

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cluain Fhionnain
Centre ID:	OSV-0003361
Centre county:	Kerry
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Lucia Power
Lead inspector:	Mary Moore
Support inspector(s):	Geraldine Ryan
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	9

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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 16 December 2016 10:00 To: 16 December 2016 17:30

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was the seventh inspection of this service by the Health Information and Quality Authority (HIQA). The first inspection was undertaken in June 2014, four inspections were carried out in 2015 and two in 2016. From the first inspection HIQA was made aware of the provider's intention to close this centre and transition the residents to supported living in the community.

Over the course of inspections, inspectors found a model of care that was institutionalised and had an unreasonable level of restrictions placed on residents. There was significant non-compliance with regulatory requirements and the provider failed to expedite the transition of residents to community living. No resident had transitioned from the service since December 2015. Areas of repeat serious failings included the safeguarding of residents, governance and management and suitable staffing.

On foot of these poor inspection findings regulatory escalation actions taken by HIQA included the issuing of immediate action plans, provider meetings and the provider was issued with an improvement notice. On the 25 October 2016 the provider was issued with notice that the Chief Inspector proposed to refuse and cancel the registration of this designated centre. In accordance with Section 54 of the Health Act 2007 the provider submitted written representation to the notice of proposal to refuse and cancel registration.

This inspection was undertaken to follow-up on what action(s) the provider had taken to address core failings as committed to in the provider's response to the last action plan and in the representation received.

How we gathered our evidence:

Prior to the inspection inspectors reviewed the information held by HIQA; this included the previous inspection findings, the actions to be taken by the provider to address the identified failings, and notifications submitted to HIQA since the last inspection.

The inspection was facilitated predominantly by the person in charge; the nominated person on behalf of the provider was also present. Inspectors spent time in the morning and in the afternoon on one of the two units in which residents lived. Inspectors met with staff and five of the residents living in this unit and reviewed and discussed with staff, records and practice pertinent to the areas under review.

Description of the service:

This centre was set up in 2001 to accommodate residents from a large local mental health facility; residents had a prolonged history of institutionalised living.

The centre comprised of three separate single storey buildings on a green-field site a short commute from the busy local town. Residents were living in two of these buildings; the buildings were separated from each other by a grassed area.

At the time of this inspection there were 21 residents living in the centre; nine in one unit and 12 in the other. There were 20 residents in the centre on the day of inspection as one resident was temporarily absent and receiving care in another facility.

In 2013 the provider commissioned an external provider to work on site with residents and staff on the process of transition to community living; this transition team remained on site.

Overall Findings;

On this inspection inspectors found there was a definitive lack of input and support from the wider organisational and governance structures so as to robustly address the identified failings, and effectively implement the actions identified as necessary to address these failings in the provider's response to the action plan.

The actions as specified by the provider in their response to the August 2016 action plan to address the high level of restrictive practice were not implemented. This lack of action was compounded by the provider failure to adequately and appropriately assess risk to support the safe reduction of a restrictive practice and thereby ensure the safety of residents. This resulted in an immediate action being issued during the inspection where the provider was required to take both immediate action and to provide a formal response to the immediate action plan within two working days. A protocol for the management of the reduction in the restrictive practice was put in place by the person in charge prior to the departure of the inspectors from the centre.

Staffing arrangements were not planned and utilised so as to meet residents' needs, maximise their potential or ensure they were supervised at all times including residents in the secure units.

There were ongoing significant deficits in staff attendance at required and mandatory training.

Deficits were identified in safeguarding measures to prevent or reduce the risk of abuse occurring. These concerning deficits included; staff requiring safeguarding training, staff safeguarding knowledge, an absence of and inadequate timely review of behaviour support plans, poor physical environment and staff training deficits in positive behavioural supports.

Inconsistent staffing, the lack of multi-disciplinary input and oversight of decision making, poor recognition and promotion of residents' rights and the providers failure to expedite the transition plan in a timely manner were also identified as deficits.

Of the five Outcomes followed up on by inspectors the provider was judged to be in ongoing major non-compliance with four and in moderate non compliance with one.

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 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Robust and safe systems for the identification, assessment and management of risks were not in place.

