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 RehabCare
Centre ID:	OSV-0002648
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Mary Moore
Support inspector(s):	Julie Hennessy
Type of inspection	Announced
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 to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 February 2016 09:00	22 February 2016 19:00
23 February 2016 09:00	23 February 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second inspection of the centre by the Authority. The first inspection was an unannounced monitoring inspection on 23 September 2014. A satisfactory level of regulatory compliance was evidenced on that inspection; actions did issue including staff training deficits and the use of wedges to hold open fire doors.

This inspection was announced following the provider's application for registration of the centre. Inspectors also incorporated information received in notifications made to the Authority by the provider into the inspection process. Questionnaires to be completed on a voluntary basis by residents and relatives were also forwarded to the

provider prior to the inspection. Completed questionnaires were returned by family members; areas of concern raised included the consistency of the workforce, the lack of suitable training for staff, risk-averse practice though this was well intentioned, supporting social and developmental needs and the suitability of the environment to both individual and collective needs. Recent changes however were also acknowledged such as efforts by staff to support residents to make their own choices and decisions. This feedback from relatives very much reflected core current inspection findings.

The person in charge was unexpectedly absent for this inspection and the inspection was facilitated by the regional manager and the recently recruited team leader. Inspectors reviewed records, spoke with management and frontline staff, met with residents and observed the delivery of services and supports to residents.

There was evidence of good practice and evidence that staff accepted failings within the service, the requirement for change and articulated a willingness to change so as to enhance the quality of services and supports provided to residents. Staff spoke respectfully and positively of residents and of the new management team and the improvements noted.

There were challenges within the service however and a considerable level of regulatory non-compliance was evidenced.

Though substantially compliant a review of the premises was required to ensure that the facilities provided met the individual and collective needs of the residents. There was an overreliance on relief and agency staff to maintain adequate staffing levels and this in turn led to failings in ensuring that all staff had the training required for supporting the specific needs of the residents in the centre.

Further failings were identified in medication management systems, timely access to multi-disciplinary supports, the progress of action plans following internal audit so as to effect improvement, risk assessment and monitoring and providing evidence that residents were consulted with and participated in decisions in relation to their choices and routines.

Ultimately the provider did not demonstrate that there were adequate systems in place with respect to positive behavioural support for residents. Inspectors found that this was a significant failing and a major non-compliance due to the high behaviour supports required by residents in this centre. As a matter of priority the provider was requested to provide all staff including staff engaged on a less than regular/full-time basis with the training required to positively and safely support residents. Subsequent to the inspection the provider confirmed that training was scheduled from the 1-3 March for all staff, including agency staff who had not yet received this training and who were supporting residents. Refresher training for the remaining staff was scheduled to be completed by June 2016.

The provider articulated its commitment to the centre and to support staff and residents so as to effect the required improvement.

Of the 18 Outcomes inspected the provider was judged to be compliant with five and in substantial compliance with three. As discussed above major non-compliance was judged in one outcome and moderate noncompliance in the remaining nine outcomes.

These findings are discussed in detail in the body of the report and the action required by the provider 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:
The records seen by inspectors as generated by staff were informative, highlighted ability and reflected respect for each resident.

Staff spoke respectfully of residents and again spoke of residents' strengths and abilities while acknowledging areas where supports were required. Inspectors noted that while acknowledging disability staff spoke of residents as peers who shared similar interests with staff such as music and sport.

It was clear on speaking with staff and observing staff/resident interactions that staff were familiar with each resident's routine, their likes and dislikes, what they enjoyed and did not enjoy. For example one staff told inspectors that talking about pets would initiate conversation with one resident and this was correct.

However, staff spoken with conceded that much of the routine within the centre was based on information from families, from the day resource and staff knowledge of residents that had developed over time rather that a process of structured consultation with residents that was clearly evidenced. For example there were no structured individual or collective "house meetings" and key worker meetings that actually involved the participation of the resident had only recently been introduced and evidenced. Staff spoken with did believe that residents with the assistance of the appropriate communication tools did have the capacity to understand and input into their routines, decisions and choices.

