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:	Cliff House
Centre ID:	OSV-0003257
Centre county:	Dublin 3
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stepping Stones Residential Care Limited
Lead inspector:	Caroline Vahey
Support inspector(s):	Marie Byrne
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. 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:
27 November 2017 08:10	27 November 2017 18:15
28 November 2017 09:55	28 November 2017 16:35

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

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

Summary of findings from this inspection

Background to the inspection:
This was a triggered inspection following receipt of concerning information relating to safeguarding and safety of residents. A one day inspection was planned, however due to concerns identified on the first day of inspection in relation to risk and safeguarding the inspection was completed over two days. The centre had previously been inspected by the Health Information and Quality Authority (HIQA) in July 2017.

How we gathered our evidence:
As part of the inspection the inspectors visited both units in the centre, met four residents, and observed staff providing support to residents. Inspectors met and spoke with the person in charge, director of service, provider representative, director of finances, person participating in management of the designated centre, and ten staff members. Documentation such as personal plans, risk management plans, minutes of meetings, medication records, staff training records and policies and procedures were also reviewed.

Description of the service:
The centre consisted of two units. One of the units was a small self-contained house for one resident whilst the other unit was a house providing residential care for three

residents. Both houses were located in suburban areas. The centre had produced a statement of purpose, which outlined the objectives of the centre which were to provide a high standard of care and support, in keeping with best practice and current legislation, to young people with an intellectual disability and autistic spectrum disorder who require residential care, while ensuring privacy, dignity and confidentiality at all times. The inspectors found the service provided did not meet the objectives as set out in the statement of purpose and the standard of care and support provided were not in keeping with the requirements of the legislations and with best practice.

Overall judgment of findings:
Overall, the inspectors found significant failings on the day of inspection and major non-compliances were identified in seven of the eight outcomes inspected against including, residents' rights, dignity and consultation, health and safety and risk management, safeguarding and safety, healthcare needs, medication management, workforce and governance and management. Inspectors found that there were ineffective management systems in place in order to support and promote the delivery of safe care in the centre. The management of risk, recent safeguarding incidents, and staff training and knowledge raised significant concerns regarding the management systems in place in the centre. There was a lack of oversight of the provision of services in the centre and a failure of those responsible to take responsive actions to issues raised. Auditing processes in the centre, while identifying issues of concern, were not appropriately responded to by the management team in order to ensure the safety and wellbeing of residents, and to drive continuous improvements. The lack of oversight of the service was resulting in poor outcomes for residents and increasing their exposure to risk. The person in charge reported back on duty on the first day of inspection following an absence of over one month from the centre. In their absence the provider had placed the director of service in the house to oversee care and support in the centre.

The staff numbers and skill mix in the centre did not meet the assessed needs of residents. Inspectors found that the unstable workforce in the centre was impacting on continuity of care for residents and on their quality of life overall. Appropriate measures were not in place to safeguard and protect residents from abuse. Residents were not provided with the emotional, behavioral and therapeutic support that promoted a positive approach to behaviour that challenges. The provider had just recruited a new behaviour therapist and had recently employed a private behaviour therapist to complete an assessment for one resident.

Inspectors found that the health and safety of residents, visitors and staff was not always protected in the centre. There was evidence of poor management of incidents in the centre. Appropriate procedures were not in place for safe administration of medicines. Each resident was not supported to receive a good standard of evidence-based care and support in the centre consistent with their assessed needs. Residents were not encouraged by staff to maintain their own privacy and dignity.

These findings are discussed in the body of the report and the regulations which are not being met in the action plan at the end of the report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, inspectors found that residents' rights, privacy and dignity were not maintained in the centre. Overall the inspectors found that personal care practices in the centre did not respect residents' privacy and dignity.

The privacy of personal information in respect of each resident was found not to be respected or kept secure in the centre. Personal information pertaining to residents was on display on a notice board in the kitchen, and folders with personal information were on the sideboard and kitchen table. There was a document which contained quick reference information relating to each resident for agency staff on display on a noticeboard in the kitchen. In addition, residents' personal information was observed to have been shared with staff through their personal e-mails and the inspector were not assured that residents' privacy and dignity was respected in this regard.

