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:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003999
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	John Greaney
Support inspector(s):	Aoife Fleming; Mairead Harrington; Vincent Kearns; Maria Scally
Type of inspection	Unannounced
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 March 2015 07:15	10 March 2015 18:30
11 March 2015 08:00	11 March 2015 17:45

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 06: Safe and suitable premises
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

On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to St Raphael's Residential Centre and is one of the nine inspections of these centres during 2015 which identified serious concerns in relation to safety of residents and poor quality of life for residents. As a result of poor governance and oversight of the centres, management had failed to identify these issues for themselves, failed to address them effectively and failed to ensure a safe and good quality service for residents.

In March 2015, following receipt of a notification about an allegation of abuse from the provider, HIQA sought assurances from the provider that there were arrangements in place to protect all residents from abuse. However, the written response from the provider did not provide adequate assurances. On 09 March 2015 the provider was issued with a warning letter stating that HIQA was not satisfied that

residents were adequately safeguarded and that the centre was being operated in compliance with the requirements of the Health Act 2007. In the absence of adequate assurances, this unannounced inspection was carried out on 10 and 11 March 2015.

Overall inspectors had significant concerns in relation to the safeguarding and the quality of life for residents in the centre. Following the inspection and in the interest of the health and welfare of residents, on 25 March 2015 the provider was issued with an improvement notice and a schedule of improvements to be implemented by dates specified by HIQA. The areas that required improvement and specified dates for completion are included in the action plan at the end of this report.

Based on the findings of this inspection, inspectors were not satisfied that measures were in place to protect residents from all forms of abuse. For example, no additional protective measures for residents were put in place in response to specific allegations of abuse. Inspectors also found that there was evidence of peer-to-peer, frequent physical altercations between residents.

The design and layout of the premises was institutional in nature and did not support privacy and dignity, primarily due to bedroom accommodation that consisted of multi-occupancy dormitory bedrooms but also due to inadequate sanitary facilities, the restrictive practice of locked external doors, limited communal space, inadequate space for residents to meet with visitors in private and limited suitable outdoor space.

Significant failings were also evident in relation to governance and management. This finding was based on the significant level of non-compliance with regulations and standards found on this inspection and also by the inadequate audit process to evaluate the quality of life and the quality of the service provided to residents, inadequate numbers of staff and the fact that the person in charge did not have capacity to manage the centre because she was also responsible for three other centres for residents with complex care needs.

Additional areas identified for improvement as a result of this inspection included:
- access to advocacy services
- management of complaints
- participation of residents in the organisation of the centre
- programme of activities
- risk management practices
- hygiene and state of repair
- fire safety
- staff training
- restrictive practices and restraint
- access to allied health/specialist services
- evidence that staff were suitable to work in a centre for vulnerable residents.

The action plan at the end of the report identifies improvements necessary 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 and the

National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

Findings:
There were inadequate arrangements for residents to access advocacy services. Inspectors were informed by the person in charge that an advocacy service had commenced meeting with residents as a group on a monthly basis, however, the minutes of these meetings were held by the advocacy group and were not available in the centre on the days of the inspection. Inspectors were informed that issues raised by residents were brought to the attention of the person in charge. Inspectors were informed that one of the issues raised by residents included requests not to share bedrooms with other residents. However, there was no evidence that these issues were being addressed to the satisfaction of the residents and there were no records available to identify what, if any, other issues were raised by residents. Another advocacy service had been contacted to meet with a small number of residents individually to support them with specific issues, however, the person in charge confirmed that this service was not available to all residents.

The person in charge stated that efforts had been made to establish a family forum through which the wishes of relatives acting as advocates for residents would be ascertained, however, the person in charge confirmed that this had not commenced.

The complaints process did not meet the requirements of the regulations. There was a complaints policy that identified the name of the complaints officer however, it did not adequately outline the appeals process. Inspectors reviewed the complaints logs. The centre had only recently commenced recording complaints and only a small number of complaints were recorded. Based on the sample of complaints reviewed, there was inadequate evidence of action in response to complaints and it was not always recorded

if the complainant was satisfied with the outcome of the complaints process, as required by regulation.

The physical environment seriously compromised the privacy and dignity of residents. Most of the bedroom accommodation was in multi-occupancy dormitory style bedrooms with inadequate screening between beds. These multi-occupancy rooms were completely unsuitable to meet the needs of residents as the design and layout seriously compromised the quality of life, privacy and dignity of residents. While screening between the beds in some dormitories comprised accordion type screens affixed to the wall, such screening was wholly inadequate. In addition, there were no screens/curtains between the beds in the 12-bedded and six-bedded dormitories. There were portable screens for use by staff when providing personal care to residents in these rooms.

Given the complex care needs of residents, many required the delivery of intimate and personal support. This could not be provided in a manner that ensured the dignity or the privacy of residents. During interview, staff members commented on the challenges of providing for residents in this environment, such as "Person centred care is difficult with the big dormitory, there is no privacy for residents, they have no inhibitions and can walk around unclothed"

The unsuitable design and layout of the premises also meant that there was nearly constant elevated noise levels. During the time that inspectors were in one unit that accommodated 17 residents there was no period when the noise levels were not high. There was significant levels of noise from residents shouting and frequently several residents were shouting simultaneously. This was a cause of upset and agitation to other residents who were assessed as requiring a quiet environment. Inspectors also saw evidence of residents being fearful at night time and choosing to sleep on a couch rather than in their bedroom.

In addition, inspectors noted that there were inadequate facilities for residents to meet with visitors in private

Residents' privacy was also compromised by the arrangements for accessing one of the units. Entrance and egress to this units was through a door that led directly to a dormitory style bedroom. Access to the unit for all routine deliveries of daily provisions by outside personnel was through this entrance and through the bedroom. In addition, inspectors observed this entrance being used by staff as a shortcut to another part of the centre due to inclement weather.

Furthermore, one of the units had male and female bedrooms beside each other. There was inadequate screening between the two bedrooms.

A religious service was available in a church on site each week and all religious preferences were facilitated. There was a policy on residents' personal property and possessions and records were maintained of residents' personal finances.

There were limited opportunities for residents to engage in meaningful activities. A number of residents attended day activation units within the grounds of the centre. For

residents that did not attend the activation units, records indicated one-to-one activities such as aromatherapy, reflexology and hand massage were provided. However, there was inadequate evidence that activities/occupation programmes available were based on residents' assessed needs or that they suited residents' needs, interests and capacities. Inspectors were informed by staff that there were insufficient staff numbers to support residents to participate in activities or to facilitate residents on trips out of the centre. Inspectors noted that there were extended periods of time when residents with significant and complex needs did not have opportunities to participate in stimulating activities.