Other staff spoken with described a rigid staff-led element to the ethos of the centre described by them as somewhat "institutional". Staff were clear that this did not equate with any harm or safeguarding issue but a reluctance by some staff to change or staff that were "risk-averse". Staff said that if a particular decision or action had proved unsuccessful in the past there was a tendency for staff to be "led by failure" and not to explore the decision or action again. This was a theme also reflected by families surveyed.

For example more than one staff member said that they had been told that residents did not interact with each other but during a recent spontaneous music session facilitated by staff, residents had without prompting engaged positively with the session and with each other.

Staff confirmed that residents' religious and/or spiritual beliefs were not facilitated in the centre yet it was clear from support plans seen that residents had in past practiced religious observance or did when with family.

The provider operated an internal advocacy process and the contact details for the confidential recipient were displayed in the staff office. However, staff confirmed that the availability or accessibly of advocacy had not been explored with residents or their representatives.

There were policies and procedures for the management of complaints. Staff spoken with were clear on roles and responsibilities and there was documentary evidence that the person in charge had recently provided each family with copies of the complaint procedure and advised them that their concerns and/or complaints were welcomed. Staff maintained a local complaints log that was reviewed by inspectors. There was a pattern to the complaints received by staff as discussed in Outcome 3. There was limited detail of the actions taken in response and whether these actions were sufficient to address the matters complained of and satisfy the complainant. Given the repeat pattern it is reasonable to assume that they were not sufficient.

There were policies and procedures for the management of residents' finances. There was evidence of each transaction, receipts including the purpose for which the monies were used and staff signatures. However, there was inconsistent evidence of countersignatures or oversight by the team leader or person in charge as required by the provider's own policy.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors saw detailed communication support plans. The plans highlighted communication ability and where augmentative supportive interventions were required such as PECS (picture exchange communication systems), visual schedules, a communication dictionary, (the language used by residents and its interpretation by staff) and interventions required of staff such as the use of short sentences and clear concise language. The communication plans acknowledged and incorporated the use of behaviours by residents as a form of communication, what these behaviours meant and the required response from staff.

Inspectors' observations of staff and resident interactions were positive with no observed barriers to effective communication. Identified augmentative strategies such as visual schedules were in use. However, staff spoken with confirmed that all of the supportive interventions highlighted in the support plans including the PECS and the communication diary were not in routine use.

Judgment:
Substantially Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
The importance to residents of family and the maintenance of strong family links and relationships was highlighted in the support plan. Staff said and inspectors saw that this was facilitated through regular home visits and family visits to the centre. Records indicated that family were invited to attend the review of the person centred plan and consultations by other health related disciplines.

The significance of family roles and relationships was further represented and reinforced for residents through the use of photographs of family and family events.

Residents were facilitated to maintain personal friendships with peers through the day support service.

Staff established and recorded each family's desired frequency and method of communication. However, inspectors noted from the complaints log a repeat pattern of dissatisfaction raised by families in relation to staff failure to communicate with them as agreed and to not having informed them of changes.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were policies, procedures and structures governing admission to and transfer and discharge from the designated centre. The regional manager confirmed that admission and ongoing residence incorporated assessment of suitably and compatibility of all residents needs; there was documentary evidence of this.

There was a detailed contract for the provision of supports and services signed by a representative of the provider and the resident's representative. However, there was no contract seen for one of the four residents currently living in the centre.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
There was a process in place for assessing and planning supports as appropriate to residents' assessed needs. The support plans seen by inspectors were detailed and personalised and overall provided guidance on the supports required by residents. The support plans were signed as reviewed and updated by staff on a regular basis. However, as discussed in other relevant outcomes it was not clear that this review process ensured that supports were monitored or that the plan clearly reflected residents' current needs. For example longstanding identified supports that had not been adequately implemented and reviewed included a referral for occupational therapy (OT) review and a health promoting weight management and exercise programme.

As discussed in Outcome 1, until very recently, it was not clear how residents participated in the development and review of their support plan. The plan was not available in a format that was meaningful and accessible to residents.