The provider's response to the last action plan stated that review of both the risk management policy and practice with the risk and patient safety advisor would be completed. Inspectors were told that a desk-top review of the risk register had been completed by the risk and patient safety advisor but there was no review or planned input in practice. The review of risk assessments including resident specific risk assessments was completed by the person in charge and/or frontline staff.

The general tone of records seen in relation to proposed changes and any reduction in restrictive practices was problem focussed and risk averse. For example, there was articulated doubt and uncertainty as to who was responsible for any evolving or perceived increased risks with the reduction of restrictions. There was recorded evidence of "opposing" views of residents' needs, of required controls including restrictive practices and the most appropriate placement of residents within the centre. One record seen by inspectors stated that there was a potential problem with the "validity" of a risk assessment and the resulting restrictive practice.

In this context and in the context of ongoing articulated concerns from staff (clearly recorded) of residents' absconding from the centre it was of serious concern to inspectors that a decision had been taken and implemented to unlock, for a period of time, one secure unit without a supporting assessment of risk. There was neither a collective assessment of risk nor a reassessment of resident specific risk so as to safely and positively support the reduction in restriction; staff spoken with and the person in charge confirmed this.

Staff spoken with were aware of the increased risk and of the requirement for enhanced staff vigilance and supervision when the door was open; required risk reducing controls

were not however explicitly identified and stated.

The provider was issued with an immediate action plan identifying the provider's failure to adequately and appropriately assess risk to support the safe reduction of a restrictive practice and thereby ensure the safety of residents. The provider was required to take both immediate action and to provide a formal response to the immediate action plan within two working days.

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:

The actions identified as necessary by the provider, in the response to the August 2016 action plan, to address the high level of restrictive practice evidenced were not implemented. Restrictive practices had not been substantively reduced in the intervening period, that is, between August and December 2016.

Inspectors were advised that a decision had been taken to grant access to the kitchenette to four residents on one unit but that this was not yet implemented and, the door of one of the secure units was unlocked for a period of time daily. There was evidence that relocation of residents within the centre itself in preparation for transition to the community and to reduce the high level of restrictive practice had been considered by staff, their representative bodies and local management

Agreement of proposed moves had been reached in the days prior to this inspection. However, these discussions and proposals emanated from staff discussions rather than from an inclusive, multi-disciplinary team based approach to assessment and decision making. This approach was of concern to inspectors given the inconsistency noted in clinical records and assessments at the time of the last inspection.

The providers response to the previous action plan had stated that a full review of

restrictive practices would be undertaken by the restrictive practice committee and that in relation to chemical restraint the psychiatrist would be asked to review all these measures and make recommendations. Inspectors were informed that there had been no individualised review of behaviours and restrictive measures by the restrictive practice committee as committed to in the providers response to the action plan. This was confirmed by the review of the minutes of the meeting of this committee dated October 2016.

Inspectors were told that there had been no prescriber review of medicines used as an adjunct to the management of behaviours that challenged or posed risk since the last inspection. These medicines included psychotropic medicines and other medicines being used for the management of behaviours that challenge; these medicines blocked the effect of hormones. The person in charge in consultation with nursing staff had in November 2016 completed pharmacological restrictive intervention procedure plans that were intended to inform prescribing reviews. The internal provider audit completed in October 2016 had identified "concerns" in relation to the "levels" of medicines in use and recommended comprehensive individualised medicines assessments; these had not been completed.

The deficit of therapeutic behaviour support plans had not been addressed. Inspectors were told that all of the current residents required such a plan but only nine of the 21 residents had a behaviour support plan. The inspectors saw that residents identified as not having a plan had a clear requirement for such a plan and included residents accommodated on a secure unit and residents in receipt of the medicines cited above.

While education and training in the management (therapeutic and reactive) of behaviours of concern and risk was scheduled, there were ongoing concerning deficits in the numbers of staff who required this training; 55% were identified to inspectors as requiring training.

Residents were not protected at all times from all forms of harm and abuse. While there was evidence that alleged, reported or suspected abuse was investigated there was evidence of deficits in safeguarding measures to prevent or reduce the risk of abuse occurring.