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:
Based on a sample of records viewed, residents had personal support plans that included an assessment of issues such as residents' likes/dislikes, preferences, education/learning and a communication profile. There was evidence of consultation with relatives in the development of the plans. Inspectors were informed by staff that the care planning process was in transition from a medical model to person centred plans, however, this had not been completed for all residents in the centre. Inspectors found that personal plans continued to focus primarily on health related issues and activities available to the residents did not corresponded with the interests of the resident identified during assessments. Records detailing the involvement of residents in activities were poor. Staff told inspectors that there were insufficient numbers of staff to support residents to participate in activities.

Training records indicated that training in person centred planning had been made available to staff. However, a significant number of staff in the centre had not attended this training.

Judgment:
Non Compliant - Moderate

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

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

Findings:
This was a three-storey premises, however, all resident accommodation was on the ground floor. Overall, the design and layout of the premises was institutional in nature, was not fit for purpose, did not meet the needs of residents and did not support privacy and dignity of residents. The centre comprised three separate units, two of which accommodated mostly elderly residents and the third unit accommodated residents with predominantly severe/profound disabilities.

The first inspection of this centre was carried out in April 2014 and found that the design and layout of the premises did not meet the aims and objectives of the service. In response to the findings of that inspection the provider stated, in their action plan that a long term strategic plan for the transition of residents from the centre to more appropriate accommodation would be developed by 31st December 2014. This plan was not yet available at the time of the inspection.

Inspectors found that the physical environment was still not fit for purpose. The first unit in the centre had capacity for 18 residents in a 9-bedded dormitory style bedroom, a 6-bedded room, a twin-bedroom and a single bedroom. There were accordion style screens which were not adequate to provide for the privacy of residents. These were fixed to the wall between each bed in the nine-bedded room. However, there was no fixed screening between the beds in the six-bedded room. There were a number of wardrobes for storing residents' clothing, however, not all of the wardrobes were located close to residents' beds and there were inadequate numbers of wardrobes or storage spaces for each resident. There was a sluice room in the unit that contained a sluice sink, bedpan/urinal washer, and hand washing facilities.

Sanitary facilities in the first unit were not sufficient and consisted of a bathroom, a shower room and two toilet cubicles. The bathroom contained an assisted bath, however, this room was also used to store a linen trolley and a non-clinical waste bin. The shower room was en suite to the single bedroom and contained an assisted shower,

a toilet and a wash-hand basin.

Communal areas in the first unit were also insufficient for the numbers of residents and comprised of a conservatory that contained comfortable seating and a dining table with seating for seat six people.

The second unit accommodated 17 residents in one 12-bedded room and five single bedrooms. There were no fixed screens between the beds and some of the beds were in close proximity to each other, which significantly infringed on residents' privacy and dignity. There were mobile screens for use by staff to provide a degree of privacy when providing personal care, however, the overall design and layout of the bedroom accommodation significantly compromised the privacy and dignity of residents. Two of the single bedrooms were located in an area of the premises that was not immediately adjacent to the main part of the unit. This area also contained a small sitting room and a shower room containing an assisted shower and toilet. Sanitary facilities in the main part of the unit consisted of a bathroom with an assisted bath and a shower room with an assisted shower. There were three toilet cubicles. There was no access to a secure outdoor space.

The third unit accommodated 16 residents in one 14-bedded room and a twin bedroom. There were accordion style screens fixed to the wall between each bed in the multi-occupancy bedroom. Each resident had a bedside locker beside their beds and wardrobes that were situated at a distance from residents' beds. There was a bathroom with an assisted bath and a shower room with an assisted shower. The were four toilet cubicles for use by residents. Communal facilities consisted of a combined sitting room/dining room. There was access to a secure garden for these residents.

In addition to the poor overall design and layout, the centre was not in a good state of repair and was not clean throughout. For example, inspectors noted that there was rust on a number of handrails in toilets and showers, the wall covering in one of the showers was damaged making it difficult to clean, plaster was peeling off the wall in one of the sitting/day rooms, mould was noted on some walls, cobwebs were noted on some windows and there was a damaged sink in a sluice room.

Inspectors saw evidence of preventive maintenance of equipment such as assisted baths, beds, speciality mattresses, hoists and chair scales.

There were hand-washing facilities in each of the bedrooms with advisory signage, liquid soap and paper towel dispensers. Each unit had a kitchen for preparing snacks and for storing food, however, main meals were always prepared in the central kitchen and delivered to the units in heated trolleys.

Judgment:
Non Compliant - Major

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 was a safety statement and a risk management policy. However, there were inadequate procedures in place for hazard identification and assessment of risks throughout the centre. For example, personal protective equipment, such as gloves and aprons, were located throughout the centre and inspectors observed appropriate use by staff. However, there was no risk assessment in relation to the choking hazard posed by the unrestricted access by residents to plastic aprons and latex gloves and at least one resident was known to have a tendency to put inedible objects in his mouth. Additional risks identified during the course of inspection included the inappropriate storage of cigarettes and matches on top of a wardrobe in a dormitory where they were accessible by residents with a cognitive impairment, the use of an electrical extension reel as a long-term power source for equipment in one of the dormitories which is a fire hazard, and a fire door was held open by a shoe lace tied to a hook on the wall.

Records of the preventive maintenance of fire safety equipment indicated that it had most recently been serviced in September 2014. Emergency lighting had most recently been tested in March 2014, however, from the records available it was difficult to ascertain if the emergency lighting in all of the units in the centre was serviced. Records viewed by inspectors indicated that the fire alarm system was most recently inspected/serviced in April 2014 but was not being done quarterly. Most, but not all, staff had up-to-date training in fire safety.

The evacuation plans for residents were not sufficient. There was a list of names of residents taped to a number of emergency exits identifying what assistance each resident required to mobilise. It identified which residents required the use of a wheelchair, which residents required assistance to mobilise and which residents mobilised independently. The purpose of the list was to support staff to evacuate residents in the event of an emergency. However, there was insufficient information for the list to be considered a personal emergency evacuation plan, as it did not take account of communication requirements, the potential psychological responses of individual residents to the requirement to evacuate or that some emergency exits required a key that was either held by staff or in the case of one exit was held in the office. In addition, inspectors noted that fire drills were held infrequently.

While incidents and accidents were recorded, there was inadequate collation and analysis of the incidents to mitigate reoccurrence, inform learning or to support quality improvement. There were hand wash sinks available for staff and advisory signage for best practice hand hygiene was displayed. There were a number of hand hygiene foam dispensers available. However, it was noted by inspectors that some of the hand hygiene foam dispensers were unclean, which could impact on the effectiveness of

infection control measures.

