 31st December 2015

Proposed Timescale: 31/12/2015

Theme: Safe Services

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

Restrictive practice used for residents were used routinely and the person in charge was not ensuring that restrictive practice were being used for the shortest time necessary.

3. 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:

The service is working on reducing the residents behaviours with the support of experts in the area of behaviours that challenge. Written guidelines are in place for staff in the forms of a current behaviours support plan, risk assessment of the current behaviour of concern, pro active and reactive strategy in relation to reducing the resident's behaviour of concern. There is currently a 1:1 supervision in place during the night time hours for the resident.

This restrictive practice is being addressed and a resolution is being explored as a matter of priority.

Proposed Timescale: 30/09/2015

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 and implement evidence based practice in the management of restrictive practices, particularly relating to the use of significant and highly unusual practices with one resident.

4. 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:

External experts have been invited to review the current sleeping arrangements to provide the least restrictive approach for this resident in line with National Policy and best practice.

To get agreement on the implementation of the recommendations from the above report, which identifies the least restrictive appropriate person centred practice for the resident, mediation has been engaged with. This is expected to conclude with a positive outcome by the end of September, following which the agreed least restrictive approach will be implemented.

This resident has been provided with additional supervision during the night.

The resident has the support of an independent advocate and a Keyworker.

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Training records indicated not all staff had not been trained in relation to safeguarding residents and the prevention, detection and response to abuse.

5. Action Required:

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

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

At the time of the inspection one staff member had been identified as not been trained in the protection of vulnerable adults. On a further review of the records, this person had been trained on 06th March 2015. Centre specific training records are now in place and will be maintained in a timely fashion. The Service has scheduled Safeguarding Training for 24th August for training for any new staff to the Centre 1 and refresher to staff already trained.

Proposed Timescale: 25/08/2015

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:

Ongoing risk to residents was identified due to inconsistent staffing levels and lack of adequate management systems to ensure the safe and appropriate delivery of care to residents.

6. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015. She is currently the PIC, is supernumerary and is contactable out of hours.

Interviews conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July with three external successful candidates identified. These will be additional management posts, with one manager dedicated to Centre 1. This manager will work with current managers in the Centre and provide supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 1 only and report to the Director of Services. This will provide a more robust management and supervision system at Centre level.

Clinical Nurse Manager 2 is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff. Additional Staff being recruited through National Recruitment Service will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times.

Assessment of Need is to be carried out by an independent organisation as a result of the ongoing service review to identify the needs of the residents. These assessments will be used to allocate staff and skill mix within a roster for the residents in an evidence based manner. In the interim clinical knowledge of the residents needs and internal assessments are being used to allocate staffing levels and skill mix.

Rosters are planned in advance to identify any gaps. These gaps are addressed by allocation of Agency staff. Arrangements have been made for the Agency staff allocated to the Service to be consistent. A recruitment process to replace agency staff with directly employed staff is underway.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

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

There were ineffective arrangements in place to support, supervise and performance manage all members of the workforce due to poor management levels at set times of the week.

7. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

Effective arrangements to supervise and manage the workforce are being developed. This includes the appointment of a dedicated Director of Services and has taken up position from 13th July 2015. This is further enhanced by the appointment of a Clinical Nurse Manager, 3 to Centre 1.

Interviews were conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July. An external candidate has been successful and will be an additional management post, dedicated to Centre 1. This manager will work with current managers in the Centre and provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 1 only. Two Clinical Nurse Manager 2 a CNM1 under the guidance of the Director of Services with the support of Assistant Programme Director currently provide support to staff to deliver safe services.

The CNM2 is only included in the roster, following a risk assessment when staffing levels are low in order to provide safe staffing. The recruitment of additional staff will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times.

As part of the roster the CNM 2 will continue to provide a level of supervision to staff.

A training needs analysis for staff has been conducted. Once the information is collated the training requirements for staff will be identified and the relevant training will be sourced.

