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:	Highwater Lodge
Centre ID:	OSV-0005407
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stepping Stones Residential Care Limited
Provider Nominee:	Steven Wrenn
Lead inspector:	Julie Pryce
Support inspector(s):	Ann-Marie O'Neill
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
03 November 2016 11:00	03 November 2016 22:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
Highwater was registered as a designated centre in May 2016 as a new build prior to any residents moving in. An inspection was conducted in July 2016 in response to information received by HIQA, and on that occasion the inspectors found significant levels of non-compliance with the regulations.

This report relates to an unannounced inspection conducted in response to a notification of serious injury notified to HIQA, and in order to monitor progress towards the agreed actions form the previous inspection. Concerns had been raised at the previous inspection conducted on 19 July 2016 in relation to the mix of residents living together, and the safety of residents in relation to behaviours that challenge. The reported injury to a resident was as a direct result of behaviours of concern.

The notification related to one resident having struck another, causing a head injury. The inspectors were not satisfied with the information submitted, both in relation to the immediate care of the injured resident, and in relation to control measures to ensure the ongoing safety of the resident. Further information was requested, and the document submitted did not address these issues.

How we gathered our evidence:

The inspectors spent time with all the residents in the centre. Inspectors also met with staff members and the person in charge of the centre. Inspectors observed practices and reviewed documentation such as personal plans, risk assessments and accident logs.

Description of the service:

The centre was a large spacious house in a rural setting which was close to the nearest town. The service is available to adult men and women, however inspectors found that the mix of residents at the time of the inspection was not appropriate.

Overall findings:

The provider had not put adequate arrangements in place to safeguard residents. As on the previous inspection, the inspectors found that there was a significant level and frequency of aggressive behaviour which required residents to be moved from their living areas in order to protect them from injury.

The provider had not put in place adequate arrangements to safeguard residents from the risk of fire, and the inspectors issued an immediate action relating to this. Inspectors requested staff to remove various items of risk in relation to fire safety. The person in charge was required to instigate a fire drill, and put in place appropriate measures to ensure the safe evacuation of residents in the event of an emergency. The provider was required to engage the services of an appropriately qualified fire safety professional on the following day to ensure that all risks associated with fire safety were assessed and mitigated.

The use of punishment was prevalent in the designated centre, involving the removal of personal items, restriction of food items and fining of residents. The inspectors issued an immediate action in relation to these practices, and required that they were discontinued immediately.

Inspectors were not satisfied that the provider had put system in place to ensure that the Health Act 2007 (Care and Support of Residents in Designated Centres for People (Children and Adults) with Disabilities) Regulations 2013 were being met. The lack of effective governance and management systems had resulted in poor outcomes for residents in the following areas:

- upholding the rights of residents (outcome 1)
- personal planning (Outcome 5)
- fire safety (Outcome 7)
- the protection of vulnerable adults from abuse (Outcome 8)
- monitoring the quality and safety of care and support (Outcome 14)

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

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

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The rights of residents were not upheld in relation to the application of punishment, and in the terminology used throughout the centre.

There was repeated use of inappropriate terminology throughout the records of residents. For example, there was frequent reference to residents being obliged to 'comply', family visits were described as 'access', and the prescribed consequences for some residents' behaviour was clearly identified as 'punishment'.

There was a section in the care plan for a resident detailing the requirement for them to leave their mobile phone with staff when they went to bed. There was no documented rationale for this other than 'health and safety' reasons. This was initially explained by staff as being in case of the risk of fire while the device was charging. The inspectors later spoke to other staff who gave a rationale for the resident not keeping the phone overnight, however this information was not documented. It was clear from the documentation that the resident did not wish to leave their phone with staff and that there was a punishment applied if they did not hand over their phone.

Residents had very little opportunity for making choices. There were various structures and rules in place, with very little evidence that some of them were in the best interest of residents, and punishment regimes including the removal of personal property and the withholding of edible treats in place throughout the centre.

Residents and staff were sharing bathroom facilities, but there were no privacy locks on the doors of bathrooms or toilets.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Personal plans were in place for residents, however they were poorly organised, not clearly based on the assessed needs of residents and emphasised behaviour modification. For the most part staff who were directly involved in residents' care were not involved in the personal planning process.

Residents' assessments of needs had not been completed comprehensively. There was a template in the personal plans relating to the assessment of residents' needs, but not all sections of this template had been filled in, and where they were filled in the information was for the most part vague or incomplete. For example, yes and no tick boxes had been used in relation to safeguarding and money management for one resident, but no additional information recorded.