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:
This inspection was a triggered inspection in response to a notification of an allegation of abuse against a member of staff that had been reported to the Authority, as required by the regulations.

Inspectors found that there was a policy on the prevention, detection and response to abuse. However, training records viewed by inspectors indicated that only one staff member had received training in the protection of vulnerable adults. A number of staff were interviewed by inspectors and inspectors found that they did not have appropriate knowledge of what to do in the event of an allegation or suspicion of abuse. Inspectors noted that this lack of knowledge was also evident for staff that were currently employed in a supervisory capacity in the centre.

Inspectors were not satisfied that residents were adequately protected from institutional abuse and peer-on-peer assault. As found on the previous inspection, care practices were institutional in nature and there was no evidence of improvement on this inspection. For example, day staff usually worked from 06:50hrs to 19:10hrs each day. Choice for residents was limited and routines and practices were influenced by the staff roster. On the first day of the inspection, inspectors visited the centre at 07:15hrs and observed the daytime routine commence with residents getting out of bed. Inspectors were informed by staff that residents chose to get up at this time, however, inspectors observed that due to the design and layout of the centre, in particular the dormitory style bedrooms, residents could not comfortably remain in bed after day staff commenced work. On the first morning of inspection, inspectors observed some residents apparently trying to sleep, lying in their beds with their eyes closed. Meanwhile, all around them staff were assisting other residents in getting up and

dressed, while others were also preparing for their day. This situation was also confirmed by staff at interview.

The incident log in one unit identified frequent physical altercations between residents. One staff member interviewed stated he/she "has seen residents hitting and kicking each other". Inspectors were made aware of specific staffing arrangements for a resident who was involved in these altercations but on the second day of inspection, nursing staff were unable to identify how these arrangements were being implemented. Inspectors issued an immediate action plan in relation to this issue.

Inspectors found that the rights of residents were not adequately respected due to the inappropriate use of restraint, the lack of respect for the privacy and dignity of residents and poorly trained staff. For example, restraint measures were being used for excessively long periods of time due to inadequate staff numbers and the poor physical environment. These practices were in contravention of the HSE policy on the use of restrictive practices. In addition, there were inadequate records of when the restraint measures were being used. Staff informed inspectors that any release from the restraint during the day were dependent upon staff availability and was not planned on the basis of residents' needs.

A number of residents presented with behaviours that challenged and most of these residents were accommodated together in one unit. Staff members confirmed to inspectors that some of these residents were frequently in conflict with each other, which often contributed to an escalation in behaviours that challenged. Inspectors observed residents who did not get along with each other being situated in close proximity to each other and causing upset and escalated behaviour issues.

In the context of a potential for peer on peer assault, the inappropriate use of restraint and the significant care needs posed by behaviours that challenge, inspectors were particularly concerned that only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of challenging behaviour and in recognising and responding to abuse. Some staff members were able to tell inspectors about the triggers for behaviour issues and the alleviating factors, but not all staff had this information and it wasn't included in residents' personal plans.

The policy on restrictive interventions was not being implemented. The policy also stated that a rights review committee should review restrictive practices. However, the rights review committee had not yet been established. In one unit, there had been a review of restrictive practices and it identified a number of residents that required a locked door policy in that unit Other residents also resided in this locked unit. This was not a requirement for those residents and this practice infringed on the rights of those residents to freedom of movement. The policy also stated that restrictive interventions should not be used to overcome lack of staff supervision. Inspectors saw evidence of restrictive practices being used due to a lack of staff supervision, and this was confirmed by senior staff on the days of inspection.

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

Findings:
Residents had access to the services of a general practitioner (GP) who was on site for a number of hours each day from Monday to Friday. Residents also had access to out-of-hours GP services at evenings and weekends. Based on a sample of records viewed by inspectors, there was evidence of regular review.

Residents had access to some allied health/specialist services such as dietetics, speech and language therapy, and dental. However, there was limited access to other services such as physiotherapy and psychology. Records viewed by inspectors indicated that a number of residents were assessed by staff as being at risk of choking and were recommended for referral to a speech and language therapist, however there was no evidence that this referral had been made.

Staff spoken with by inspectors were knowledgeable about residents' health and social care needs. Personal support plans had been developed for each resident, and many were comprehensive in relation to addressing healthcare needs. There were records of assessment of issues such as falls risk, risk of developing pressure sores, manual handling assessment and nutritional assessments. However, as identified on the previous inspection, the daily care record was tick -box in nature and it was not possible to understand what care and support had been provided to residents or the condition and wellbeing of the resident during that day.

Meals were prepared in the central kitchen that also prepared food for other designated centres and were then collected from the kitchen in a heated delivery trolley. There was a choice of food available at mealtimes and residents spoken with by inspectors were complimentary of the food provided. Some residents had their meals in the dining areas of each of the units and others had their meals in a large dining room located beside the central kitchen. Residents from the day service and other centres located close by also had their meals in this dining room.

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

Findings:
There was a comprehensive, centre-specific medication management policy dated January 2015 that addressed the prescribing, administration, recording and disposal of medicines. There was a documented process for the management of PRN (as required) medications, and based on the observations of inspectors and discussions with staff, there was no covert administration of medicines. Prescription and administration records contained appropriate identifying information to support the safe administration of medicines. Each resident had two prescription sheets one for "psychiatry" medications and the other for "medical" prescriptions,

Based on inspectors' observations, medication administration practices were in compliance with relevant professional guidance.

There were adequate procedures in place for the management of drugs requiring special control measures. There was a procedure in place for the return of unused/out-of-date drugs.

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

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

Findings:
Inspectors found that the provider had not put sufficient governance arrangements in place to identify unacceptable staff practices, to identify gaps in the service and to identify actions that needed to be taken to address these deficits and improve the safety and quality of life for residents.

A new provider nominee had been appointed in October 2014 but had only visited the centre once between the date of the appointment and the date of this inspection. The person in charge of this centre was also the person in charge for three other centres for people with complex care and support needs. Based on the level of non-compliances found on this and the previous inspection, inspectors found that there were not suitable governance and management arrangements in the centre. The person in charge informed inspectors that due to inadequate resources, insufficient staffing and the complexity of the centres involved, that she felt she did not have the capacity to fulfil the role of person to be in charge for the four centres.

The provider nominee and the person in charge confirmed that there was no annual review of the quality and safety of care as required by the regulations. There was minimal evidence of an audit process to evaluate the quality of life and the quality of the service provided to residents. There was a review and categorising of accidents and incidents by the nature of the accident/incident, such as a fall or a medication error, however, there was no record of an analysis to support the implementation of an improvement plan.