Proposed Timescale: 31/10/2015

Theme: Leadership, Governance and Management

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

Management structures in the designated centre were not adequate, particularly at weekends. The clinical nurse manger assigned responsibility for the centre was working as part of the rota, assigned to a specific unit within the centre and could not be accountable for the service provision throughout the centre.

8. Action Required:

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

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

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015. Currently the CNM2's report to the Director of Services and they have monthly meetings. Clinical Nurse Manager 2 currently provides the governance in Centre 1 and is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff. The recruitment of additional staff will ameliorate the aforementioned risk and allow the CNM2's to be supernumerary.

The Clinical Nurse Managers are currently engaged in a Leadership and Development training programme to enhance their skills specific to their role and responsibilities.

The management structure will be enhanced with the appointment of a CNM3 specifically for Centre 1. Interviews were conducted by external experts on 23rd and 24th July. An external candidate has been successful and will be appointed as an additional management post, dedicated to Centre 1. This manager will work with current managers in the Centre and provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 1 only.

Proposed Timescale: 31/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Residents were not receiving continuity of care due to an over reliance upon agency staff and inconsistency in staffing arrangements.

9. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Rosters are planned in advance to identify any gaps. These gaps are addressed by allocation of Agency staff. Arrangements have been made for the Agency staff allocated to the Service to be consistent. These dedicated agency staff undergo training within the Service. Agency staff are allocated to work with permanent staff to ensure continuity of care. Staff are also providing flexibility within the roster to ensure consistency by working additional hours and cross covering roster days.

In an effort to reduce the reliance on agency staff, National Recruitment Service are conducting interviews for nurses in particular for Aras Attracta on 03rd August 2015. National approval has been granted to recruit 33 WTE Care Assistants into the service to further reduce reliance on Agency and provide consistency of care. This recruitment process is underway.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

The staff rota did not contain the required information. Twilight staff were not listed. In addition, the common practice of moving staff between the three designated centres within the campus was not been appropriately recorded and reflected within the staff rota(s).

10. 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:

Since the Inspection, all rosters have been reviewed. All staff and the shifts they are working are identified on the roster. In addition, their locations of work are identified on the roster. The policy on Roster Guidelines has been redrafted and has been sent for peer review.

Proposed Timescale: Complete

Proposed Timescale: 22/03/2016

Theme: Responsive Workforce

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

Staff were not provided with access to appropriate training in relation to the challenging behaviour programmes assessed as required for all staff.

11. 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:

The service has changed its approach to the management of challenging behaviours and is retraining staff in a less restrictive low arousal approach in the management of challenging behaviour.

Staff training in the low arousal approach has been ongoing every month since April 2015 and is planned for August 31st, 01st and 02nd of September 2015 and 15, 16th and 17th September. Further training is being planned for October, November and December 2015, dates to be confirmed. Three staff are being trained as Train the Trainers in Studio3 to deliver ongoing training and provide support in the development and implementation of behavioural support plans. Once all staff are trained, one day refresher training will be provided.

Practitioners are providing onsite support to Clinical Nurse Specialist in Behaviours that Challenge in the management of challenging behaviour. Additional Support is being provided in the month of August.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

Staff were inadequately supervised and supported at weekends as the clinical nurse manger assigned management responsibility was not supernumerary and was based in one unit throughout most of the weekend.

12. Action Required:

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

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

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015.

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015. She is currently the PIC, is supernumerary and contactable at all times.

Currently the CNM2's report to the Director of Services and they have monthly meetings. Clinical Nurse Manager 2 currently provides the governance in Centre 1 and is supported by a Clinical Nurse Manager 1 and is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff. The recruitment of additional staff will ameliorate the aforementioned risk and allow the CNM2's to be supernumerary. A suitably qualified staff nurse works with care staff and provides them with appropriate direction and supervision.

The management structure will be enhanced with the appointment of a CNM3 specifically for Centre 1. Interviews were conducted by external experts on 23rd and 24th July. An external candidate has been successful and will be appointed as an additional management post, dedicated to Centre 1. This manager will work with

current managers in the Centre and provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 1 only and report to the Director of Services.

Proposed Timescale: 30/11/2015