Personal care practices did not ensure residents' privacy and dignity was respected. The inspectors observed that due to a lack of working bathroom facilities and a resident's bedroom visible from the external garden, that residents' privacy and dignity was not maintained during intimate and personal care.

There was information on advocacy services available in an accessible format which was displayed in a prominent area in the centre.

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:
Overall, inspectors found that residents were not supported to receive care and support in the centre in line with their assessed needs. Personal plans were in place however, plans were not consistently implemented. Improvements were required in relation to review of personal plans and goals set for children.

Personal plans had been developed for residents' social, personal and behavioural needs. However, a number of healthcare plans were not developed. There were plans in place for review of goals on a monthly basis. However, it was found that this had not been carried out consistently. Review of personal plans did not consistently assess the effectiveness of the personal plans. Personal plans were available in a format accessible to residents.

There was evidence that residents were not consistently engaging in meaningful activities in line with their interests and preferences. Activity records for residents were reviewed by the inspectors. Comparisons were made between the level of activities which residents engaged in when there was a more stable workforce, and now. There was a marked decrease in meaningful activities especially community based activities in recent times. Staff reported to inspectors that due to the unstable workforce at the time of inspection they were limited to supporting residents to engage in meaningful activities close to the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Overall inspectors found that the health and safety of residents, visitors and staff was not consistently protected in the centre. Risks in the centre were not appropriately assessed or managed. There were poor hand hygiene practices in the centre. Some aspects of the fire evacuation procedure in place had not been trialled to ensure they were effective.

There was a risk management policy in place in the centre. The policy detailed risk identification, risk analysis, risk evaluation, risk treatment, monitoring, review and learning, recording of risk management procedure, hazard identification and severity of events. There were risk management plans in place in the centre, however; control measures were not implemented in practice. For example, the inspectors reviewed adverse events reported through incident reports and through notifications to HIQA however; the measures outlined in the risk management plans were not consistently implemented. In addition, the measures outlined in response to information received by HIQA in October 2017 were discussed with the director of services who outlined these measures had also not been implemented.

There had been a reduction in staffing levels for one resident in July of this year from 2:1 staffing to 1:1 staffing. The inspectors were informed by the person in charge this followed an assessment by the provider, and the inspectors requested information to demonstrate how this decision was reached, and to view risk assessments in relation to this staffing reduction. This information was not made available to the inspectors within a specified timeframe, and had not been made available to the person in charge or staff on the ground.

A number of risks were identified on inspection. The inspectors found that the temperature in the kitchen radiator in one unit was 54.5 degrees Celsius presenting a risk of burn to residents in the centre. This was highlighted to the person in charge by the inspectors and works were completed to rectify this issue by the end of the first day of inspection. Eight thermostatic radiator valves were missing for radiators in the centre. This was also highlighted to the person in charge and works completed to rectify this issue by the end of the first day of inspection. In addition, loose paving stones were found on the access route to the garden which residents used for recreational purposes.

The arrangements in place for investigating and learning from serious incidents were not found to be consistently implemented in the centre. The inspectors reviewed incidents records and restrictive practice records in the centre. There were high levels of adverse incidents in the centre as evidenced in a restrictive practice log. Incident reports were not always completed following these adverse incidents involving residents. In addition, there was limited evidence of follow up or learning following some incidents in the

centre in order to reduce risks and prevent reoccurrence.

There were fire evacuation plans for day and night time. However, there was no documentary evidence that since the last inspection by HIQA to show how some residents could safely evacuate through the window exits, or at night time in the event of a fire. A number of doors were found to be wedged open on the first day of inspection, including the kitchen door, and the lower corridor door, negating the function of these doors in the event of a fire.

Satisfactory procedures were not in place for the prevention and control of infection. There was no hand soap available in areas of the centre. Hand soap was stored in a safe for safety purposes. However, a staff member could not access the safe as they did not know the code or how to use it. There were three doors between the bathroom and the hand washing facilities in the kitchen. The hot water tap was not working at the hand washing sink in the kitchen. There were no hand towels available in areas of the centre.

Since the previous inspection suitable colour coded cleaning equipment had been provided.