An unannounced visit to the designated centre at least once every six months had not been carried out, as required by the regulations, to report on the safety and quality of care and support provided in the centre.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:

Inspectors found that there was insufficient staff to meet the needs of residents and to fulfil the requirements of the roster. The staffing shortfall was filled by staff working protracted overtime. Inspectors were informed that, including scheduled and overtime shifts, some staff could work up to ten 12-hour shifts each fortnight.

Based on observations of inspectors and interviews with staff, inspectors also found that there were insufficient numbers of staff on duty in each of the units to meet the physical, psychological and social needs of the residents. Examples of the impact that this had was on the excessive use of restraint in some areas of the centre due to insufficient staffing to supervise residents. Also, staff numbers were reduced during lunch time periods for residents with high physical and psychological needs. In addition activities for residents both within the centre and external to the centre were limited due to inadequate staffing.

There was inadequate evidence of a coordinated strategy for staff development to ensure they had the required training to support residents and meet their care and support needs. For example, there was poor attendance at training in relation to the provision of positive behavioural support to residents and training in the recognition and response to abuse. This was in the context of a centre that was home to a large number of residents with complex physical and psychological needs. Inspectors were informed that a number of staff were in attendance at training in protecting vulnerable persons on the second day of the inspection.

This was a HSE centre and operated under the HSE national policy for the recruitment and selection of staff. Inspectors reviewed a sample of personnel records and noted that the records did not contain many of the requirements in Schedule 2 of the Regulations to indicate that staff were suitable to work in the centre. Not all personnel files contained evidence of:
• the person's identity, including a recent photograph
• the dates of commencement and cessation of employment
• Garda vetting disclosure
• a full employment history together with satisfactory history of gaps in employment
• two written references
• the position the person holds at the designated centre
• evidence of relevant qualifications

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003999
Date of Inspection:	10 March 2015
Date of response:	30 April 2015

Requirements

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

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

Outcome 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:
Not all residents had access to advocacy services.

1. Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

Please state the actions you have taken or are planning to take:
Arrangements are being made with the National Advocacy service to formalise Advocacy arrangements in the centre whereby a representative from NAS will attend the centre on a monthly basis. The Cork Advocacy service runs a monthly residents forum which all residents are invited and facilitated to attend.
A member of staff is currently training with Sage Advocacy service and will offer Advocacy services to the residents.

Proposed Timescale: 31/07/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While inspectors were informed that there was a process for consulting with residents on the running of the centre, there was no evidence that this consultation resulted in actions by the provider on the areas of concern to the residents.

2. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
The resident's forum is private and confidential, to the residents that attend and as a group have made a decision to keep the minutes of their meetings private with an assurance that any issues that may be raised will be brought to the attention of management.

A Service User feedback form has been developed and has been given to the members of the Service User Forum at the scheduled meeting on 20th July 2015 to enable them to raise any topics which they would like to be addressed by the Centre.
The outcome and whether the person raising the concern is satisfied with the resolution / outcome will also be documented.

Proposed Timescale: 20/07/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were being applied to all residents in some areas of the centre, regardless of whether they required such measures. In one of the units, some residents required a locked environment for safety reasons, but all residents in that unit were subjected to this restriction.

There was inadequate evidence that the programme of activities took into consideration the interests and hobbies of residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

3. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
An additional 3 staff have been allocated to the day services to increase the amount of activation that can be facilitated both on and off site. In addition, arrangements have been made for residents from one unit to be provided with additional time to attend the activation centre from four pm to seven pm each evening. Additional activities, relevant to residents' interests, are being sourced including music and reminiscence activities.
Of the seventeen individuals within this unit, seven residents have been assessed as requiring restricted access due to the risk of absconding.
However, the remaining individuals do not have sufficient road safety awareness to leave the unit, unaccompanied at present, due to the proximity to a busy internal access road.
A keypad system for doors will be installed in early May.
An outdoor space will be provided, adjacent to the Unit, which residents can access freely without compromising safety an assessment of a suitable area will be carried out by the HSE Estates department.

A database of restrictive practices has been put in place. The required paper records will be monitored on an on-going basis at CNM 2 level. All restrictive practices will be reviewed on a 3 monthly basis at CNM 3 level.

A current audit of all residents' Personal Plans will be completed by 24/5/2015. The outcome of this audit will form the basis for the timelines for updating Personal Plans as appropriate.

Proposed Timescale: 24/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate screening between the male and female bedrooms, and within dormitory style bedrooms to ensure the privacy and dignity of residents

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

4. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of

each resident.

Please state the actions you have taken or are planning to take:
1. As an immediate interim measure screening has been enhanced through the fixing of opaque 'contact' material to the windows between the bedroom and dormitory area described. Blinds have been ordered and their delivery is awaited for immediate installation.

The family of the identified resident have not to date expressed any dissatisfaction with his current placement in a unit dedicated to elder / continuing care. However, in the planned closure of the unit this resident will be prioritised for transfer to an appropriate alternative placement.

2.Arrangements are explored to transfer this resident to a local residential centre for older people as an interim measure, he will continue to access day services within the centre

Proposed Timescale: 1.30/4/15 2.30/05/2015

Proposed Timescale: 30/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Sleeping accommodation for most residents was in multi-occupancy dormitory style bedrooms which compromised the privacy and dignity of residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required the provider to submit a detailed, viable plan with timelines by 10 April 2015 to address all design and layout contraventions.

5. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and 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:
In 1999, the decision was made to transfer a number of residents from this centre to more appropriate accommodation through the construction of a new facility on the campus. This facility comprised of 5 bungalows each accommodating 6 residents.
The final stage of capital approval was secured for this project in 2007. Construction was completed in 2010. With the reduction in the health budget, the new centre had to be opened with the existing level of staffing. This delayed the transfer to the centre until 2011 with the final bungalow opening in 2013.
It had been intended to progress a second development similar to the above, to address the needs of residents accommodated in the centre. However with the national

economic situation, capital funding to the health sector was substantially reduced making it not possible to progress this development.
In addition, in recent years the broader service has facilitated a number of people to move to community settings.

A detailed plan has been submitted for the transfer of residents from this centre to more appropriate environments. This is in line with 'Time to move on – report on congregated settings'.

The National Director of Social Care has briefed the CEO of HIQA in relation to the preparation of a national strategic plan to address key priority institutional settings. This strategy includes a service reform fund which will allow for special measure to be taken to escalate key priorities.

Plans already submitted by management for the transfer of residents from one of the units in this centre and a community hostel, as part of the HSE programme of transfer of residents from congregated settings have now been extended to include all of the units in this centre. These are being considered as part of the national strategic plan outlined above.

Aside from funding requirements, the transfer of this number of residents from the designated centre to community settings requires a major change programme which will include detailed transition plans for individuals, and engagement with families as well as sourcing appropriate accommodation. This programme will be carried out in line with the principles of the national programme for transfer of individuals from congregated settings.