This assessment document in one of the resident's personal plans had not been filled in at all. The planning section of this record had been completed, however while various pieces of information were typed onto the form there were also handwritten comments and crossings out, so that it was not possible to ascertain which pieces of information were relevant.

For some of the areas in which residents had been identified as requiring support, there was a 'standard operating procedure' (SOP) in place. These SOPs all included behaviour modification methodology, but there was insufficient evidence of supportive person centred planning. For example, the SOP in relation to supporting residents to take essential medications focused on modification of the behaviour of refusing medication, but did not include any information around positive support or informed decision making.

However, where a section of the personal plan for one of the residents in relation to gaining independence in money management had been devised by direct care staff, this section was person centred, and was developed to meet to the particular needs of the resident. Staff were also supporting a resident to gain functional literacy and numeracy skills.

While there were some goals set for residents they related to the management of support needs or behaviours, and did not include steps towards residents' aspirations or personal goals.

Weekly reviews were recorded in personal plans, and signed by residents. However the last entry for one of the residents was five weeks prior to the inspection.

Personal planning was poorly organised between various files and locations. The inspectors were concerned that disjointed nature of the information would lead to important information or direction being missed.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
There were inadequate structures and processes in place in relation to fire safety, and the inspectors issued an immediate action in relation to this during the inspection. Some improvements had been made in the management of other risks in the centre.

Various aspects of fire safety were insufficient to ensure the safety of residents. Fire safety training involved staff undertaking an e-learning course, and no on-site or practical training had been provided. There were no records of fire drill having taken place. Personal evacuation plans had not been completed for any of the residents. The inspectors requested the person in charge to instigate a fire drill during the course of the inspection. Staff demonstrated during this fire drill that they were unable to evacuate one of the residents.

During the discussion following this drill the person in charge suggested a strategy which could assist with the evacuation of this resident. Inspectors requested that this

strategy be attempted, and this took place successfully.

Additional fire hazards identified by the inspectors included the following: a large volume of lint in the dryer and combustible material stored nearby, candles in residents' and staff bedrooms, poor management of cigarette smoking and extinguishing of cigarettes. There were no fire risk assessments in place to manage and mitigate fire risks.

Due to the high level of risk in relation to fire safety the inspectors issued an immediate action. Staff were requested to remove the items of immediate risk. The provider was required to engage the services of an appropriately qualified professional in fire safety management the following day to conduct a complete audit of fire safety, and to implement any immediate actions identified by this professional. The provider was required to confirm that this had been done by 17.00hrs the day following the inspection. This confirmation was submitted by the person in charge.

The inspectors were concerned that these and other issues related to an overall lack of oversight of fire safety in the designated centre. For example, it had been noted on weekly fire check sheets in June and again in August that the smoke alarm in the living room had to be reset. It was then recorded as a fault in the weekly checks in August and September. This issue was not rectified until 22 October 2016. As further discussed under outcome 14 an audit undertaken by the Quality and Assurance Personnel on 7 September 2016 had recorded that fire drills were conducted in accordance with policy, that records were kept of fire practice and drills, and that all service users were aware of the fire safety systems in operation and could respond to emergencies. This information was inconsistent with the findings of the inspectors.

Some improvements had been made in the system of risk assessments in the designated centre since the previous inspection. The person in charge had prioritised identified risks for service users, and had commenced the development of risk assessments and management plans. Those reviewed by the inspectors contained all the information required. The inspectors requested that the risk management policy be submitted to HIQA on the day following the inspection which was 4 November 2016. It was submitted on 7 November 2106.

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:
While there were documents relating to behaviour support in place for residents, there was an emphasis on behaviour modification techniques including punishment. Various documents presented a significant risk of abuse to residents and inspectors issued an immediate action in relation to this during the inspection.

As with other documentation in the personal plans, documents providing guidance for staff in the management of behaviours of concern were titled 'standard operating procedures' (SOPs) for the most part. They included significant use of behaviour modification and applied behaviour analysis jargon, but did not give clear guidance to staff as to their practice. The use of punishment was evident throughout, and was identified in the documents as such. For example a phrase in one of the guidance documents was 'These procedures all incorporate a component of punishment'.

The inspectors issued an immediate action in relation to the use of punishment, the practice of personal examinations of residents and the inappropriate guidance in the use of food items in relation to behaviour.