Each resident had a written personal plan. Inspectors reviewed all four personal plans and found that they had been reviewed within the previous 12 months. Family involvement in personal pans was evident. However, the review of the personal plan was not multi-disciplinary (MDT), as required by the Regulations and as appropriate to residents' needs and the MDT supports that they were in receipt of.

There was some limited evidence of goals and objectives but it was not clear that personal goals were based on a current assessment of residents' health, personal development and social care needs and abilities. It was not clear how goals were progressed, by whom and if not why not. Ultimately, a link between the assessment process, the setting of personal goals and the review of the personal plan and its effectiveness was not demonstrated.

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):
No actions were required from the previous inspection.

Findings:
Overall inspectors were satisfied that the location and general design and layout of the premises were suited to its stated purpose. However, review was required to ensure that it met both the individual and collective needs of the current residents.

The premises was a domestic style two-storey building located on a spacious site in a rural location but a short commute from any required amenities; transport was available.

Private accommodation for residents was provided on both the ground and first floors. Each resident had their own bedroom that offered sufficient space and reflected their own individual requirements.

Adequate communal space was provided and the available space was allocated to meet the individual needs of residents.

The kitchen was adequately equipped with an annexed utility area with facilities for the laundering of personal clothing. A separate dining area was provided.

There was evidence of recent maintenance and redecoration.

There was provision for two fully fitted bathrooms, one on each floor and two of the bedrooms had en-suite facilities. However, inspectors saw that the en suite facilities were very compact. Staff confirmed that one shower enclosure that was raised above floor level and did not allow sufficient space for staff assistance was not accessible and therefore not suited to the needs of the resident. Other modifications had been required to manage behaviours that posed a risk to residents and therefore at the time of this inspection there was only one functioning bath and one functioning shower, both in the same room, used by all four residents. Inspectors were not satisfied that this was a suitable arrangement particularly in promoting the privacy and dignity of each resident.

Judgment:
Substantially Compliant

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 requirement for robust health and safety measures in the centre to promote the safety and wellbeing of residents. There were measures in place including

the most recent version of the provider's health and safety statement, procedures for risk identification and assessment and for the reporting and management of accidents and incidents. Inspectors saw a broad range of completed risk assessments including assessment of the risks as specifically mentioned in Regulation 26 (1) (c); risk assessments were signed off by staff as read and understood.

However, given the robustness required in this centre some of the identified controls were broad and vague; there was duplication of risk assessments, and inconsistency of both assessment and control implementation. Inspectors saw that items either identified in risk assessments or by staff spoken with as requiring secure storage and restricted access were unrestricted on the first day of inspection. A further identified control, training for all staff in managing and preventing potential and actual aggression was not implemented. In this context while there was evidence of investigation by the provider of adverse events and of action taken, it was difficult for inspectors to be reassured that there was sufficient learning and monitoring to prevent a reoccurrence.

The premises was fitted with fire safety measures including an automated fire detection system, emergency lighting and fire fighting equipment. A fire register was maintained and certificates were available of the inspection and testing of these systems at the prescribed intervals most recently in October 2015, January 2016 and March 2015 respectively. Staff completed and recorded daily, weekly and monthly visual inspection of fire safety measures. Training records indicated that fire safety training for staff had been completed in March 2015 and was scheduled for March –May 2016; staff spoken with confirmed their attendance at training.
Both evacuation and fire action notices were displayed; the former was also in a format that enhanced its accessibility to residents.

Each resident had a personal emergency evacuation plan (PEEP) and records indicated that four simulated evacuation drills had been completed with residents between March and January 2016. Records indicated that good evacuation times had been achieved on each occasion. However, one record identified that staff should develop social stories to assist resident understanding of evacuation and staff confirmed that this had not been developed. The same escape route was used for all drills and only one was clearly indicated on the day of inspection; two were noted on the diagrammatic plan of the building. Internal doors had door closures and some had automatic hold open and release devices, however inspectors also noted the use of door wedges, one door was wedged open with a retail catalogue. This was a finding on the previous inspection and there was no evidence that the requirement for the use of door wedges had been risk assessed.