Residents will be relocated to a number of settings including; community houses, nursing homes, community hospitals. Work has commenced on sourcing a project manager and change management team to support the identification of the most appropriate accommodation due to the particular needs, age profile and physical dependency of the residents in these units. This team will facilitate the phased transfer of residents as appropriate accommodation is identified and secured.

The closure plan and associated timelines were identified in the context of the profile of residents in St Raphael's including individuals with challenging behaviour, often with dual diagnosis i.e. autism or mental health along with frail, older people with significant disabilities.

The risks arising from the relocation of both groups to community settings can only be managed by a comprehensive process of assessment, planning and phased implementation of the transfer to community settings. This, along with the need to identify suitable premises, requires time.

However, since the response was returned in April, a number of residents have moved from St Raphael's Centre either on a permanent or a temporary basis. It is anticipated that the maximum numbers in the Centre by December 31st will be 30.

Following the feedback, given by HIQA at the end of the inspection on 26.05.15, the

closure plan and timelines will be reviewed by the HSE to determine what is required to complete closure before 31.10.16. We would welcome an opportunity to meet with HIQA to discuss the details of the closure plan.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Measures had not been put in place to ensure the privacy of each resident's bed space.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required interim measures to be put in place to enhance the privacy of each resident's bed space by 24 April 2015.

6. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and 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:
A plan has been agreed and funded with HSE Estates for immediate works which provide for partitioning and acoustic panels in each unit to increase privacy and reduce noise levels. A tendering process is currently in train and it is anticipated that the contractor will commence work on May 18th 2015. The works will take approximately eleven weeks to complete for all of the three units. The refurbishment will be completed for the first unit by 12.06.15 and residents will benefit from an improved environment and increased privacy. Arrangements are being put in place with a facility for older people to secure temporary accommodation for residents while this work is being carried out.

Refurbishment has now been completed in one unit and will be completed in the remaining units by 31/12/15. This will increase the privacy and dignity of residents in relation to living spaces. The numbers accommodated in each unit will be substantially reduced on completion of the refurbishment.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was significant levels of noise from residents shouting and frequently several residents were shouting simultaneously. This was upsetting to other residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required a plan for the reduction of noise levels in the centre to be submitted by 24 April 2015.

7. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and 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:
A plan has been agreed and funded with HSE Estates for immediate works which provide for partitioning and acoustic panels in each unit to increase privacy and reduce noise levels. A tendering process is currently in train and it is anticipated that the contractor will commence work on May 18th 2015. The works will take approximately eleven weeks to complete for all of the three units. The refurbishment will be completed for the first unit by 12.06.15 and residents will benefit from an improved environment and increased privacy.

On completion of these works, it is intended that the numbers accommodated in the centre will be reduced. This will assist in reducing noise.

A closure plan for this centre is being developed as outlined above. The closure of the unit where significant levels of noise are most prevalent will be prioritised within this plan. The noise levels will be reduced as resident numbers are reduced on a phased basis.
Part of the refurbishment currently being planned by HSE Estates includes the provision of acoustic measures, including wall finishes, to reduce noise.

A system is now in place to support the service users in a reduction of noise level and in availing of alternative space. This is facilitated by the staff assisting a number of service users in spending time to the Day Service between 4pm to 7pm each evening.

Additional staff training is being delivered to meet the needs of people with behaviours that challenge. This will assist in reducing incidents of challenging behaviour and significant noise levels.

An additional range of activities provided for residents will also assist in reducing incidents of challenging behaviour and significant levels of noise.

Proposed Timescale: 24/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One of the units, including a bedroom, was used by staff as a shortcut to access other parts of the centre, which compromised the privacy of residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed immediately.

8. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and 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:
The practice of using this area to access other parts of the centre has now ceased and a written instruction to this effect has now been issued to all staff.

Proposed Timescale: 01/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a complaints policy that identified the complaints officer, however, it did not adequately outline the appeals process.

9. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The current complaints policy appendix is being updated and will take cognisance of the concerns raised .An accessible version of the procedure is available for the residents and at the weekly residents' meeting in each area the easy read complaints leaflet is discussed with the residents so that they are familiar with the process.
It is proposed that the individual PIC in each area will become a designated complaints officer and the complaints will be reviewed by the CNM3 each month. Should an independent review of any complaint be required as per "Your Service Your Say" this can be facilitated through the Director of Nursing or via the HSE Consumer Affairs department.

Proposed Timescale: 30/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on the sample of complaints reviewed there was inadequate evidence of action in response to all complaints and it was not always recorded if the complainant was satisfied with the outcome of the complaints process.

10. Action Required:
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The current complaints policy is being updated and will take cognisance of the concerns raised.

A system will be developed to identify lessons learned from complaints so that the service and experiences for the services users can be improved. Complaints logged and how they were dealt with and the outcomes/satisfaction will be reviewed monthly and discussed at staff meetings to ensure compliance.

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Activities that corresponded with the assessed interests of the residents were not being made available to residents..

11. 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 Day Service has recently completed a questionnaire with the service users .There is a check list of the service user's interests and hobbies. The Day Service provided will be planned based on the interests and choices of the Service Users.
The allocation of an additional 3 staff will allow for more flexibility in delivering activation to the residents.

Proposed Timescale: 30/05/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the centre was not suitable to meet the needs of the residents:

In the improvement notice issued on the 25 March 2015, the Chief Inspector required the provider to submit a detailed, viable plan with timelines by 10 April 2015 to address all design and layout contraventions.

12. 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:
Plans already submitted by management for the transfer of residents from one of the units in this centre and a community hostel, as part of the HSE programme of transfer of residents from congregated settings have now been extended to include all of the units in this centre. These are being considered as part of the national strategic plan outlined above.

A detailed plan has been submitted for the transfer of residents from this centre to more appropriate environments. This is in line with 'Time to move on – report on congregated settings'. In the interim HSE Estates have carried out an assessment of the current environment. Work will commence on 18.05.15 on the refurbishment of the current units which provides for partitioning and acoustic panels within each unit. The refurbishment will improve privacy and reduce noise levels.

the closure plan and associated timelines were identified in the context of the profile of residents in St Raphael's including individuals with challenging behaviour, often with dual diagnosis i.e. autism or mental health along with frail, older people with significant disabilities.

The risks arising from the relocation of both groups to community settings can only be managed by a comprehensive process of assessment, planning and phased implementation of the transfer to community settings. This, along with the need to identify suitable premises, requires time.