There was a standard operating procedure in place to ensure that the resident who was required to hand over their mobile phone to staff complied with this requirement. The documentation outlined the procedure staff were to follow to ensure compliance, and also guided staff in the punishment that was to be applied the following day if the resident did not comply.

Guidance for staff in relation to behaviours which might result in the damage of items was that the resident involved was to pay for the item, and that the staff on duty were to apply this charge immediately.

The provider was required to immediately ensure that all staff were informed that punishment was no longer to be used in the designated centre. A review of all personal plans was required by the close of business the day following the inspection to ensure that all reference to punishment was removed.

There were two standard operating procedures in place providing guidance to staff as to how to conduct personal examinations of a resident of the type which should only be conducted by an appropriate healthcare professional for the purpose of health assessment. There was no rational documented for this practice. Staff reported that the resident requested these examinations, but this issue had not been addressed in any of the guidance in the management of behaviours of concern.

The provider was required to ensure that the practice of inappropriate personal examinations was to stop immediately, and all documentation guiding staff to conduct such examinations was to be removed the following day.

Some of the guidance in relation to the management of behaviours of concern and in relation to ensuring compliance with activities of daily living included the withholding of snacks and treats, and as further discussed under outcome 11, extensive nutritional guidance in place had not been developed by an appropriate healthcare professional.

The provider was required to ensure that all reference to the use of withholding snacks as a punishment was to be removed, and all guidance relating to nutrition which had not been developed by an appropriate professional was to be removed by the close of business the following day.

Confirmation that these immediate actions had been implemented was submitted by the person in charge within the required timeframe.

Improvements were required in the training in relation to the management of behaviours of concern. Some staff had only received one day of training which included restrictive interventions.

Prior to the inspection a notification had been submitted to HIQA in relation to a physical assault of one resident on another, which had resulted in a head injury. The information included in the notification was insufficient, and further information was requested. An additional document was submitted, but again there was insufficient information to ensure the safeguarding of the residents.

The following information was requested:

Additional interventions put in place following the incident, given that the strategies at the time did not safeguard the resident;
Any review that has taken place of the living arrangements in relation to the suitability of the mix of residents;
Policies or procedures relating to the management of head trauma.

None of this information was submitted at the time it was requested, and was not presented to the inspectors during the course of the inspection. Documentation relating to the management of this type of incident emphasised the modification of the behaviour of the resident at risk of assault in order to ensure that they left the living area, or the house, in the event of an aggressive outburst. The resident did not wish to leave the living areas, so there was a strategy in place in relation to ensure compliance. There was no evidence of an assessment of the suitability of the accommodation where a resident had to leave their living environment in order to ensure their safety. Staff described occasions where two of the residents had to be taken out to the car to ensure their safety from the behaviour of the other resident.

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:
There was very little information available in relation to the healthcare needs of residents. For example there was no medical history available for some residents. There was no information available in the event of the transfer for one of the residents, for example to an emergency visit of medical appointment.

There were no care plans in place relating to medical issues, and no documentation other than occasional entries in the daily notes, for example 'has a rash, the same as the one on another named body part'. There was no further entry relating to this matter, and no guidance for staff as to how to proceed. The only record of another healthcare issue was that it was marked on their body chart, but there was no further information and no plan of care.

The recent episode of behaviour of concern notified to HIQA resulted in a resident receiving a head injury. The response to this head injury at the time was inappropriate, and medical attention was not sought until the following day. However, there was no guidance available to staff as to the correct procedure in the event of a head injury, or in the management of other emergency healthcare issues.

There was a set of nutritional guidelines in place which was prominently displayed in the staff office, and which was to be applied to all residents. The guideline included restrictions of 'treats' for all residents, and the withholding of the one permitted daily treat for one resident as a punishment if they did not comply with personal care. The guideline gave various instructions relating to the nutritional intake of residents, but had not been developed in conjunction with an appropriate healthcare professional, for example a nutritionist or dietician. Examples of guidance included the limitation of the number of slices of bread allowed daily for every resident, whether or not this was appropriate to their individual needs. There was no evidence of choice being facilitated for residents, only various rules, such as 'no fizzy drinks', being applied to all residents.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Some improvements had been made by the person in charge in relation to 'as required (p.r.n.) medications and stock control, but staff training was inadequate to ensure the safe administration of medications, administration recording was not robust, and there were no meaningful audits.