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

Findings:
Overall, inspectors found that measures were not in place to safeguard residents and protect them from abuse. Residents were not provided with the emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

Each resident had a positive behaviour support plan in place. However, the inspectors found these plans did not sufficiently guide staff practice in supporting residents particularly in relation to the use of physical restrictive procedures. In addition, a resident's behaviour support plan had not been updated to reflect the removal of the

use of physical restraints. For another resident, the behaviour support plan had not been updated to reflect a changing need, following a significant increase in risk. The inspectors were not assured, given the instability of the workforce and the reliance on these plans to guide the day-to-day provision of care, that residents were safely supported in the centre.

Some staff had not been trained in managing behaviour that is challenging. In addition some of these staff had not completed training on the use of physical holds, however, were required to support residents, with whom the use of physical restrictive holds formed part of the reactive strategies employed to manage behaviour that challenges. Some staff spoken with by inspectors could not describe proactive or reactive strategies in place for residents, or when to use physical holds techniques outlined in residents' behaviour support plans.

A behaviour therapist had been recruited and had recently commenced working in the centre. Prior to this support from a behaviour therapist had not been available for a number of months and staff reported there was a significant increase in incidents and the use of restrictive measures, reflective of the findings on the day of inspection.

Some adverse incident reports were not made available to the inspectors on the day of inspection. The use of restraint log did not correlate with the incident reports in the centre. The inspectors reviewed logs on the use of restrictive practices and found the use of these practices had significantly increased in recent months. Staff reported this was due to the instability of the workforce and a lack of therapeutic support to implement agreed strategies to reduce the use of some practices. In addition, the inspectors found an environmental restrictive practice of locking a resident's bathroom was in use. The person in charge and a staff member were unclear as to the rationale for use of this practice.

Notifications had been made to HIQA recently following allegations of abuse and the provider had investigated these incidents. However, some recommendations arising following a recent investigation in the centre, to ensure all residents were safeguarded were observed not to be implemented. This resulted in residents being exposed to potential risk.

Some staff spoken with by inspectors were found not to be knowledgeable on safeguarding. Some staff could not identify the types of abuse or the procedure to follow if there was an allegation of abuse. The inspectors reviewed staff training records provided by the person in charge and found records were not available to confirm some staff had training in safeguarding children.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Overall, inspectors found that each resident in the centre was not supported with their healthcare needs.

Each resident had a health assessment commenced. However, complete assessments were not available. From the information available, health action plans had been identified following assessment. These action plans were discussed with the person in charge, who confirmed that most actions had not been completed. The healthcare assessments had not been reviewed in line with changes in residents' needs and medication regimes.

Healthcare plans to guide staff practice were not in place for some identified healthcare needs of residents and given the inconsistent workforce and a lack of appropriate induction, the inspectors were not assured that appropriate provision of care could be provided. A number of staff spoken to by an inspector could not describe the care and management of residents' healthcare conditions in line with the assessed needs.

Residents had access to a general practitioner and allied health professionals in line with their assessed needs. However, one resident was seen by his general practitioner five days prior to the inspection, and medication prescribed on that day had yet to be sourced from the pharmacy, and administered to the resident. The inspectors found this was also contrary to the organisation's policies and procedures on medication management. In addition there was no healthcare plan put in place for the resident.

The inspectors found a resident had not been provided with medical attention following an adverse event, despite the resident presenting with a known risk. Medical attention was sought a number of weeks after the event, through emergency services. This followed reporting of the adverse incident through the required statutory agencies. Procedures were now in place to guide staff in relation to contacting medical services.

Judgment:
Non Compliant - Major

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 were organisational policies and procedures in place for ordering, storing, administration and disposal of medicines, and local guidelines including those for ordering medication following medication changes made by resident's general practitioner (GP). However during the inspection it was identified that medication prescribed to a resident by their GP five days prior to inspection, had not been sourced from the pharmacy, or administered to the resident. This was brought to the attention of the person in charge immediately and the medication was sourced and present in the centre before the completion of the inspection.

The inspectors reviewed medication prescription and administration records for three of the residents living in the centre. There were two medication prescription records in place in one resident's medication folder. Neither of the medication prescription records had a date on them, and they contained some conflicting information regarding prescribed medications. This was brought to the attention of the person in charge by inspectors and was rectified prior to completion of the inspection.