However, since the response was returned in April, a number of residents have moved from St Raphael's Centre either on a permanent or a temporary basis. It is anticipated that the maximum numbers in the Centre by December 31st will be 30

Following the feedback, given by HIQA at the end of the inspection on 26.05.15, the closure plan and timelines will be reviewed by the HSE to determine what is required to complete closure before 31.10.16. We would welcome an opportunity to meet with HIQA to discuss the details of the closure plan.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The centre was not maintained in a good state of repair, for example:

13. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The refurbishment work to commence on 18.05.15 will address all of these issues.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not suitably clean throughout, for example:

14. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
Cleaning System is currently being reviewed to ensure all daily routine schedules will ensure the centre is clean and maintained.
Deep cleaning will be undertaken to remove any mould or stains that can be removed
Plans have been submitted for more suitable premises that meets residents and collective needs in a comfortable and homely way.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the centre did not meet the requirements of the residents as specified in Schedule 6 of the regulations.

15. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Plans already submitted by management for the transfer of residents from one of the units in this centre and a community hostel, as part of the HSE programme of transfer of residents from congregated settings have now been extended to include all of the units in this centre. These are being considered as part of the national strategic plan

outlined above.

A detailed plan has been submitted for the transfer of residents from this centre to more appropriate environments. This is in line with 'Time to move on – report on congregated settings'. In the interim HSE Estates have carried out an assessment of the current environment. Work will commence on 18.05.15 on the refurbishment of the current units which provides for partitioning and acoustic panels within each unit. The refurbishment will improve privacy and reduce noise levels.

the closure plan and associated timelines were identified in the context of the profile of residents in St Raphael's including individuals with challenging behaviour, often with dual diagnosis i.e. autism or mental health along with frail, older people with significant disabilities.

The risks arising from the relocation of both groups to community settings can only be managed by a comprehensive process of assessment, planning and phased implementation of the transfer to community settings. This, along with the need to identify suitable premises, requires time.

However, since the response was returned in April, a number of residents have moved from St Raphael's Centre either on a permanent or a temporary basis. It is anticipated that the maximum numbers in the Centre by December 31st will be 30

Following the feedback, given by HIQA at the end of the inspection on 26.05.15, the closure plan and timelines will be reviewed by the HSE to determine what is required to complete closure before 31.10.16. We would welcome an opportunity to meet with HIQA to discuss the details of the closure plan.

Proposed Timescale: 31/10/2016

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:
While incidents and accidents were recorded, there was inadequate collation and analysis of the incidents to mitigate reoccurrence or to support quality improvement.

16. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A HSE Risk Manager is to commence a programme of training with nurse managers at this centre in relation to
• Risk Identification and Risk Management processes

• Incident management and Incident Reporting processes
The centre administrator will access NIMS training (National Incident Management System) on 29/4/15. He is also being facilitated to have immediate access to the STARSweb system for reporting incidents.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate procedures in place for hazard identification and assessment of risks throughout the centre.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed immediately.

17. 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:
A HSE Risk Manager is to commence a programme of training with nurse managers at this centre in relation to
• Risk Identification and Risk Management processes
• Incident management and Incident Reporting processes
The centre administrator will access NIMS training (National Incident Management System) on 29/4/15. He is also being facilitated to have immediate access to the STARSweb system for reporting incidents.

Management are developing systems for reviewing all incidents that will involve a procedure for investigating and learning from near misses and serious incidents .

The residents individual evacuation plan will be updated and reflect their individual needs in the event of an evacuation.

The speech and language therapist is currently reviewing all residents in this area; all those that were deemed as requiring a S&LT assessment have been reviewed. She will commence on Saturday 29/07/2015 (next date of visit) to commence assessments of all residents so that they will all have a baseline S&LT assessment. This will take a number of visits to complete. This process is ongoing.

Proposed Timescale: Completed

Proposed Timescale: 29/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate procedures in place for hazard identification and assessment of risks throughout the centre.

18. 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:
Alternative arrangements now in place for the safe keeping of the residents Cigarettes/Matches.
All staff have been made aware to follow the Regulations and guidance in relation to all fire doors.
The on-going refurbishment work will remove the requirement to use an electrical extension reel as a long term power source.

Risk assessments are up date with reference to the use of PPE's.
Dani centres which house PPE's have been removed from each area and relocated to the bathroom/shower room areas.
The issue of door being held open with an inappropriate tie has been addressed and no longer occurs. The refurbishment includes ensuring that all fire doors are fitted with magnetic catches.

Proposed Timescale: 20/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some hand hygiene foam dispensers were unclean.

19. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
System in place to review cleaning schedules and ensuring the Housekeeping staff adhere to the schedule.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not adequate plans in place for the evacuation of residents in the event of a fire taking into account the physical and psychological needs of residents or locked emergency exits.

20. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
All residents in the event of a evacuation can be facilitated in the dining hall area and if necessary in the 3 day service areas, these areas all have suitable water, power and heat to accommodate residents for up to 4 hour period.

All personnel evacuation plans have been updated taking into account the physical and psychological response of the residents. In operation since 01/06/2015

Proposed Timescale: 01/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Emergency lighting had most recently been tested in March 2014, however, from the records available it was difficult to ascertain if the emergency lighting in all of the units in the centre was serviced.

21. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
All residents in the event of an evacuation can be facilitated in the dining hall area and if necessary in the 3 available day service areas, these areas all have suitable water, power and heat to accommodate residents for up to 4 hour period. In the event of the building being deemed unsuitable for return contact will be made with the HSE Emergency response team who will liaise with other establishments to organise suitable alternative accommodation.

As part of the contract with Horizon all emergency lightening is checked in each area on a quarterly basis.
The company has been contacted to supply up to date servicing records.

Proposed Timescale: 01/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records viewed by inspectors indicated that the fire alarm system was most recently serviced in April 2014 and was not done quarterly.

22. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
As part of the contract with Horizon all the fire alarm systems are checked in each area on a quarterly basis.
The company has been contacted to supply up to date servicing records.

Proposed Timescale: 01/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all, staff had up-to-date training in fire safety.

23. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Consultation will take place with the Fire officer to roll out training in fire safety on an ongoing basis.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were held infrequently.

24. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety

management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A review of the Fire Evacuation will be carried out which will incorporate schedules of Fire Drills at six Monthly intervals and Fire Records will include the details of the fire drills, Fire Alarm testing, and fire safety equipment.

Proposed Timescale: 31/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices and restraint measures were not based on the assessed needs of residents and were impacting negatively on the safety and wellbeing of residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed immediately.

25. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
The provision of additional 1:1 supports for the identified resident in one unit has been agreed and will be put in place immediately, subject to staffing availability. Pending staff recruitment, all measures will be taken to minimise the use of restraint. The individual is scheduled for transfer to another residence where the environment presents less risk.
Of the seventeen individuals within this unit, seven residents have been assessed as requiring restricted access due to the risk of absconding.
However, the remaining individuals do not have sufficient road safety awareness to leave the unit, unaccompanied at present, due to the proximity to a busy internal access road.
A keypad system for doors will be installed in early May.
An outdoor space will be provided, adjacent to the Unit, which residents can access freely without compromising safety subject to an assessment by the HSE Estates department.

A database of restrictive practices in use in the centre has been put in place. The required paper records will be monitored on an on-going basis at CNM 2 level. All restrictive practices will be reviewed on a 3 monthly basis at CNM 3 level.

Two introductory meetings of the rights committee for the centre have been held. All

family members were invited to same. A follow up meeting was held on 8/4/15. 5 family representatives and 3 staff representatives attended this meeting to agree Terms of Reference and appoint a Chair to the Committee. This will include a regular review of all restrictive practices in the centre.

Proposed Timescale: 01/06/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Only a small number of staff had received the required up-to-date training on identifying and alleviating the underlying causes of challenging behaviour.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

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

Please state the actions you have taken or are planning to take:
HSE is committing to ensuring staff in this centre have training in behaviour that is challenging including de-escalation and intervention techniques. The plans and timescales for delivering this training are influenced by the current extensive training being delivered in safeguarding to all staff in the centre (incorporating 3 other designated centres.)

Training on challenging behaviour is currently being sourced via Joe Wolfe & Associates. This training includes a focus on the development of positive behaviour support plans. This training will be a two day programmes for 30 staff initially, in the centre with dates on the first and third weeks of May. A total of 30 staff will be trained by 22nd of May 2015. This training will be further enhanced with the support of the Clinical Nurse Specialist (Positive Behaviour Support Planning) appointed in November 2014.

In addition, a consultant from Joe Woolfe and Associates will work with staff in the Centre to support them in putting the positive behaviour supports into practice.

To date 68 staff in total throughout the four designated centres, of which 18 staff members are currently rostered in this centre have received training in PMAV (Prevention & Management of Aggression & Violence).
This training includes didactic components and comprehensive intervention techniques in respect to the management of behaviours that challenge. i.e. The training focuses on; stage specific interventions and de-escalation, causes of behaviours that challenge, impact of same, as well as the psychological and physiological impacts of behaviours that challenge.

Proposed Timescale: 22/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Alternative measures to restraint had not been adequately considered before restrictive procedures were used; and staff were not ensuring tthat the least restrictive procedure, for the shortest duration necessary, is used.

In the improvement notice issued on 25 March 2015 the Chief Inspector required this failing to be addressed immediately.

27. 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 rights Committee has been set up in supporting the rights of residents in the use of restrictive practices.
Plans are being developed to Strengthen the Governance and provide training to staff on the use of restrictive procedures and that all alternative measures are considered before a restrictive procedure.
Where restrictive procedures are assessed as being required by the Multidisciplinary team involvement, the least restrictive procedure, for the shortest duration will be used.
The monitoring of restrictive practices will be reviewed monthly by the Management team.

Proposed Timescale: 20/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate arrangements to protect from all forms of abuse, including institutional abuse and physical peer-on-peer assault.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed immediately.

28. 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:
Risk assessments are currently being completed in each unit. These will be reviewed

and updated in line with the HSE Risk Management Policy.

Target date for completion: 30.04.15

An audit tool is currently being developed to evaluate staff learning and competencies in this area following training.

Target date for completion: 31.05.15

All staff have now been briefed by Nurse Managers at CNM 3 / CNM 2 level with regard to recognising abuse, staff responsibilities regarding reporting abuse and the procedures for same.

Target date for completion: completed

2 Nursing Staff have completed 'trainers' training in the area of safeguarding and protection of vulnerable adults within an I.D. setting (J Wolfe & Associates). This has been rolled out to staff in the Centre. This training referenced Trust in Care and the HSE Safeguarding Vulnerable Adults policies. This is a very comprehensive training programme tailored specifically for an I.D. setting.
Target date for completion: 24/4/15

The 3 CMN1s in this centre completed the Trust in Care training module on 7/4/15. This training was being facilitated by Performance and Development, HSE. It provided an understanding of the HSE Trust in Care policy and will serve to increase the capacity and knowledge of nurse managers around the identification and management of any concerns regarding abuse.
Target date for completion: 7/4/15
Arrangements have been made to ensure that safeguarding and protection is on the agenda for all unit meetings and nurse management meetings.
Target date for completion: completed
The establishment of a safeguarding committee is being initiated.
Target date for completion: 30/6/15
A HSE Risk Manager to commence a programme of training with nurse managers at this area (4 designated centres) in relation to:
• Risk Identification and Risk Management processes
• Incident management and Incident Reporting processes
Target date for completion: 31.05.15

The HSE National Quality Improvement Team, which has completed an initial assessment in this area on 10/03/2015, will as part of their brief, monitor the effectiveness of the planned safeguarding training. They will escalate any issues to management immediately. They will focus in particular on the Continuing Professional Development needs of nursing staff.

Target date for completion: ongoing (next visit before 8/5/15)

A systems analysis investigation has been commissioned on foot of the incident reported on 23/2/15. Terms of Reference have been finalised and the investigation

team identified by the Commissioning Officer. Any shortcomings identified and actions suggested will be implemented as a matter of urgency.

Staffing levels will be increased in the Activation service to provide residents with increases activation so that the number of residents in the units is decreased so it will lessen the possibility of peer on peer abuse,

The information sessions regarding staff awareness of what constitutes all forms of abuse will be continuous enabling staff to react in an appropriate manner to identify and address issues of abuse.

The proposed improvements in the sleeping arrangements will enhance the privacy and dignity of the residents and this will lessen the potential of peer on peer abuse and institutional abuse.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not been provided with training in safeguarding residents and responding to allegations of abuse.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

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

Please state the actions you have taken or are planning to take:
All staff have now been briefed by Nurse Managers at CNM 3 / CNM 2 level with regard to recognising abuse, staff responsibilities regarding reporting abuse and the procedures for same.

Target date for completion: completed

2 Nursing Staff have completed 'trainers' training in the area of safeguarding and protection of vulnerable adults within an I.D. setting (J Wolfe & Associates). This has been rolled out to staff in the Centre. This training referenced Trust in Care and the HSE Safeguarding Vulnerable Adults policies. This is a very comprehensive training programme tailored specifically for an I.D. setting.

Target date for completion: 24/4/15

The 3 CMN1s in this centre completed the Trust in Care training module on 7/4/15.