These concerning deficits included; staff safeguarding training deficits, staff safeguarding knowledge deficits, an absence of and inadequate timely review of behaviour support plans, poor physical environment, staff training deficits in positive behavioural support, inconsistent staffing, the lack of multi-disciplinary input and oversight of decision making, poor recognition and promotion of residents' rights and the failure to expedite the transition plan in a timely manner.

Records submitted to HIQA and records seen on inspection confirmed that all staff did not have adequate knowledge of what constituted abuse or adequate knowledge of the importance of the implementation of positive behaviour support plans and appropriate interventions in response to behaviours of concern.

There was also evidence of safeguarding measures that were not outlined in the centre specific safeguarding policy: at the time of inspection it was not demonstrated how

these measures promoted and protected residents rights. These measures included the request for intervention from legal authorities in response to behaviours that challenged and posed risk to other residents and to staff.

There was no evidence of the formal multi-disciplinary assessment of resident capacity, of the precise purpose of this intervention or the resident's right to representation particularly where the rationale of a possible criminal offence by the resident was provided to inspectors for the intervention.

The provider had failed to provide all the required therapeutic support to the resident. It was clearly recorded that the escalation in behaviours that challenge and posed risk were "as a result of the length of time" it was taking to "transition" the resident to their preferred living arrangement. Inspectors were advised that while there was a behaviour support plan in place it required updating, and, given the inconsistency in staffing, assurance could not be provided to inspectors that the plan was implemented consistently by all staff so as to reduce the risk of the escalation of behaviours.

A safeguarding plan seen by inspectors required a resident to be interviewed on three separate occasions in response to allegations they made so as to substantiate or not these allegations. Staff spoken with were not aware of, said they had not seen this plan/process and said that they would not like to do anything that would "pressurise" the resident in response to any allegations made.

This process of triple interviewing was of concern to inspectors in the context of the resident's disability and understanding, the lack of multi-disciplinary input and oversight of the plan, the identified deficits and failings in staff training in and understanding of safeguarding, and the questions to be asked, for example "are you telling the truth".

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

No action emanated from the last inspection however, inspectors reviewed healthcare needs and supports as relevant to a prescribed medicine that action of which was to block hormones and whose administration required specific healthcare monitoring.

There was evidence of some of the required interventions such as regular blood-profiling, physical examination and monitoring of body weight. However, it was unclear if these interventions were in place as general good practice or because of their direct relevance to the prescribed medicine and its side effects. Inspectors noted there was no specific health care plan in place that addressed all of the possible negative side-effects. For example, the possible impact on bone density; the health monitoring interventions that were in place were inconsistently implemented (based on the records seen).

Judgment:

Non Compliant - Moderate

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:

These inspection findings supported a definitive lack of input and support from the wider organisational and governance structures so as to robustly address identified concerning failings and effectively implement the actions identified as necessary to address these failings by the provider in the provider's response to the action plan.

The person in charge confirmed that since the last inspection there had been only one meeting (on the 29 October 2016) of the multi-disciplinary restrictive practice committee. The provider nominee confirmed that due to poor attendance it had been possible to only convene one meeting of the multi-disciplinary management governance group since the last inspection. This meeting had not taken place until the 13 December 2016; three persons attended. Yet it was clearly recorded that the support and approval of the latter group was required to endorse the work of the restrictive practice committee.

It was evident throughout this inspection that the person in charge, with the support available from the provider nominee, took responsibility for the governance of the centre and the implementation of the action plan. This included communicating with staff, negotiating with staff and their representative bodies, liaising with the transition team and other relevant stakeholders such as clinicians, reviewing risk assessments and

restrictive practices and investigating any alleged, reported or suspected abuse. This was evident from speaking with the person in charge and the provider nominee and from records seen including the monitoring plan for the implementation of the HIQA action plan.

While the intent of the person in charge was clear; to effect the required change and positive outcomes for residents, there was little evidence of input and support from the broader governance structures so as to support team based decision making, promote the required change and thereby promote the quality and safety of the care and services provided to residents.

This was compounded further by the local management structure as neither the person in charge or the provider nominee had a line management function or authority for staff working in the centre.

Reviews of the quality and safety of care and services provided to residents, including HIQA inspections, did not result in change and improvement. In line with the requirements of Regulation 23 the nominated provider had undertaken a review in one of the units in October 2016. The report of this review was available to inspectors and the nominated provider confirmed that the review findings demonstrated little change or improvement on the HIQA findings of August 2016.

