## Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

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<tr>
<th>Centre name:</th>
<th>Cluain Fhionnain</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003361</td>
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<tr>
<td>Centre county:</td>
<td>Kerry</td>
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<td>Type of centre:</td>
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<td>Registered provider:</td>
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<tr>
<td>Lead inspector:</td>
<td>Gary Kiernan</td>
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<td>Support inspector(s):</td>
<td>Ciara McShane</td>
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<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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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 announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 19 December 2017 08:45  
To: 19 December 2017 17:30

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

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**Summary of findings from this inspection**

**Background to this inspection:**

This inspection was carried out to monitor compliance with the regulations and standards. HIQA had previously identified a range of significant issues in this centre and had highlighted to the provider the potential consequences of continued non-compliance. Widespread changes to the service had taken place and were ongoing at the time of inspection.

The provider had responded to these concerns and had put a plan in place which was based on the imminent closure of the centre and facilitation of the residents to move to more suitable community homes of their choosing. A number of residents had successfully moved to their new homes in 2017. Additionally the service had undergone significant change from a medical model of care to that of a social model aimed at better supporting residents to move into their new homes and communities.

**How we gathered our evidence:**

Inspectors met residents present in the centre on the morning of inspection and spoke to four residents in more detail. Residents had freedom to move within the centre and access the outside spaces as they wished. Residents appeared to know staff well and were observed interacting with them freely and comfortably. Interactions observed between staff and residents were respectful and caring and showed that staff had a good understanding of residents’ communication and wider...
needs.

Inspectors met staff members, the person in charge, the provider representative, both clinical nurse managers (CNM) and the staff supervisor. Inspectors observed practices and reviewed documentation such as personal plans, risk assessments, audits and behavioural support documentation.

Description of the service:
The centre was set up in 2001. At the time of inspection the service supported male residents who required care and support for a range of needs but primarily in relation to mental health. As a result of reduction in numbers, the service was now operated from one large institutional building. Residents also had access to another building for hobbies and activities of interest to them. The physical environment was not appropriate for the service being provided. The centre was bleak in appearance and had not been decorated or maintained to an appropriate standard. It did not provide residents with a therapeutic environment where individualised support could be provided. The centre was located on the outskirts of a large urban centre.

Overall findings:
Inspectors found that while staff and management in the centre had introduced a range of improvements which had direct positive impacts on residents, the service was not adequate to meet residents’ needs in areas including positive behavioural support and in the provision of a therapeutic physical environment.

Inspectors noted that residents had busy schedules and were much more involved and connected with their communities than before and this included forming ties in the areas where their new homes would be located. Significant progress had been made to review and reduce restrictive practices and residents enjoyed a much greater degree of freedom as a result. Staffing arrangements had also improved and supported a more person-centred approach to care.

However, sufficient progress had not been made in a number of key areas. The systems for the identification and management of risk required review to ensure residents’ safety was prioritised. The arrangements for meeting residents’ behavioural support needs in a consistent and evidence-based way were not adequate. Residents continued to be accommodated in a premises which was institutional in nature and was not meeting their needs. Staffing arrangements also required review to ensure residents were safe and adequately supported at all times of the day and night.

The reasons for these findings are explained under each outcome in the report.
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 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):

Findings:
The inspectors were satisfied that the care and support as described by the person in charge and documentation had led to positive impacts for many residents. Residents were experiencing a better quality of life than before despite living in an institutional setting. However, improvement was required to ensure that residents social care needs were accurately assessed and up-to-date plans put in place to meet those needs in a consistent and planned way.

Further to changes to staffing arrangements and the model of care in 2017 residents had begun to experience a much broader range of social activities and community integration than before. Residents were now visiting their local communities on a much more regular basis and using local services and amenities. Where residents were planning on moving to new homes and the location had been identified there was an emphasis on supporting residents to access these communities and use local shops and services in these areas. A number of residents were also supported to form new bonds or renew bonds with family members.

The inspectors reviewed a sample of personal plans and found that some assessment of residents’ needs had taken place and planned supports put in place to help residents achieve identified goals. Goals such as visiting a restaurant or renewing family contact had been achieved. However, as identified by staff in the centre, the process of assessing and identifying residents’ preferences and social care needs required improvement. Some of the personal plans outlined goals which had already been achieved or which were not based on updated assessment or consultation with the residents. Inspectors were informed that plans were in place for a "discovery process" to
take place in more detail.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and suitable premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

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

**Findings:**

While the provider had made some improvements to the physical environment and there was a plan to eventually close the centre this inspection found that the layout and design of the premises was not suitable for its intended purpose and did not provide a therapeutic or homely environment.