Each resident had a medication plan in place which detailed the resident's GP, psychiatrist, pharmacist, and how the resident preferred to take their medicines. Residents had a self-medication assessment carried out. PRN (medicine given as the need arises) protocols were in place for residents which clearly guided staff practice. Records of administration of PRN medicines were reviewed and there was evidence of clear rationale for their administration in line with PRN protocols.

All staff in the centre were required to complete Safe Administration of Medication and Buccal Midazolam training. The organisation's policy outlined steps to be taken to ensure staff competency prior to administering medications, including a competency assessment be carried out by the person in charge. A number of competency assessments for staff currently administering medications in the centre were reviewed. Only one part of the competency assessment had been completed by the person in charge, therefore in line with the centre's policy the competency assessments were incomplete.

An inspector spoke to two staff who had completed the morning medication round. Neither staff could tell the inspector the use or side effects of all the medicines they had just administered to residents, or when to administer rescue medication in line with resident's prescription or PRN protocol.

There was safe storage of medicines in the centre. There was a separate storage area for out-of-date medicines and records maintained of returns to the pharmacy. There were records kept in the centre of what medicines were ordered in the centre, medicines removed from the centre and receipt of medicines however the inspectors identified medicines in the medication press which were not labelled for the resident for whom they were prescribed. There was an ordering medication template in place for

each resident, however there were large amounts of stock found in one of the medication presses.

Controlled drugs were appropriately stored, and records of administration and stock control kept in line with legislation.

Judgment:
Non Compliant - Major

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:
The inspectors found the management systems in place had not ensured a safe service consistent with residents' needs. There was inadequate monitoring of the service provided and a failure of the provider to ensure the actions arising from audits and monitoring of practice were completed. Major non compliances were identified in seven of the eight outcomes inspected against.

The provider had failed to ensure continuity of care and an unstable and insufficiently skilled workforce had resulted in poor outcomes for residents. There was evidence that the standard of care provided in recent months had declined, and had resulted in an increase in incidents of challenging behaviour, an increase in the use of restrictive practices for residents and a decrease in social opportunities for residents.

The provider had not ensured the service was safe and had not ensured the measures recommended following investigation of a safeguarding concern were implemented in practice, thereby exposing residents to risk. The provider did not ensure there were appropriate systems in place to manage risk including the identification of risks and ensuring that appropriate resources and support were in place in accordance with those risks which were identified. There were poor infection control procedures relating to hand washing exposing residents to an on-going risk of harm.

The inspectors found there was an overall lack of accountability on all levels of service

provision to ensure residents were supported and cared for in a safe and effective manner. Those personnel identified as responsible for ensuring the delivery of a quality service had failed to take responsive actions to key areas of risk including the provision of healthcare, implementing safeguarding measures, providing consistent and skilled workforce, implementing actions to ensure safe medication management practices, appropriate supervision of staff, and maintaining the privacy and dignity of residents.

The inspectors reviewed records of unannounced visits to the centre conducted over a three month period in 2017. While there was evidence that some actions arising from audits had been completed, issues relating to staff knowledge of medication and to staffing arrangements in the centre had not been satisfactorily addressed on the day of inspection.

An annual review of the quality and safety of care and support had been conducted and actions had been identified in order to improve the service. The inspectors discussed the review with the person in charge and the progress of actions however, a significant number of actions had not been completed by the day of inspection, and the date for completion of these actions had since passed.

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:
Overall, inspectors found that the staff numbers and skill mix in the centre did not meet the assessed needs of residents. Residents were not found to receive continuity of care due to the unstable workforce in the centre. There were a number of staffing vacancies and a high dependency on relief and agency staff. The provider representative informed inspectors at the feedback meeting that three staff vacancies had just been filled and that they were recruiting for another three staff. They reported that in the interim they had secured a regular bank of agency staff with the necessary experience and training.

Staff reported that the unstable workforce was negatively impacting on residents and

this was evident from records, resulting in an increase in incidents of behaviours that challenge, an increase in the use of restrictive practices and a reduction in the social opportunities for residents within the centre and in the community.