The provider had a centre specific business continuity plan that set out for staff the actions to be taken in defined emergency situations; the plan included alternative accommodation for residents if required.

There was a central transport department that co-ordinated the maintenance and servicing of the vehicle. Records were in place of the maintenance and servicing of the vehicle in 2015/2016.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
There were measures to protect residents from injury, harm and abuse. These measures included organisational and national policies and procedures, designated persons, risk assessments, staff training and education. However, failings were identified in these measures and ultimately the provider did not demonstrate that there were adequate systems in place with respect to positive behavioural support for residents.

Inspectors spoke with staff who demonstrated an awareness of what constitutes abuse. Staff were clear in relation to their responsibilities in the event of a suspicion, allegation or incident of abuse.

Regular staff had received training in responding to behaviour that was challenging and the use of any breakaway techniques and physical interventions, specifically, the therapeutic management of potential and actual aggression and violence (MAPA). However, staff working in this centre on a less than full-time basis had not received this training. As a result, not all staff had the required knowledge and skills to equip them to respond appropriately and safely to behaviour that was challenging and to support residents to manage their behaviour. Inspectors found that this was a significant failing due to the high behaviour supports required by residents in this centre.

Where residents had behaviours that may challenge, a behaviour support plan was in place. The sample of behaviour support plans reviewed had been recently signed off by a behavioural therapist. Incident reports demonstrated and staff confirmed that physical intervention was being used in the centre. However, individual behaviour support plans did not provide clear specific guidance for staff with respect to what physical restraint was approved for use. Staff gave conflicting information to inspectors about what physical restraint was used in the centre. Staff told inspectors that they did not have sufficient guidance in the behaviour support plans and inspectors concurred with this having reviewed the plans.

Inspectors reviewed incident related records and saw that other unapproved and potentially unsafe interventions had been used by staff during an incident in an attempt to "distract" the resident. These specific interventions were discussed at verbal feedback. While the incident had been investigated inspectors were not satisfied that these particular interventions had been satisfactorily explored by the provider to provide adequate re-assurance that unapproved and unsafe interventions were not and would not be used in the centre.

A folder of approved restrictive procedures was maintained in the centre. However this did not include the interventions mentioned above or the use of sedation to facilitate the taking of blood for testing of blood levels as evidenced on other records seen.

Inspectors were not reassured as to the timeliness of access for residents to other healthcare professionals including behavioural therapy and psychological review to support the resident and staff in the positive support of behaviours. While factors outside of the control of the provider such as the cancellation of one appointment impacted on this, ultimately inspectors were not satisfied that reviews took place during the period of time that the resident was in most need of the review.

Inspectors reviewed the use of chemical restraint and PRN ("as required") medication in the centre. During periods of frequent usage (3-5 times per day), regular contact by staff with the prescribers of the medication was demonstrated. Advice from the psychiatrist was sought and provided on a frequent (sometimes daily) basis. Family involvement in consultations with the psychiatrist was demonstrated.

However, the recording of restraint and restrictive procedures was not in line with the Regulations and associated guidance published by the Authority. A detailed log of every episode of restraint or use of a restrictive procedure that included details of the reason, type and duration of restraint and/or restrictive procedure used was not available in the centre to inspectors. While some of this information was kept in different formats, such as ABC (antecedent, behaviour, consequence) charts, incident forms and restrictive practice documentation, the absence of a detailed log did not support effective oversight and monitoring of restraint and restrictive procedures by management or medical and allied health professionals who provided care and support for individual residents. It was not demonstrated that all alternative measures were considered before a restrictive procedure was used.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
There were policies and procedures for the identification, recording, reporting and investigation of accidents, incidents and adverse events. Staff confirmed that the current electronic system alerted relevant personnel including the person in charge and health and safety once data was submitted by staff. Staff were clear on the submission of notifications to the Chief Inspector. However, based on the notifications submitted, staff spoken with and records seen on inspection, any and all occasions where a physical restrictive procedure was used had not been notified as required by Regulation 31 (3)(a).