Staff in the centre showed inspectors a range of improvements which had been initiated. One of the most significant of these was the removal of restraints and restrictive practices which had prevented residents from moving freely with the centre and accessing kitchens and dining areas. Residents were also seen accessing the garden and could leave the centre as they wished. In preparation for their move to community houses many residents were now actively involved in using the kitchens and laundry areas to enhance their life skills and become more involved in the operation of the centre. This was observed to be a positive and enriching experience for residents many of whom had not been assessed as having skills and ability in these areas formerly.

Some residents had also been involved in redecorating their bedrooms in order to make them more personalised and homely. Residents had chosen colours and furniture and proudly showed inspectors what they had achieved. Again this was a new experience for many residents.

However, the centre was institutional in nature and did not meet the needs of the residents. The provider's own audit report of October 2017 referred to the centre as "bleak", "dated" and "in a poor state of repair". Inspectors found that this assessment continued to be accurate. While some living areas had been made more homely, for the most part the centre was sparsely decorated and lacking the comforts of a homely environment. The layout of the centre was not conducive to a therapeutic environment. Residents who presented with behaviours of concern were in close contact with residents who required a calm and quiet environment and some residents had
complained to staff regarding the noise and disruption which this caused to them. Given the numbers of staff and residents in the centre noise levels were noted to be very elevated at certain times during the day and often when some residents were resting.

**Judgment:**
Non Compliant - Major

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**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**
Effective Services

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

**Findings:**
Inspectors found that while the health and safety of residents, staff and visitors was promoted, significant improvements were required in relation to risk management, incident review and oversight of risk in the designated centre.

Inspectors found that there was a system in place for the recording and reporting of accidents, incidents and adverse events in the centre; a log of which was maintained. Inspectors found that while incidents were being logged there was an absence of analysis to identify trends or emerging patterns to prevent the likelihood of incidents reoccurring. For example, from a high level review of incidents, over a two month period, inspectors found a large number of adverse incidents occurred when the staffing levels had reduced i.e. from the hours of 20:00 to 08:00. The provider had not identified this trend as part of their own systems and had failed to use this information to inform and review safety arrangements for the resident. The provider acknowledged this was a gap and analysing incidents would be implemented as part of planned changes to quality, safety and compliance processes.

While some positive practices were noted, such as multi-disciplinary risk reviews for individual residents, systems for managing risk were not consistently effective and required review. While there were risk assessments and a risk register in place action was required to ensure the system was effective and keeping residents safe.

For example, the risk associated with residents smoking was not appropriately managed. Smoking was identified in the risk register but had not been adequately reviewed since October 2016. On the day of inspection some residents were observed smoking. While some controls were in place such as smoking care plans and safe storage systems for cigarettes and lighters, the residents chose not to avail of a number of safety arrangements as outlined in the risk register. The provider had not reviewed or updated the controls in place to take account of this. As a result, residents were exposed to risks which in once case resulted in significant burn marks in clothing. This was brought to
the attention of the provider at feedback who stated they would address this as matter for priority.

A risk assessment form was completed for each resident whose personal plan was reviewed. The risk assessment form looked at risks in categories such as mobility, violence and aggression. Although the risk assessment form looked at these broad categories it failed to identify risks and control measures in sufficient detail to guide the safety of residents. A multi-disciplinary review of risk which took place in October 2017 did not address these issues.

Inspectors found that arrangements were in place to promote safe evacuation of residents in the event of fire. Regular fire drills had been carried out with good evacuation times noted. Personal evacuation plans were in place and staff spoken with by inspectors were knowledgeable regarding fire safety and evacuation procedures.

**Judgment:**
Non Compliant - Moderate

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**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):**

**Findings:**
While there were some measures in place to safeguard residents, further improvement was required to ensure that residents were safe and that residents were not negatively impacted on as a result of other residents whom they lived with. Inspectors also found that while there was an awareness regarding residents’ behavioural support needs there was an absence of appropriate multi-disciplinary support in this area. The behaviour support plans in place were not adequate, were not based on assessment of residents needs and were not detailed enough to guide staff in responding to residents in a consistent and therapeutic manner.