The person in charge had ensured that there was a detailed protocol in place in relation to the administration of rescue medication for epilepsy, and had drawn on the expertise of the nurse who was attached to the organisation's day service. This document included thorough guidance for staff in the event of an emergency.

The person in charge had introduced a system of stock control and management which was sufficiently robust as to ensure the safe management of stocks.

Staff training involved staff individually undertaking an e-learning package. There was no evidence that management had assessed this training package as being adequate to meet the training needs of staff. There was no assessment of the competency of staff prior to the commencement of administration of medication, and no oversight of practice by an appropriately qualified healthcare professional.

That the training was insufficient was evidenced in practices reviewed by the inspectors, and in the knowledge of staff members. Staff demonstrated that they were not aware of the purpose of medications being administered to residents, or of the expected effects or potential side effects. In addition administration records examined by the inspectors had not been completed in accordance with best practice. On the previous day a temporary prescription sheet had been put in place for one of the residents which inadvertently did not include any numbering or lettering of medications for the purpose of recording. However staff had continued to record administration under the letters which had been used on the previous day's recordings. The inspectors were concerned that staff were merely copying the previous day's entries, and not actually checking which medications were being administered. The required action relating to staff training is outlined under outcome 17.

However, where appropriate training had been provided for staff, for example in the administration of rescue medication for epilepsy, staff demonstrated the required knowledge, could describe the procedures involved, and could identify the conditions under which a medication would be administered.

As further discussed under outcome 14, there was no meaningful audit of medication management conducted.

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:
Management systems were not in place to ensure that the service provided was monitored, or that it was appropriate to the needs of residents.

There was a newly appointed person in charge in the centre, who was appropriately skilled, qualified and experienced, and who had begun to make some improvements in the centre. However, the oversight of the centre overall was inadequate, and had resulted in continued poor outcomes for residents.

There was an identified management structure in place, and staff reported that they felt supported within the structure. The person in charge had introduced clear lines of communication with staff.

An audit had been undertaken by the Quality and Assurance Monitor on 7 September 2016 based on the 18 outcomes under the regulations. However the inspectors did not find any evidence to support some of the findings of this audit, in particular in relation to fire safety as discussed under outcome 7.

The area relating to medication included eight questions, only four of which were relevant to the designated centre, and was inadequate to monitor the safety of medication management.

In addition the audit was not made available to the person in charge, other than a weekly email from the quality monitor requesting certain tasks. No other audits had been undertaken.

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

Findings:
Improvements had been made in staffing numbers since the previous inspection, however staff training was not adequate.

The two-to-one staffing for one of the residents was under review, and the provider gave assurances that at thorough assessment of risk would be conducted prior to any reduction in numbers.

All mandatory staff training was undertaken by staff as e-learning packages, including fire safety, the protection of vulnerable adults and the safe administration of medications, all of which were areas in which the inspectors found high levels of non-compliance with the regulations and significant risks to the safeguarding of residents. There was no evidence that the provider had assessed the competency of staff following any training.

Staff had not received training in risk management, and the training for some staff in positive behaviour support was inadequate given the significant risks to residents of the behaviour of others.

Improvements had been made in the staff files since the previous inspection, and all the documentation required by the regulations was in place.

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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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stepping Stones Residential Care Limited
Centre ID:	OSV-0005407
Date of Inspection:	03 November 2016
Date of response:	16 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no privacy locks on shared bathrooms

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

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

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

Please state the actions you have taken or are planning to take:
Privacy locks have been fitted to all shared bathrooms and toilets in the property

Proposed Timescale: 04/11/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of punishment was prevalent in the centre.

2. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
The Person in Charge has reviewed all documentation in the centre and removed all reference to use of punishment. Staff have been advised regarding the changes to documentation through the communications log and at team meetings.

The Person in Charge and psychologist have reviewed all behaviour support plans and ensured that positive support is the focus of all interventions.

The Person in Charge and Psychologist are reviewing the token economies in use with service users to ensure they are appropriate to the needs of the service user and that they do not contain any element of punishment.

Easy to read versions of all BSP's will be drafted to ensure that staff are clear on the support needed by each service user. Any clinical or practice reference to punishment has been removed.

Proposed Timescale: 18/12/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal planning was inadequate to ensure that the assessed needs of resident were met.

3. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The Person in Charge has reviewed the personal plans in place and completed them. These plans now detail the arrangements in place to meet the assessed needs of the service users. Plans will be reviewed and checked for accuracy by the PIC in the coming week. Keyworkers are instructed to then review regularly.