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 actions outlined in the provider's response to the action plan had not been implemented with effect. Inspectors were not satisfied that staffing arrangements were planned and utilised so as to meet residents' needs or maximise their potential.

The person in charge again confirmed that the staff rota was not completed locally but was completed and finalised centrally within the mental health service. Any vacant shifts

were filled from a central bank of overtime staff; some of these staff were staff employed in the centre but staff from the local mental health service catchment area were also utilised on a regular basis. There was ongoing significant reliance on both overtime and relief staff from this pool of staff.

The person in charge told inspectors that meetings had been convened in relation to the arrangements in place for the staffing of the centre and that at these meetings she had requested consistency in the staff deployed to work in the centre. The person in charge clearly understood that this consistency was required for residents particularly in relation to appropriately supporting behaviours of concern.

The person in charge told inspectors that the requested consistency was not provided and that she had no control over this. The person in charge was monitoring the level of inconsistency on a weekly basis; for example six different relief staff covered eleven vacant shifts week commencing the 12 December 2016.

While the numbers of staff on duty appeared to give an adequate staff to resident ratio, (there were five nursing staff on duty to support and supervise 12 residents), inspectors saw that given the support needs of residents and the layout of the building residents did not have access to staff at all times and were not supervised at all times by staff. For example, inspectors saw that residents were unsupervised on one secure unit while a staff attended to the personal care needs of another resident; one resident was observed to be left on another secure unit without a staffing presence.

While there was evidence of action taken, that is, all staff had been formally communicated with and training was scheduled, there were ongoing concerning deficits in staff attendance at mandatory training. The person in charge told inspectors that only a minority of staff (five of approximately 19) who worked in the centre on an overtime/relief basis had provided details to the centre of the training completed by them as requested by the provider.

The person in charge had completed an analysis of the training completed by staff assigned on a permanent basis to the centre. Based on this analysis 55% of these staff required training in the professional management of aggression and violence (PMAV), 55% required training in positive behaviour support, 19% required fire-safety training and 45% required updated training in safeguarding (the figures provided to inspectors indicated that 15% of staff had no safeguarding training).

While training in safeguarding, positive behaviour support and autism was scheduled, some but not all required staff were reported to have indicated their intention to attend. The person in charge said that the provider was also limited in its capacity to release staff to attend training while maintaining staffing levels.

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:

Mary Moore
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-0003361
Date of Inspection:	16 December 2016
Date of response:	28 February 2017

Requirements

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

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

Outcome 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 provider failed to adequately and appropriately assess risk to support the safe reduction of a restrictive practice and thereby ensure the safety of residents.

1. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated

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

centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Response to Immediate Action Plan; The provider has carried out a risk assessment to implement the reduction of a restrictive practice in Unit 6 which will support the opening of the closed unit for one hour per day pending a review in four weeks. Individual assessments have been carried out to implement the reduction of the restriction. Implemented 20 December 2016.

- The movement of residents to reduce restrictive practices was discussed at the Restrictive Practice committee meeting on the 1st of February 2017. It was agreed by the committee that it would not be appropriate to move residents now as it would involve two moves in a short space of time and would be unsettling for the residents as they will be moving over to one unit following the transition of 8 residents between March and May.
- The move will reduce restrictive practices where some residents will now be supported in an open unit. The supports required to ensure the safety of the residents will need to be discussed and agreed by the Multi-Disciplinary Management Team.
- The required supports will need to be agreed with the Restrictive Practice committee and endorsed by the Governance Management Group.
- In preparation for this move the CHO4 HSE Patient Safety Advisor will commence reviews of the current Restrictive Practice documentation in conjunction with the Risk Assessment in place with the PIC, Key Worker, A/CNM11. The individual reviews will commence on the 23rd of February 2017. These reviews will inform the supports required to ensure safety.
- Remedial work to the units to support the move will be discussed and agreed with the maintenance manager to determine time lines for completion of works required.

Proposed Timescale: 28/04/2017

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:

55% of staff required training in the professional management of aggression and violence (PMAV), 55% required training in positive behaviour support.