On the morning of first day of inspection there were insufficient numbers staff on duty in line with statement of purpose of the centre and the identified staffing needs of residents. Again on the second day of inspection there were insufficient staff in line with assessed needs of residents. A staff member who usually works in another centre was moved to the centre on the first day of inspection. They reported to inspectors that they had worked in the centre once before, and staff had briefly inducted them on the first day they were in the centre.

The inspectors were not assured that the staffing arrangement overnight could ensure residents were safe and the inspectors requested the provider to give assurances that residents would be safe and supported by trained and competent staff. Subsequently revised staffing arrangements were put in place by the end of the first day of inspection and the provider representative provided the inspectors with a written document confirming they were assured the residents were being cared for by a competent staff team.

Some actual rosters were not available in the centre. These were requested by inspectors for a two month period on the first day of inspection but not provided. They were requested again on the second day of inspection but not provided within the timeframe specified. There were some rosters available in the centre. The inspectors reviewed these rosters however and found they were not accurately maintained and differed from those staff recorded in the centre's visitor book as being present in the centre. On reviewing the visitor book there were a number of staff who did not regularly work in the centre identified including relief and agency staff. The training records for some of these staff were not available in the centre.

Some staff were not found to have mandatory training completed, or other training in line with assessed needs of residents. Some staff did not demonstrate to inspectors that they were competent to deliver care and support residents. They could not describe care and management of conditions residents present with, when to administer rescue medicines, how to safeguard residents, or how to support residents displaying challenging behaviour.

Overall inspectors found that there was no evidence of a thorough induction process in place for new or relief staff. The person in charge outlined that as part of induction observations of practice were completed by the person in charge and recorded however, on review of records there was limited evidence that this had been completed. The person in charge confirmed that the records were maintained were reflective of the number of observations of practice which had been completed and that they were not assured that this was sufficient to ensure staff were competent. In addition, the inspectors found a number of staff had not received any induction training since commencing employment in the centre.

The person in charge outlined the arrangements for formal supervision at six to eight weekly intervals were not implemented in practice. The inspectors reviewed supervision

records for one staff member, and supervision meetings had been completed twice in the past 12 months. In addition, some issues discussed had no actions developed and actions agreed to improve practice were not consistently implemented, for example, training needs relating to restrictive practices and medication management.

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:

Caroline Vahey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stepping Stones Residential Care Limited
Centre ID:	OSV-0003257
Date of Inspection:	27 & 28 November 2017
Date of response:	12 February 2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Each resident's privacy and dignity was not maintained in relation to personal care practices as outlined in the body of the report.

The privacy of residents' personal information was not respected in the centre as

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

outlined in the body of the report.

1. 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 Registered Provider has completed the following maintenance works to ensure the privacy and dignity of residents is maintained:

1. The cistern of one resident's toilet which required repair was replaced.
2. Additional privacy screening is now in place in all residents' bedroom windows and on the sitting room window.

The Registered Provider in conjunction with the Person in Charge has ensured that:

3. All personal information relating to residents has been removed from notice boards in the kitchen.
4. New documentation containers are in place in the kitchen to safely store and facilitate appropriate access to information required on residents' care and support needs.
5. Private emails are not permitted to communicate any information regarding residents living in the designated centre. A memorandum will be issued to all staff members by the registered provider.

Proposed Timescale: 30/01/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to meet the assessed social care needs of residents in accordance with their personal plans.

2. 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:
1. The Person in Charge has conducted a review of each resident's personal plan. Outstanding actions under healthcare, social care needs & personal development have been identified. Healthcare appointments required for each resident have been scheduled.

2. The Person in Charge in conjunction with keyworkers has updated critical information documents, intimate care plans and risk assessments for each resident.
3. Staffing arrangements are now in place to ensure residents attend their preferred weekly social activities such as swimming, club and art therapy.
4. Social experiences and community based activities are recorded in daily documentation & being monitored monthly by a social activity record.
5. The Person in Charge has liaised with each resident's representative(s) and circle of support to agree a date to review the personal plan and agree priorities based on assessed needs of each resident.
6. Each key-worker in conjunction with the Person in Charge will update remaining sections of the personal plan following these meetings.

Proposed Timescale: 23/02/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews did not assess the effectiveness of the plan and were not consistently reviewed.

3. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
1. Health action plans are now immediately reviewed and updated if required following each medical appointment or multidisciplinary team consultation. A pre/post consultation sheet is now operational for each resident.
2. Quarterly reviews of the personal plans are scheduled for 2018 to ensure effectiveness of each personal plan and to ensure changes in circumstances and developments are reflected clearly.
3. A personal planning audit will be conducted in quarter 1 of 2018 to monitor improvements agreed regarding personal planning and regulation requirements.

Proposed Timescale: 30/03/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Risks in the centre were not appropriately identified assessed or managed.

The measures outlined in risks management plans were not implemented in practice.

Environmental risks in the centre had not been identified and as such remedial action taken to mitigate the risk of injury.

4. 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:
The registered provider in conjunction with the person in charge will:

1. Review all risk assessments in use to ensure they are accurate up to date and that the identified controls are being used in practice.

2. Devise a required suite of environmental risk assessments to ensure risk is being managed to safeguard residents, staff members and visitors in both houses.

3. Update risk register once the risk assessments have been reviewed and updated.

Proposed Timescale: 19/01/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for investigating and learning from serious incidents were not found to be consistently implemented in the centre. There was no evidence of follow up or learning following some incidents in the centre.

Adverse incidents in the centre were not consistently recorded.

5. 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:
The Registered Provider has introduced a revised risk log with the Person in Charge:

1. This log is populated following daily review of incidents. This log documents follow up action implemented post incident to reduce likelihood of recurrence or to manage the risk.
2. A monthly incident review forum is now in place with the Registered Provider/representative/ the Person in Charge and behaviour therapist to review trends of incidents, success of follow up and shared learning from incidents.
3. Shared learning notices will be issued each month following this monthly incident review meetings.

Proposed Timescale: 10/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Satisfactory infection control procedures were not in place in the centre. There was no hand soap available in areas of the centre. There were no hand towels available in areas of the centre.

6. 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:
The Registered Provider has ensured that:

1. Hand soap and hand towels are now available in main bathrooms and kitchen area of the designated centre.
2. New hand soap containers have been ordered for ensuite bathrooms in line with safety needs of 2 residents.
3. The hand hygiene sink in the kitchen is in the process of upgrading. Works have been scheduled to complete this task.

Proposed Timescale: 09/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A number of fire doors were wedged open on the day of inspection, negating their function in the event of a fire.

7. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The Registered Provider ensured that:

1. Door wedges were immediately removed.
2. Magnetic door strips are now in place so automatic closure of doors occurs as required in the event of fire and residents continue to have open access to and from kitchen.

Proposed Timescale: 15/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were evacuation plans for day and night time. However, there was no documentary evidence to show that some aspects of the evacuation plans had been trialled to ensure they were effective as outlined in the body of the report.

8. 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:
Following the inspection the person in charge conducted a fire drill to demonstrate that all residents could safely evacuate from the centre in the event of a fire.

The record of this drill was logged with all other drills for 2017 in the fire register folder.

Proposed Timescale: 07/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not completed training in behaviour that challenges, including the use of physical holds, in line with the assessed needs of residents.

9. 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:
1. 10 staff members received behaviour support training from the behaviour therapist regarding principles of positive behaviour support.
2. 8 staff members received refresher MAPA training.
3. 2 staff members who require refresher MAPA training are attending the next training days. All other staff members are now MAPA trained.
4. Onsite positive behaviour support training has been scheduled with the behaviour therapist for the full staff team regarding the revised behaviour supports in place for residents. This training involves role play and the recording of behaviours/restrictive practices.

Proposed Timescale: 26/01/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff were not knowledgeable on the proactive or reactive strategies, including the use of physical holds, to support residents in line with their support plans.

Behaviour support plans did not guide practice, and had not been consistently updated to reflect changes in residents' needs and in response strategies.

10. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
1. A behaviour therapist has commenced in a full time post.
2. Three out of the four behaviour support plans have been updated post assessment by the behaviour therapist. The remaining behaviour support plan is in the final stages of updating.
3. The behaviour therapist has dedicated hours working frontline with residents and staff members to ensure consistent and comprehensive implementation of behaviour strategies.
4. The behaviour therapist reviews all behaviour incident forms weekly & adjusts behaviour supports accordingly.
5. The behaviour therapist provides a weekly report on progress of behaviour supports for the registered provider.
6. The behaviour therapist meets with the PIC monthly to review behaviour incident data and monitor progress of behaviour support plans.

