Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Centre 3 - Aras Attracta
Centre ID:	OSV-0004911
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;
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
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 16:15	12 July 2015 19:00
13 July 2015 09:45	13 July 2015 11:30

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 3.

This was a triggered inspection following the receipt of a number of notifications submitted to the Health Information and Quality Authority (HIQA) 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 also requested to attend a meeting with HIQA on 29 June 2015 to discuss the three centres. At that meeting, the inspectors were not satisfied that the actions taken by the provider were sufficient to safeguard residents.

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, particularly from peer-to-peer altercations that were resulting in the injury of residents. Subsequent to the meeting the provider was required to submit a schedule of improvement actions to HIQA by Friday 3 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, changing residents' living arrangements and the appointment of additional management staff, but these actions 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.

Overall the findings on the inspection of this centre were that these immediate actions had been implemented and that there were strong governance arrangements in the centre. There was a clinical nurse manger in place that was available to residents and staff and provided strong oversight over the three bungalows comprising this designated centre. The rosters demonstrated there was a clinical nurse manager on duty at all times.

However, concerns in relation to staffing supports were substantiated, specifically in relation to the common practice of moving staff between the three designated centres within the campus which was not being appropriately recorded or reflected within the staff rotas. This meant that the provider could not demonstrate if adequate staffing levels were maintained at all times in the centre, and could not accurately reflect the specific staffing at specific times in the designated centre. Outcome 17; workforce was judged to be moderately non-compliant.

Outcome 8; safeguarding and safety was also found to be moderately non-compliant due to inadequate policies and procedures in relation to safeguarding investigations and staff training requirements.

Outcome 14; governance and management was judged to be complaint, although issues are raised within this outcome which are reflected within the other outcomes inspected against. The findings are discussed in the body of the report and included in the action plan 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. HIQA 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 non-compliances 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:
In general it was found that measures were in place to protect residents from being harmed or suffering abuse in this centre.

There had previously been issues in this centre relating to the safeguarding of residents from the impact of behaviour that challenges. The plan submitted by the provider on 3 July 2015 committed to moving residents to alternative accommodation within the centre due to ongoing peer-to-peer incidents between specific residents. These residents had expressed a desire to be moved from their existing living environment. These moves had since taken place. Inspectors spoke with one of these residents who spoke of their satisfaction with the move and said that they were 'happy now'. The staff and clinical nurse manger in charge reported that these moves had worked out well and that the centre was generally more relaxed, with a calmer atmosphere throughout. Inspectors found this to be the case and observed lots of activity and interaction between residents and staff. Inspectors observed staff members treating residents with warmth and respect.

Staff spoken with were knowledgeable on what constitutes abuse and on the reporting procedures. However, not all staff had completed training in safeguarding and protection. In addition, while positive behaviour support plans were in place, many staff had not been provided with the specialist training identified as required for staff working in the centre.

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:
As referred to within the summary of this report this inspection was triggered due to concerns relating to ineffective governance and management in relation to investigation processes in place following an allegation of abuse. The management of these concerns was explored during this inspection.

In general, inspectors were satisfied that there was adequate governance and management provided in this centre. On both days of the inspection it was found that the clinical nurse manager assigned responsibility for the centre was able to provide appropriate governance or supervision across the centre comprising three separate bungalows. Staff stated they felt supported and the clinical nurse manger stated she could provide adequate supervision of staff assigned to the centre. However, she expressed some frustration with the constant strain on her resources as staff were often moved to different centres with minimal notice. This issue is highlighted and actioned within Outcome 17.

The provider nominee had carried out regular visits to the centre and had produced a report on the quality and safety of care and support provided in the centre. The last such visit had taken place on 5 June 2015 and a copy of this report was made available to the inspectors. It was noted that clear actions had been identified and that the local clinical nurse mangers were overseeing implementation of agreed actions. Staff also stated that the person in charge visited the centre frequently and it was noted that the residents and the person in charge were known to each other when the inspector was walking through the campus with the person in charge.

Judgment:
Compliant

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 inspectors were unable to determine required staffing levels for this centre as there was no assessment of the needs and support requirements of residents with regard to staffing levels. A previous inspection in September 2014 highlighted this issue, and the provider had committed to putting an assessment of need and 'protocol for staff allocation' in place by 29 May 2015. This time-frame was found not to be met on this inspection. The provider referred to bringing in an external group to carry out the assessment of need in August 2015; the tendering process to identify an organisation that will carry out a full needs assessment of the residents has just begun.

Overall it appeared that there were adequate staffing levels to provide the required supports to residents and to provide the safe delivery of services. However, there was a significant reliance upon agency staff members. The staff rota did not identify all staff who had worked in the centre as agency staff and twilight staff were not listed. In addition, the common practice of moving staff between the three designated centres within the campus was not being appropriately recorded and reflected within the staff rotas. The person in charge could not demonstrate if adequate staffing levels were maintained at all times in the centre, and could not clearly demonstrate which staff were in a particular centre at any given time.

Approximately 25% of staff members were not provided with appropriate training in managing behaviour that challenges and inspectors could not be assured that all staff had completed safeguarding training. The training records maintained were poorly managed, for example, some staff listed had retired and were no longer working in the centre and the records were not centre specific.

Staff were adequately supervised and supported as clinical nurse mangers assigned with management responsibility were found to be providing good quality supervision.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004911
Date of Inspection:	12 & 13 July 2015
Date of response:	06 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:
25% of staff working in this centre was not provided with the required up to date training to respond to behaviour that is challenging and to support residents to manage their 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 less restrictive arousal approach.

There has been ongoing training since April 2015.
Staff training 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 the low arousal approach. . Additional support is being provided from 17th to 19th August 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:
Not all staff were trained in the safeguarding and protection of vulnerable adults.

2. 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:
The Service has scheduled Safeguarding Training for 24th August for training for new staff to the Centre and as a refresher to staff already trained. This training will be ongoing.

Proposed Timescale: 25/08/2015

Outcome 17: Workforce

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 include twilight staff. In addition, the common practice of moving staff between the three designated centres within the campus was not being appropriately recorded and reflected within the staff rota(s).

3. 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: 06/08/2015
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. Some staff did not have safeguarding training.

4. 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:
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.

Staff training in the management of challenging behaviour is ongoing 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 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 in the low arousal approach.
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.

The Service has scheduled Safeguarding Training for 24th August for training for new

staff to the Centre and as a refresher to staff already trained. This training will be ongoing.
Proposed Timescale: 31/12/2015