Staff working at the centre for the most part had up-to-date training regarding the protection of vulnerable adults (95% of staff were trained), the management of actual or potential aggression (95% of staff were trained) and 86% of staff had received training in behavioural support as well as separate training in relation to autism. Staff
who spoke with inspectors demonstrated knowledge regarding these areas and relayed to inspectors how they would support residents should concerns regarding safeguarding arise such as peer to peer abuse or self injurious behaviours. Staff spoken with also demonstrated understanding of their reporting obligations in this area and relayed that there were no barriers to communicating any cause for concern.

However, the provider’s response to incidents were residents were the subject of actual or potential abuse was not adequate and did not sufficiently protect residents. Inspectors saw a number of preliminary screening forms completed where safeguarding matters had arisen, however these were not consistently completed. For example, there were two incidents of peer to peer abuse in October 2017 and these had not been screened. This did not provide for an appropriate system or follow up.

Safeguarding plans were in place for residents living at the centre, however a number required review. Some had not been reviewed since February 2016. Another safeguarding plan stated that it should be reviewed within three months of its development however this had not occurred despite the plan being dated 19 October 2017. A number of safeguarding plans required a review to ensure they were specific to the area of vulnerability such as residents entering other residents' bedrooms uninvited.

A number of residents residing at the centre required behavioural support and input. At the time of inspection an external consultant was providing sessional hours to mainly support one resident. There was no other behavioural support being provided at the time of inspection. The provider had stated that it was proving difficult to recruit to this role, however, they continue to endeavour to appoint a person. An external consultant had also assisted the provider in 2015 with the development of behaviour support plans but these had not been robustly reviewed since and were not live documents.

The inspectors reviewed two behaviour support summary reports which had been developed. These were not formal behaviour support plans and failed to provide clear direction to staff on how to consistently and effectively support the residents. The inspectors also noted that two of the summary reports they reviewed were very similar in nature therefore the individualisation of each plan was unclear. Overall there was an absence of clear behavioural support plans guiding staff on how to consistently support residents with their complex needs.

Chemical restraint was being utilised at the centre, however the protocols to guide the use of same were clear and were found to be implemented well. The inspectors reviewed documentation which outlined the rationale for the use of the chemical restraint which captured if all other potential strategies of a lesser restriction were exhausted. A number of staff spoken with clearly stated all other strategies were exhausted prior to the use of PRN medication (medication taken as the need arises). Inspectors were also informed that for one resident a review of their medication resulted in the discontinuation of a medication that was used to block hormones. This was done on a phased basis and at the time of the inspection the resident had not experienced any adverse effects as a result.

**Judgment:**
### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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<th>Outstanding requirement(s) from previous inspection(s):</th>
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**Findings:**
Inspectors were satisfied that residents’ health needs were regularly reviewed with appropriate input from multidisciplinary practitioners and family members as and when required.

The inspector saw that residents' healthcare needs were met and supported with regular access to the services of the general practitioner (GP), psychiatry, psychology, dietician and physiotherapist. The provider had also recently begun to introduce the services of a physical therapist which two residents were finding very beneficial. Instructions and recommendations which were made by medical and allied health practitioners were clearly set out in care plans to guide staff. Inspectors were also also satisfied that systems were in place so as residents' nutritional needs were met and provided for.

**Judgment:**
Compliant

### Outcome 14: Governance and Management

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

**Theme:**
Leadership, Governance and Management

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<th>Outstanding requirement(s) from previous inspection(s):</th>
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**Findings:**
Inspectors found that the governance system provided for the satisfactory oversight of
the service. The addition of two clinical nurse managers had further strengthened these systems. Changes aimed at enhancing the governance structure were underway and were at an advance stage.

The service had undergone significant change in 2017 moving from a medical to a social model of care. The provider had instigated and implemented this change with the aim of improving the service provided to residents and helping residents to move to the community. The provider had also overseen the transition of a number of residents to more suitable community homes and at the time of inspection suitable properties had been purchased to allow all residents to move out.

Inspectors found that there were appropriate management agreements and supervision systems in place with the agency which the provider had contracted to provide the staffing resource to the centre. Inspectors found that the change to this staffing system had been managed well and had resulted in a stable workforce in the centre as described in outcome 17. The management agreement in place was overseen by the person in charge. This arrangement was working effectively and all staff were accountable for the quality of their work and participated in a formalised supervision system.