Proposed Timescale: 04/02/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The least restrictive measure for the shortest duration was not evident in the use of restrictive practices in the centre.

Agreed measures to reduce the use of a physical restraint had not been applied, due to the instability of the workforce and a lack of therapeutic support to implement these measures.

11. 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:
1. A review of restrictive practices was conducted with the Person in Charge, Behaviour Therapist and External Quality and Safety Advisor. All prescribed restrictive practices are now populated and monitored through a restrictive practice register.
2. A review of the effectiveness of this register to ensure restrictive practice use is in line with best practice has been scheduled with the person in charge and behaviour therapist.
3. A behaviour therapist has commenced in a full time post.
4. Three out of the four behaviour support plans have been updated post assessment by the behaviour therapist. The remaining behaviour support plan is in the final stages of updating.
5. The behaviour therapist has dedicated hours working frontline with residents and staff members to ensure consistent and comprehensive implementation of behaviour strategies.
6. The behaviour therapist reviews all behaviour incident forms weekly & adjusts behaviour supports accordingly.
7. The behaviour therapist provides a weekly report on progress of behaviour supports for the registered provider.
8. The behaviour therapist meets with the PIC monthly to review behaviour incident data and monitor progress of behaviour support plans.
9. Onsite positive behaviour support training has been scheduled with the behaviour therapist for the full staff team regarding the revised behaviour supports in place for residents. This training involves role play and the recording of behaviours/restrictive practices.

Proposed Timescale: 26/01/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received training in safeguarding of children.

Some staff could not identify the types of abuse and were not aware of the procedure to follow in the event of a safeguarding concern.

12. Action Required:
Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

Please state the actions you have taken or are planning to take:
1. A meeting was facilitated with the staff team to review policies and procedures

applicable to safeguarding children.
2. All staff members have completed a competency assessment regarding the application of mandatory safeguarding procedures.
3. All staff members have completed the TUSLA online Children's First Training.
4. All scheduled staff supervision includes staff members' knowledge of safeguarding policies and procedures applicable to children's welfare.
5. A staff reference folder is available to all staff members to check procedural steps of applicable safeguarding policies/protocols.

Proposed Timescale: 04/01/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Recommendations arising from an investigation of an allegation of abuse had not been implemented, thereby exposing residents to a potential risk of harm.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has submitted a 20 day update to the authority regarding the NF06.

All staff members have completed the TUSLA online Children's First Training.

A weekly safeguarding risk assessment is conducted to monitor safeguarding of residents in the designated centre.

The Person in Charge is supervised weekly by an external quality and safety advisor to monitor required improvements in the designated centre. A weekly report is submitted to the registered provider.

Proposed Timescale: 26/01/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A resident had not been provided with medical attention at the time of an adverse event, despite a known risk.

Healthcare assessments were incomplete and the healthcare actions arising from those

assessments were not implemented. The existing healthcare assessments for residents had not been reviewed in line with changes in resident's needs and medication regimes. A number of healthcare plans were not available on the day of inspection.

Staff were not knowledgeable on the interventions to support residents with some identified healthcare needs.

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

Please state the actions you have taken or are planning to take:
1. The registered provider in conjunction with the Person in Charge has identified any outstanding allied health appointments required for each resident. These appointments have been scheduled and are in progress.
2. Current health assessments have been reviewed and updated where applicable.
3. Health care plans specific to each resident's needs which have emerged from assessment are in the final stages of devisal.
4. A revised quarterly review document is now in place to show consistent review of all health care needs.

Proposed Timescale: 30/03/2018

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication prescribed for a resident five days prior to the inspection had not been sourced and therefore not administered to the resident.

Medications were not correctly labelled with the correct resident's name, for whom the medication had been prescribed.

Conflicting information, including prescribed medications were identified in two separate medication prescriptions records for one resident. In addition, there were no dates available on these records.

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

Please state the actions you have taken or are planning to take:
1. Medication prescribed for the resident was sourced administered and recorded during the inspection in conjunction with the G.P./Pharmacist.