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:

- 63% of nursing staff have now completed the training in positive behaviour support with an external facilitator. We are awaiting further dates for training from that facilitator.
- The PIC has liaised with the Practice Development Co-ordinator who is in the process of organising training in PMAV. She will revert back to the PIC with dates.
- Once dates and times have been finalised letters will be issued to all staff to attend this mandatory training. This provision and offer of training will continue while nursing staff remain in Cluain Fhionnain to ensure that residents received the appropriate care.
- Social care model –Phase 2 of the closure plan will introduce a social care model of care into the new setting in Archview. This will mean the replacement of Nursing Staff with a skills mix of Social Care staff appropriate to the remaining residents needs. All of the Social Care staff will have the required mandatory training and security checks prior to commencement with the service.
- Two nursing staff will remain to provide clinical governance with medication administration and to support the transition of daily operations. The nursing staff that remain will be required to have all of the mandatory training completed prior to being engaged in this new role.

Proposed Timescale: 01/06/2017

Theme: Safe Services

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

The deficit of therapeutic behaviour support plans had not been addressed. Only nine of the 21 residents had a behaviour support plan; residents identified as not having a plan had a clear requirement for such a plan and included residents accommodated on a secure unit and residents in receipt of medicines reportedly used to manage behaviours.

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 use of specific medicines was reviewed by the Restrictive Practice Committee on the 1st of February 2017. The consultant who is a member of the committee has completed extensive research in this area and there are conflicting findings in the medical journals as to whether the use of this medicine is a restrictive practice or used

to treat an underlying condition, the consultant psychiatrist is still reviewing this. Clinical alterations have however been made and will be monitored by nursing staff.

A referral has also been sent to an external facilitator to assist in the development of a Behavioural Support Plan to manage behaviours that challenge which did previously present.

- The Behavioural Support Plan will be utilised in both the 24hr and day service settings to ensure consistency in approach.
- The consultant psychiatrist has sourced a detailed care plan template which will be completed with staff and put in place for residents.
- The restrictive practice committee will continue to review with the consultant psychiatrist on a monthly basis. Complete and Ongoing.

Proposed Timescale: 27/02/2017

Theme: Safe Services

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

There was insufficient evidence to support an inclusive, multi-disciplinary team based approach to assessment and decision making. There had been no individualised review of behaviours and the restrictive measures in place by the restrictive practice committee as committed to in the providers response to the action plan including the review of medicines used to manage behaviours. These medicines included psychotropic medicines and other medicines being used for the management of behaviours that challenge; these medicines blocked the effect of hormones.

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:

An external resource was commissioned by the transition team provider to complete a Psychological Needs Assessment and Treatment Report for each resident in Cluain Fhionnain. Each resident was assessed psychologically in order to identify what their specific developmental presentation is and the supports which will be required to help facilitate community transition as well as support their on-going care under the supervision of the transition team. Additionally, specific behaviour support plans (BSP) were documented for utilisation by the community care team.

- Both care groups (the transition team and Nursing staff) have reviewed and discussed the BSPs for each resident and because they can be generalised across all settings we have introduced them into the day service and twenty four hour setting.

- For those residents who have already got BSPs we will continue with the more current plans.
- Staff have been asked to familiarise themselves with the BSPs and a review will take place in relation to implement of the BSPs as at this point in time there is a gap in relation to the utilisation of the plans. To effect this we are looking at a resource to assist with this implementation
- The roll out of the Positive Behavioural Support Plan training for all staff will continue.
- In June we will audit and review the BSPs for the remaining residents as eight persons will have transitioned to their new home by the end of May. As we are reducing restrictive practices by moving the remaining residents to the open unit this will need to be incorporated into their BSPs to ensure that any change in behaviours as a result of the move are managed in a positive way. 31st July and for review.