The centre was managed by a suitably qualified and experienced person in charge who met the requirements of the regulations. The inspectors found the person in charge to be very knowledgeable about the residents and their needs. The person in charge was supported two clinical nurse managers and staff supervisor who was responsible for overseeing the cohort of agency staff.

There was a defined management structure in place and a clear line of accountability from person in charge to senior management in the Health Service Executive (HSE). Inspectors saw minutes which showed that the senior management group had met in September 2017 and drafted revised terms of reference for the operation of a "Governance, Quality and Safety Committee" which had been set up to support and monitor the service. These terms of reference provided for sub-committees to oversee critical areas in the centre including compliance, local management and restrictive practices. Arrangements were in place for this committee to be accountable to the Chief Officer in the HSE. Inspectors were informed by the nominee of the provider that it was planned for these enhanced arrangements to be fully implemented in January 2018.

The provider had carried out unannounced visits to monitor the quality and safety of care in the centre. The most recent visit had been carried out in December 2017. An action plan had been issued and there was evidence that work was underway to address the areas for improvement which had been identified.

Inspectors reviewed the actions taken by the provider in relation to an incident where a resident had experienced an injury in the centre. The incident had been appropriately recorded and was escalated. In response the provider initiated a "A Safety Incident Management Team Meeting". This process involved a detailed examination of the incident and resulted in a series of follow up actions and recommendations for learning in the centre. Inspectors reviewed the file of the resident involved and found that all follow up actions had been responded to and addressed to a high standard. It was
noted that these actions had been effective and no further adverse events involving this resident had occurred. Inspectors found that this was a good quality management response to an identified area of concern.

**Judgment:**
Compliant

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**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):**

**Findings:**
Inspectors found that changed staffing arrangements had recently been implemented and this has had a positive impact on residents. Improvements regarding staff training had also occurred although some gaps in training still remained.

In June 2017 the model of service being provided to the residents changed from a clinical led model to a social care model. The provider seconded use of an agency who provided the service with staff, 34 of whom were assigned as health care assistants and social care workers. In addition to these staff, an additional fifteen staff were used on a relief basis. At the time of inspection two clinical nurse managers and an operations manager were also based at the centre.

Inspectors found the these arrangements resulted in care being provided to residents, for the most part, in a consistent manner by staff who knew and understood the residents' needs. The staffing arrangements had also facilitated residents to become much more involved in their communities. For example, residents were now facilitated to attend their medical and allied health appointments outside of the centre at a time of their choosing. Visits to see family, barbers, library, restaurants and shops were now common place for residents and this had not previously been the case. Some residents told inspectors how much they enjoyed this.

Inspectors found the number and skill mix of staff was in keeping with residents' needs on the day of inspection. Sufficient staff were available to accompany many of the residents on trips out of the centre on the day of inspection and one to one support was provided for some residents. A review of incidents found a significant number of adverse events occurred after 20:00hours. The staffing levels at night-time therefore required
review by the provider.

Staff spoken with throughout the inspection were well informed of residents’ needs and were knowledgeable in areas such as safeguarding and fire safety. Staff told inspectors they felt well supported in their roles and would communicate any concerns they had. Staff received formal supervision on a regular basis and attended daily handovers which occurred at the change of shift.

While there had been a significant amount of training recently at the centre some gaps still remained:

- 27% of staff required training in fire safety
- 14% required training in behaviour support
- 14% of staff required training in risk management
- 5% of staff required training in the management of potential and actual violence
- 5% of staff required training in safeguarding.

**Judgment:**
Non Compliant - Moderate

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**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:**

Gary Kiernan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

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<td>Centre ID:</td>
<td>OSV-0003361</td>
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<tr>
<td>Date of Inspection:</td>
<td>19 December 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29 January 2018</td>
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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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that personal plans were based on updated assessment and consultation with residents.

1. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
1. PCP Annual Review for each resident will commence in consultation with residents and their families. A schedule for this will be put in place by 02/02/2018 for these meetings, and meetings will be completed by end of 31/03/2018.
2. Social Care Worker training to support the personal planning process to be undertaken and to commence in mid February.
3. The provider has submitted a proposal to utilise funding that has been secured for two additional staff in the evening from 5-10pm or 6-11pm X 7 days (i.e. 70 hours per week).