2. All medication labels were checked for accuracy. All current medication is clearly labelled.
3. All over stock of medication was returned to the pharmacy.
4. The registered provider in conjunction with the Person in Charge & external quality and safety advisor conducted a review of medication practices in the designated centre.
5. The medication procedures were updated to improve the dispensing, administration ordering, receipt, prescribing and storing of medication for residents.
6. Residents' medication folders were checked and updated this included kardex of each resident. Old kardexs were removed from medication folders.

Proposed Timescale: 12/01/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management systems in place had not ensured a safe, effective and consistent service for residents resulting in poor outcomes for residents.

There was inadequate monitoring of the service and the management system had not appropriately responded to issues highlighted through auditing and investigation processes.

16. 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:
1. The registered provider has recruited a director responsible for the oversight of compliance and quality improvement. This director will work directly with the person in charge, staff team and management team to improve systems and processes regarding safety, risk management and effective consistent services for residents. An initial phase of audit and improvement planning has commenced.
2. This director is supporting the registered provider in the implementation and review of the improvement plan.

Proposed Timescale: 09/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

Actual rosters were not consistently maintained or available in the centre during the inspection.

17. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
1. The roster has been revised to include each staff member's full name and grade. A shift leader is assigned to each shift (indicated on roster) to coordinate roles and responsibilities. These responsibilities are documented on a whiteboard to guide staff members.

2. The Person in Charge and HR officer maintain copies of all rosters. A master copy is maintained in the designated centre.

Proposed Timescale: 18/12/2017

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Adequate staffing levels were not provided in the centre consistent with the assessed needs of residents and with identified staffing requirements.

Sufficiently skilled staff were not consistently provided in the centre in order to ensure residents were safe.

Staff knowledge of the needs of the residents and of their care and support requirements was not adequate to ensure the safe delivery of care and support.

18. 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:
1. 1 behaviour therapist (full time post), 2 social care workers (full time) and 1 healthcare assistant (full time) have commenced in post since the inspection. 2 social care workers & 1 healthcare assistant have moved from the relief panel part time to full time staff members. An induction process was facilitated off and on site prior to commencement. 1 additional social care worker is due to commence in February 2017.
2. The HR officer and Person in Charge initially met weekly to review planned rosters and agree skill mix based on residents' needs and planned activities. This process is now on a monthly basis.

Proposed Timescale: 30/01/2018

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Continuity of care was not maintained for residents due to an unstable workforce and a reliance on agency staff to fill vacancies.

19. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
1. Workforce has stabilised since January 2018 with drop in agency use. Where agency staff are in use consistent agency staff are sought. All agency staff have all required mandatory training completed.
2. All agency staff members now receive a revised induction checklist on commencing shift.
3. Recruitment continues for 2 additional social care workers.

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised on a day to day basis.

Formal supervision was not completed in line with the stated frequency. Issues identified through supervision meetings were not consistently acted upon. Actions arising from supervision were not consistently implemented.

20. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
1. All staff members have completed a competency assessment and formal supervision sessions are being coordinated to address performance issues.
2. The Person in Charge is implementing a weekly schedule of formal supervision.
3. The Person in Charge will conduct informal periods of observations of staff members' interactions with residents to ensure person centred approaches to care and supports. These observations will be recorded by the Person in Charge.
4. The Director of Compliance and Quality Improvement will review standard of supervision records on a weekly basis.
5. The Director of Compliance and Quality will conduct 'check and challenge sessions' with staff members on weekly visits to the centre.

Proposed Timescale: 30/01/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training was not provided to staff relating to the specific assessed needs of residents.

Some staff had not completed induction training in the centre.

Training in medication management and induction training were not completed for some staff specifically relating to observation of practice.

21. 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:
1. A programme of induction was completed for all newly recruited staff members who have commenced in the designated centre since December 2017.
2. All staff members have completed a competency assessment and formal supervision sessions are being coordinated to address performance issues.
The Person in Charge is implementing a weekly schedule of formal supervision.
3. SAM's & Buccal midazolam training is scheduled in quarter 1 of 2018 for staff members requiring this training.
4. The HR officer has conducted a analysis of all mandatory training with training dates planned to address gaps in manual handling and first aid.

Proposed Timescale: 15/02/2018