Proposed Timescale: 31/07/2017

Theme: Safe Services

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

Figures provided and records seen indicated that there were deficits in both staff attendance at training and in staff knowledge of safeguarding and what constituted 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:

- Safeguarding -There are deficits in attendance at training by staff in the Vulnerable Adult policy awareness programme. There are two further training sessions planned for the 24th of February and the 28th of April 2017. To attempt to address the deficits two further training dates will be offered the 28th of March and the 9th of May 2017
- Risk Assessment - The CHO4 HSE Patient Safety Advisor will review the current Restrictive Practice documentation in conjunction with the Risk Assessment in place with the PIC, Key Worker and A/CNM11. The individual reviews will commence on the 23rd of February 2017.
- Poor Physical Environment- This will be addressed when residents move over to one unit following the transition of 8 residents.
- The lack of multi-disciplinary input and oversight of decision making –scheduled meetings for the year have been put in place for Management Governance Group and the Restrictive Practice Committee. On going

- Review Multi D- A Multi-Disciplinary team will be put in place which will comprise of the PIC, ACNMIIIs in each unit, Key Worker and staff on duty on the day and a member of the Transition team if available. (Outcomes will be brought up for discussion with the consultant at the Restrictive Practice committee meetings or as need arises on her weekly visit as she does not have capacity to attend and we no longer have support from psychology). Once the new social care team are in place they will be included on the Multi-Disciplinary Team. This will commence 2 March 2017
- Poor recognition and promotion of resident's rights – We acknowledge that the delay in expediting the transition plan to move residents to community housing. Phase one will transition 8 residents by the end of May 2017. Phase Two is currently under discussion and a plan will be submitted to HIQA by 27th of February 2017.

Proposed Timescale: 30/06/2017

Theme: Safe Services

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

There were concerning deficits in safeguarding measures to prevent or reduce the risk of abuse occurring. These concerning deficits included; staff safeguarding training deficits, staff safeguarding knowledge deficits, an absence of behaviour support plans, poor physical environment, staff training deficits in positive behavioural support, inconsistent staffing, the lack of multi-disciplinary input and oversight of decision making, poor recognition and promotion of resident's rights and the failure to expedite the transition plan in a timely manner.

6. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

- There are deficits in attendance at training by staff in the Vulnerable Adult policy awareness programme. There are two further training sessions planned for the 24th of February and the 28th of April 2017. To attempt to address the deficits two further training dates will be offered the 28th of March and the 9th of May 2017.
- For those residents who did not have active BSPs in place at the time of the monitoring inspection the plans compiled by an external party have been introduced to support daily care following discussion with both staff groups.
- Staff have been asked to familiarise themselves with the BSPs and a review will take place in relation to implement of the BSPs as at this point in time there is a gap in relation to the utilisation of the plans in practice. To support this implementation we are currently reviewing additional support in this area.
- The roll out of the Positive Behavioural Support Plan training for all staff will continue.

- The poor physical environment will be addressed when the eight residents' move out and the remaining thirteen residents move over to Archview
- In June we will review the BSPs for the remaining residents in the context of the reduction in restrictive practices achieved when the remaining residents move to the open unit as this will need to be incorporated into their BSPs to ensure that any change in behaviours as a result of the move are managed in a positive way.
- This review will be done in conjunction with the new social care team. This will not only provide structure to induction to the BSPs for each resident for the new staff team but should provide a forum which will enable impartial discussion on how best to implement the BSPs and inform change and improvements.
- A Multi-Disciplinary team will be put in place to comprise of the PIC, ACNMII's in each unit, Key Worker and staff on duty on the day and a member of the Transition team if available. (Outcomes will be brought up for discussion with the consultant at the Restrictive Practice committee meetings or as need arises on her weekly visit as she does not have capacity to attend and we no longer have support from psychology). Once the new social care team are in place they will be included on the Multi-Disciplinary Team.
- Following the completion of the Restrictive Practice reviews and Risk Assessments with the Patient Safety Advisor, Multi-Disciplinary team meeting will take place with the staff on each unit to discuss the supports identified as required for each resident to move, how the move can be effected to ensure the least disruption for each resident and any other safety issues outside of the move which need to be addressed. Operational issues will also form part of the agenda. This will take place on a weekly basis or as need arises. MDTM will begin 2 March 2017.

Proposed Timescale: 30/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was no specific health care plan in place that addressed all of the possible negative side-effects; health monitoring interventions were inconsistently implemented (based on the records seen).

7. Action Required:

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

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

- Since the last inspection staff have commenced a specific care plan with the

consultant psychiatrist which will address all of the negative side effects of this specific medication and the consultant has sourced a template to reflect same which she will complete with staff.