This training was being facilitated by Performance and Development, HSE. It provided an understanding of the HSE Trust in Care policy and will serve to increase the capacity and knowledge of nurse managers around the identification and management of any concerns regarding abuse.
Target date for completion: 7/4/15

Arrangements have been made to ensure that safeguarding and protection is on the agenda for all unit meetings and nurse management meetings.
Target date for completion: completed

Proposed Timescale: 24/04/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents had access to some allied health/specialist services such as dietetics, speech and language and dental, however, there was limited access to other services such as physiotherapy and psychology. Staff had not made referrals to health specialists that were recommended for residents

30. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
A Speech and Language Therapist (SALT) has attended the service since January 2015 and all residents who were deemed as requiring an assessment by the SALT have been assessed and the completed assessments have been filed in their personal care plans. Residents who were identified as not requiring an assessment will be assessed to have a baseline of their needs.

An OT has been sourced and has commenced assessments March 2015 on residents who have been deemed as requiring priority assessment. This is ongoing and all residents will be assessed

A dietician has been sourced from Nualtra and has visited the service on 21/04/2015 and will visit every 4-6 weeks to assess resident's needs.

Physiotherapy services are available from the HSE and also residents can and are referred to a private physiotherapist as the need arise; this cost of this is met by the service.

The provision of a psychologist has been requested as part of the recruitment of a MDT submitted to the HSE.

Proposed Timescale: 30/07/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not have the capacity to meet the requirements of the role as required under the standards and regulations.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required the provider to appoint a person in charge solely for this centre immediately.

31. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
Arrangements are being made to identify a designated person in charge for this centre and the HSE will revert back to HIQA by Friday 1st May with a nominated name.

Proposed Timescale: 01/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on the findings of this inspection and the level of non-compliance, inspectors found that there were suitable governance and management arrangements in the centre.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

32. 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:
A CNM2 has recently been appointed to this area that is supernumerary post.
A dedicated person in charge will be identified for this centre by 01.05.15.

From the 13th March 2015 the CNM2/CNM3 met with all staff to remind staff of the HSE Trust in Care/Protection of Vulnerable adult's policies, and their responsibilities to report any concerns.
The Quality improvement team have visited the centre to discuss and address issues highlighted to them.
HSE Quality manager will deliver training on systems of audits in the centre the week beginning the 25th of May 2015 to CNM's and senior staff.
HSE Risk manager will deliver training to a cohort of senior staff on Thursday 30th April 2015 to address issues re risk management.

Nominee Provider reiterated to all managers that all complaints and concerns will be dealt with as per policy and outlined the importance of staff highlighting any concerns they have, even if this relates to colleagues. The service will support all staff involved and also the Employee assistance programme is an additional to staff involved in the complaints

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care to inform improvements in the service to residents, as required by the regulations.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015 and to submit the report to the Chief Inspector.

33. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
A system of regular audit is currently being explored in consultation with other service providers and the HSE Quality Improvement Team.
Liaison with the Quality Manager is on-going regarding the provision of training for nurse management in audit systems.
The training being sourced through the Quality Manager) and Risk Manager will facilitate the development of an appropriate review system. It is envisaged that this could be completed by 30/9/15.

Proposed Timescale: 24/04/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An unannounced visit to the designated centre at least once every six months had not been carried out, as required by the regulations, to report on the safety and quality of care and support provided in the centre.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required the provider to carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the Chief Inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. Make a copy of this report available to the Chief Inspector

This action to be addressed 24 April 2015.

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

Please state the actions you have taken or are planning to take:
The Nominee Provider did an unannounced visit on the 22nd April 2015 and has since submitted a report to the Authority.

Proposed Timescale: 24/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient staff on duty in each of the units to meet the physical, psychological and social needs of the residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed immediately.

35. 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 following recruitment plan for this and three other designated centres in the area

has been approved by HSE management.
1. recruitment of 12 Registered Nurses in ID through
• national and local competitions
• engagement of recruitment agency on 'finder fee basis'
Target date for completion: 31.07.15

2. increasing Care Assistant Complement
• recruit 13 additional support staff (housekeeping role)
• re-assign 13 staff with FETAC qualifications from housekeeping to Care Assistant
Target date for completion: 30.6.15

3. Social Care Workers
• recruit 12 additional Social Care Workers and assign to replace nurses in community houses
• reassign nurses from community houses to St Raphael's Centre

The initial focus of the recruitment plan is to reduce reliance on overtime. As the complement of staff available increases, and reliance on overtime reduces, the service will be able to ensure on an ongoing basis that staffing levels and skill mix are maintained at appropriate levels.

With the current refurbishment works the number of residents that will be accommodated will be significantly reduced.
30 residents will be accommodated in these 3 areas and the staffing per unit each with 10 residents will be 5/6 staff members in each area delivering direct care, 1 housekeeping staff and both 1-1 specials in situ day and night will continue.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all personnel files contained the information required under Schedule 2 of the regulations.

36. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The majority of staff files are compliant with schedule 2, those who are not are currently been reviewed and will be compliant.

Proposed Timescale: 31/05/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of a coordinated strategy for staff development to ensure staff had the required training to provide appropriate support and care to residents.

In the improvement notice issued on the 25 March 2015, the Chief Inspector required this action to be addressed by 24 April 2015.

37. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
A CNS in Positive Behaviour support planning has been appointed since Nov 2014 and is currently assessing residents needs with regards to challenging behaviour and will work in conjunction with Joe Wolfe.

Plans are in place to deliver training in relation to behaviours that challenge via Joe Wolfe and Associates, external training consultant. This training includes a focus on the causes of challenging behaviour, and positive behavioural supports. The training will be a two day programme. Fifteen staff will be trained by mid (May 7th and 8th May) with a further fifteen staff to be trained by the end of May (21st and 22nd May) Other training dates are as scheduled.
11 and 12th June
9th and 10th July
13th and 14th August
10th and 11th September
8th and 9th October
22nd and 23rd October
12th and 13th November
26th and 27th November

A trainer from this course will work in SRC for 10 days, commencing May 6th, and continuing on the following dates: 18/05/15
3/6/2015
8/6/2015
19/6/2015
25/6/2015
3/7/2015
6/7/2015
17/7/2015
24/7/2015

He will assist staff in translating the principles of person-centred practice and positive behavioural supports from training into day-to-day work.

The impact of this training and ongoing support work will be that person centred plans for individuals will be implemented more effectively. Staff will be better placed to identify the causes of challenging behaviour and diffuse incidents, leading to better quality of life for residents with behaviours that challenge and reduced incidents of peer abuse.

In association with Joe Wolfe and associates additional training in physical interventions will be sourced.

Manual handling training/fire training and hand hygiene are currently ongoing.

The impact of the training and progress on person centred planning will be monitored through the Quality Improvement Team.

Proposed Timescale: 01/12/2015