Proposed Timescale: 08/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not a comprehensive assessment in place for each resident.

4. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Person in Charge has completed comprehensive assessments of each service users needs which have been included in each service users personal plans. Assessments will be reviewed and checked for accuracy by the PIC in the coming week. Keyworkers are instructed to then review regularly.

Proposed Timescale: 08/12/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective fire management systems were not in place.

5. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The registered provider arranged for all staff to receive on-site fire safety training which was completed on 30th November 2016.

The person in charge has drafted personal evacuation plans for each service user. The PEPs have been reviewed following each evacuation. Current evacuation time is reduced to less than one minute. A further night time drill was held on 10/12/2016,

Arrangements regarding fire safety in the smoking area have been reviewed and staff have been made aware by use of the communications book.

The Person in Charge has developed a schedule for fire drills as well as a 'fire safety file' which contains important information regarding fire and fire risks

An up to date system for reviewing fire risks will be developed based on the fire safety audit completed on 4th November 2016 and the on site staff training delivered on 30th November 2016. This will be completed by 31/12/2016

Installation of additional emergency signage will be completed by 28th February 2017.

Installation of automatic closure fitting will be completed by the 28th February 2017.

The person in charge and monitor will draft an assessment of staff competency in the area of fire safety to ensure that all staff display their knowledge and ability in this area on a regular basis. This will be completed by 31/12/2016

Proposed Timescale: 31/12/2016

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:
There was insufficient evidence that staff training was adequate to meet the needs of residents.

6. 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:
Training in Safeguarding Vulnerable Adults was held on site on 21st December 2016.

An item 'Safeguarding' will be on the agenda at each team meeting, to discuss any issues arising and to promote debate on best practice.

Proposed Timescale: 31/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the use of punishment was a last resort, and that all alternatives had been considered.

7. 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 Person in Charge has reviewed all documentation in the centre and all references to use of punishment or other inappropriate terms have been removed.

The Person in Charge will review any future documents to ensure that the language in use and the directions given are appropriate. A review committee will be established to assist with this process by 31/01/2017. This committee will review all documents regularly to ensure that guidance is given on how to investigate and alleviate the likely causes of service users challenging behaviours in a manner that is not restrictive.

The Person in Charge and psychologist have reviewed all behaviour support plans and ensured that positive support and addressing care needs are the focus of all interventions.

Any restrictive practice, which may be deemed necessary for a service users' safety or protection will be referred for screening and approval by a monitoring committee.

The staff team will be encouraged and supported to ensure that the causes of service users behaviours are identified and alleviated through the following measures:

• Supervision by PIC focusing on person centred approach, service users welfare and safeguarding.

• A resource file is to be established by 1st March 2017, containing up to date information on low arousal approaches, research articles and training available. This will be updated by PIC regularly.

• PIC will guide staff team by example and mentoring. Staff are now actively encouraged to challenge any negative language or approach in their colleagues, in their professional capacity. Team dynamics will be a standing item on team meetings and supervision agendas and recorded for review. A review of progress in this area will be carried out by 31st March 2017.

• Dedicated handover time attended by the Person in Charge is allocated each morning at change of shift, to enable open discussion on issues that have arisen in the previous 24 hours, allowing for de-briefing, peer-to-peer support and open reflection on practice.

• A new rostering system will commence in January 2017 to allow for handover times and to promote continuity and consistency and a reduction in stress for service users. A review of the effectiveness of the new rostering system will be carried out by 31st March 2017.

Proposed Timescale: 31/03/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not safeguarded from assault by fellow residents.
Guidance to staff around personal examinations presented a risk of abuse of residents.

8. 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:
The following measures have been devised to ensure that all residents are safeguarded against the risk of abuse including assault by fellow residents:

• The person in charge attends handover meetings and monitors incidents and interactions between service users.

• Staff have received further training in the identification of abuse so that they can accurately report issues of concern to the Person in Charge.

• The Person in Charge monitors staff interactions and behaviour and incident report forms to ensure that positive support strategies are implemented. PIC screens reports for patterns of negative-type interactions between service users and between service users and staff. Staff alert psychologist by direct contact or by referral form to request psychology input or advice.

• Risk assessments are in place for each service user. In the event that a service user's safety is compromised for any reason, risk assessments are reviewed and updated. Behaviour support plans and 'standard operating procedure' documents will be developed to help protect service users from risks. If needed, detailed safeguarding plans will be drawn up in consultation with social workers and HSE Safeguarding Team.