- All residents have yearly physical reviews, bloods are monitored six monthly and those on specific medication have blood monitoring more frequently as recommended. All residents are seen by the GP (who attends daily) and reviewed as required with appropriate diagnostic tests completed as and when required. These reviews are undertaken as part of general good practice. There is record book in place to capture when the above was completed and next due which is detailed and current.
- Health Care plans are currently being developed to include medication management plans for all residents. These will include details of when the medications were last reviewed by the Consultant. Protocols for the administration of PRN medication have been put place.

Proposed Timescale: 30/04/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Reviews of the quality and safety of care and services provided to residents including HIQA inspections did not result in change and improvement.

8. Action Required:

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

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

- Under Regulation 23 two unannounced inspections were carried out in 2016. The yearly inspection will be completed by an external inspector to include a written report on the safety and quality of care provided in the centre and from that a plan will be put in place to address any concerns regarding the standard of care and support.

Proposed Timescale: 31/07/2017

Theme: Leadership, Governance and Management

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

There was little evidence of input and support from the broader governance structures

so as to support team based decision making, promote the required change and thereby promote the quality and safety of the care and services provided to residents.

9. 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 lack of multi-disciplinary input and oversight of decision making –scheduled meetings for the year have been put in place for Management Governance Group and the Restrictive Practice Committee.
- The Terms of Reference for the Management Governance Group are currently under review.
- A Multi-Disciplinary team will be put in place to comprise of the PIC, ACNMIs in each unit, Key Worker and staff on duty on the day and a member of the Transition team if available. (Outcomes will be brought up for discussion with the consultant at the Restrictive Practice committee meetings or as need arises on her weekly visit as she does not have capacity to attend and we no longer have support from psychology). Once the new social care team are in place they will be included on the Multi-Disciplinary Team.
- Following the completion of the Restrictive Practice reviews and Risk Assessments with the Patient Safety Advisor, Multi-Disciplinary team meetings will take place with the staff on each unit to discuss the supports identified as required for each resident to move, how the move can be effected to ensure the least disruption for each resident and any other safety issues outside of the move which need to be addressed. Operational issues will also form part of the agenda. This will take place on a weekly basis or as need arises.

Proposed Timescale: 31/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing arrangements were not planned and utilised so as to meet residents' needs or maximise their potential. Residents were seen to not be supervised by staff at all times; one resident was left on a secure unit without a staff present.

There was on going reliance on relief and overtime arrangements. Consistency of staffing had not been facilitated.

10. 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:

- Staffing arrangements will be looked at and utilised so as to meet residents' needs and maximise their potential. This is form part of the phase 1 and 2 process as outlined in the documents submitted.

Proposed Timescale: 05/06/2017

Theme: Responsive Workforce

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

There were ongoing concerns concerning deficits in staff attendance at mandatory training. Records seen indicated that 55% of staff required training in the professional management of aggression and violence (PMAV), 55% required training in positive behaviour support, 19% required fire-safety training and 45% required updated training in safeguarding (the figures provided to inspectors indicated that 15% of staff had no safeguarding training).

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:

- Safeguarding -There are deficits in attendance at training by staff in the Vulnerable Adult policy awareness programme. There are two further training sessions planned for the 24th of February and the 28th of April 2017. To attempt to address the deficits two further training dates will be offered the 28th of March and the 9th of May 2017
- 63% of staff have now completed the training in positive behaviour support with an external facilitator. Ten staff assigned to the Unit (5 had already completed the training in 2014). Ten staff assigned to the Unit (5 had already completed the training in 2014), 2 support staff and 3 staff who work in the unit to cover relief attended the training. We are awaiting further dates for training the external facilitator.
- The PIC has liaised with the Practice Development Co-ordinator who is in the process of organising training in PMAV. The PDC will revert back to the PIC with dates. Once dates and times have been finalised letters will be issued to all staff to attend this mandatory training.
- The PIC has met with the fire Officer and training dates are currently being finalised.
- Every effort will be made to offer the appropriate training to nursing staff while they remain as the core group of care givers for the residents.

Proposed Timescale: 05/06/2017