**Proposed Timescale:** 30/04/2018

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The premises was institutional in design and presentation.

The premises did not provide an environment where residents could be cared for appropriately and where residents could be comfortable.

2. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
A comprehensive closure plan has been put in place and the centre is on target for closure of the centre and relocation of residents to community houses by 31/12/2018.

In the interim, staff continue to review how to make the place more homely for the residents, given the fact that some residents do not tolerate soft furnishings.

Staff will also continue to support residents to paint their bedrooms in the colour they have chosen. Some residents have selected pictures for their bedroom which will be put up once bedrooms are painted. This will be completed by 28/02/2018.

From 05/02/2018 the provider has sanctioned an additional Social Care Worker by day, who will take responsibility for Activities outside of the residents living areas. The Activation Centre and sensory room will be better utilised to support residents who are distressed by noise.
Proposed Timescale: 28/02/2018

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The risk management system was not effective in some areas and required review.

Individual risks were not clearly assessed and failed to clearly outline the corresponding control measures to mitigate the risk. The management of risk associated with smoking required review.

There was an absence of a review and analysis for incidents, accidents and adverse events to promote safety.

3. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated 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:
Risk Management Training has commenced since Nov 2017 for all staff and managers, with an additional date scheduled for 07/03/2018 to capture those staff who have not previously been trained.

The risk register and all individual risk assessments will be reviewed by the Keyworkers and Managers – this is to be completed by 31/03/2018.

The National Incident Management System is being updated to ensure all incidents are being entered into the system, and this will facilitate a system going forward for analysing incidents. Incident reports will be generated on a monthly basis and reviewed by the Quality and Safety Committee.

Smoking Risk Assessments have been updated, and the Care Plans have also been updated to include the risk.

Proposed Timescale: 31/03/2018

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 an absence of appropriate multi-disciplinary input for resident who required
There was an absence of behaviour support plans to guide staff to support residents. Where behaviour support plans were in place they required a review to ensure they were relevant and updated to reflect resident's individual needs.

4. **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:**
A proposal has been submitted to employ psychology input for 19.5 hrs per week. It is envisaged that the psychologist will work on the ground to develop and support the delivery of Positive Behavioural Support Plans and work directly and collectively with the residents. Behavioural Support Plans will be reviewed as part of the persons plan. This is to be completed by 30/04/2018.

**Proposed Timescale:** 30/04/2018

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider's response to incidents where residents were the subject of actual or potential abuse was not adequate and did not sufficiently protect residents. Preliminary screening had not been consistently completed for incidents such as peer to peer abuse.

5. **Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
The PIC will review the incidents and will follow up on any screening requirements. This will be completed by 09/02/2018.

**Proposed Timescale:** 09/02/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The PIC will review the incidents and will follow up on any screening requirements.
requirement in the following respect:
Staffing levels and staffing arrangements at night time required review to ensure residents were safe and appropriately supported.

6. 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:
The provider has submitted a proposal to utilise funding that has been secured for two additional staff in the evening from 5-11pm or 6-12pm X 7 days (i.e. 70 hours per week).

The current arrangement where an extra member of staff works until 10pm to support night staff until many residents have settled for the night will remain in place.

The PIC will carry out a detailed analysis of incidents at night time for any patterns or trends, specifically for one individual resident. The Development of a Behavioural Support Plan for that individual will be part of the overall approach to supporting residents at night time.

Proposed Timescale: 30/04/2018
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At the time of inspection all staff had not received training in key areas. For example,

- 27% of staff required training in fire safety
- 14% of staff required training in behaviour support
- 14% of staff required training in risk management
- 5% of staff required training in the management of potential and actual violence
- 5% of staff required training in safeguarding

7. 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:
Fire Safety theory training – we are awaiting dates from the fire safety officer. In the interim, simulated Fire Evacuations will continue on a regular basis.

Behaviour Support – we are awaiting dates from An Cuan for same.

Risk Management training is planned for 07/03/2018.
Management of Potential and Actual Aggression training will take place on 24/01/2018 and 26/01/2018.

Safeguarding of Vulnerable Adults is scheduled for the 06/02/2018.

**Proposed Timescale:** 07/03/2018