• Focus of keyworking will be on skills development and self-care.

• Staff have attended an information session on 21/12/2016 on how to adopt a low-arousal approach and manage the environment, to reduce the potential for escalation, leading to acting out behaviour.

• All staff are MAPA trained, in the use of protective stance and breakaway techniques and are aware of the need for vigilance to protect all residents from all forms of abuse.

• A review of the mix of residents was completed in January 2017 and an action plan to ensure the safety and satisfaction of service users has been agreed.

• The review of mix will be carried out twice each year or prior to any request for admission to the service. This is to ensure the on-going safeguarding of current or potential service users.

Personal physical examinations do not take place. Any service user requesting an examination is to be brought to a GP for a medical examination. The service user who has requested this in the past now has a 'standard operating procedure' in place, read and signed by staff. This informs staff of the proper procedure to follow in the event of such a request arising.

Proposed Timescale: 31/03/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare was not provided for some residents.

9. 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:
Health needs assessments for all service users are being completed.

Health action plans will be drafted based on the information received.

Alternative GP services are being sought for one service user.

Service users are currently linked in with Chiropody, OT, Dental and GP services and records of medical contacts are kept up to date.

Pre and post consultation forms are to be completed for medical appointments.

Hospital Passports will be updated following all hospital visits or relevant medical treatments.

Proposed Timescale: 31/01/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the strict nutritional guidance in place related to the assessed needs of all residents, that their preferences had been included or that the appropriate healthcare professionals had been involved in drawing up the guidance.

10. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
Guidelines in place on November 3rd were removed immediately. No nutritional guidelines are currently in place as service users do not present as needing specialist interventions. Normal healthy eating is encouraged and supported. If health assessments or staff indicate that guidance in this area is needed, appropriate healthcare professionals will be consulted.

Menus take into account each service user's meal preferences and are based on their choices. Strict 'menu plans' have been removed and discouraged. Flexibility and choice is encouraged.

Completed: 30th November 2016

Proposed Timescale: 30/11/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate practices were not in place to ensure the safe administration of medications.

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

Please state the actions you have taken or are planning to take:
Medication Administration Record Sheet formats have been updated to allow for the recording of additional times.

All Kardex's have been updated to ensure all letters are visible.

Information on all medications has been sourced from the pharmacy and all staff have been made aware of this through use of the communication log.

Staff Training in Medication Administration took place on 21/12/16.

Ongoing competency assessments for all staff will be carried out following this training. This means PIC overseeing each staff member while processing an administration of medication to a service user, and monitoring whether the staff member meets a list of competencies while carrying out the procedure. Assessments will take place on a rotation, or as necessary, so that individual staff members are assessed 4 times per year for evaluation of their safe administration of medication skills.

Proposed Timescale: 31/01/2017

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:
Management systems were not in place to ensure that the service provided was safe. Management systems were not in place to ensure that the service provided was monitored, or that it was appropriate to the needs of residents.

12. 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:
Copies of all action plans have been made available to the Person in Charge.

Robust competency based audits are being designed for use in medication and fire safety and similar audits will be introduced into other areas through consultation between the Person in Charge and Monitor.

The Director of Service will draw up an induction protocol for use with new PIC's

An induction schedule is drawn up for newly appointed PPIMs.

The Director of Services will continue to visit the centre weekly and the Monitor at least monthly.

An 'essential guide' for Killavill is in place and it and the Staff handbook are on display in the office.

3 Shift Co-Ordinator posts have been created and additional PPIMs are appointed.

A copy of this report and action plan will be available to staff and discussed in supervision and at team meetings.

Proposed Timescale: 31/01/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training was not adequate to meet the needs of residents, or to ensure safe practices.

13. 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:
Staff training in the area of Fire Safety was completed on 30/11/2016

Safe Administration of Medication training took place on site for all staff members on 21/12/2016.

Safeguarding Vulnerable Adults training took place on site for the staff team on 21/12/16.

The Person in Charge will provide training in risk assessing to PPIMs as part of their induction into the role. Risk assessments will be completed by PIC until PPIMs achieve a level of competency in assessing risk and will continue to devise and supervise risk assessments following this.

A competency assessment in the area of medication to be used with all staff has been drafted.

A competency assessment in the area of fire safety to be used with all staff will be drafted by 31/12/16

Proposed Timescale: 31/01/2017