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
All residents had access to a day service. Most residents attended a service outside of the centre. Where beneficial, residents availed of an individualised day service. Where an individualised day service was provided, a weekly plan was in place. This included activities such as swimming, horse riding and music. Staff reported that the provision of such an individualised service had a demonstrable benefit. Further records indicated that staff supported residents to enjoy walks, trips to the beach, the local shop, the barbers, music therapy, coffee shops and restaurants and family contact.

However, as discussed in Outcome 5 the process of identifying, agreeing and supporting personal goals was unclear; for example there was strong evidence that a resident enjoyed sporting fixtures but no evidence if and how this was facilitated on a regular basis. In addition staff accepted that there was some risk adverse practice in the centre. It was therefore difficult for inspectors to be reassured that residents were supported on an ongoing basis to have opportunities for development, for new experiences and social engagement. This was also reflected in the feedback received from families. This deficit is addressed under Outcome 5.

Judgment:
Compliant

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:
Residents' medical needs were attended to by the same General Practitioner (GP). Staff said that this arrangement was acceptable to both service users and their representatives and there was no evidence to the contrary.

Staff said and records seen indicated that staff facilitated residents to access timely medical review and care including if necessary the out-of-hours service.

As appropriate to their individual needs staff supported residents to access other services including psychiatry, psychology, neurology, ophthalmology and dental care. Nursing services if required were access through the providers own resources or an agency if required. Staff said that families were informed of all appointments and reviews and did attend some with staff and the resident. Records were maintained of referrals and reviews.

The needs assessment incorporated an assessment of health and the required health related supports; for example inspectors saw plans for the management of seizure activity. An area also identified as requiring support was the area of promoting healthy meal choices and exercise. Staff had arranged for a nutritional consultation and had put in place a daily food intake and exercise monitoring tool. However, inspectors noted several blanks in this record and there were no records available for inspection of the monitoring of residents' body weight; a fundamental requirement in evaluating both the need for and the effectiveness of such a health promoting plan.

As discussed in Outcome 8 inspectors were not satisfied as to the timeliness of all referrals to and reviews by other disciplines including psychology and behavioural therapy. A further deficit was timely referral to occupational therapy services.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There were policies and procedures governing the management of medication and staff involved in medication management had undertaken the required training and competency assessment.

However, inspectors were not reassured that medication management systems were conducive to safe medication management practice as;
• medications were supplied by a community pharmacy in their original containers and while stored securely some were not stored in any particular order making it difficult to identify and retrieve them readily
• one container had an illegible affixed label
• staff were unaware that medications requiring stricter controls were in stock and their custody was not in line with legislative requirements
• medications requiring disposal within a specified timeframe were not signed and dated by staff when opened
• staff confirmed that they supplied medications to the day service for residents from the stock available in the centre. Inspectors were not satisfied as to the safety and suitability of this practice and it was not directly addressed in the medication policy
• two PRN (as required) prescription records were in place for two residents which meant that two different medications had the same alphabetical identifier. It was not possible therefore to know from the administration record which medication was administered by staff
• there were ten medication errors reported between 1 November 2015 and 9 February 2016. These included the failure to administer in line with the prescribed instructions, the non-recording of the administration of medication, and six medication count discrepancies leading to an assumption by staff that medications had not been administered as prescribed.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose submitted with the application for registration contained most of the required information; it did not however reflect the new governance structure nor set out the arrangements for residents to access education, training and employment. These omissions were rectified by staff based on verbal feedback and the updated version was submitted to the Authority.

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):
No actions were required from the previous inspection.

Findings:
The management structure of this centre had been somewhat unstable with three changes of person in charge since January 2014; this was acknowledged by the provider.

The current person in charge was appointed to the role in late November 2015 and while unexpectedly absent for this inspection, had been previously met with in the capacity of acting person in charge, by inspectors in another designated centre. Ordinarily the person in charge worked full-time and to strengthen the governance structure the provider had made the decision to locate the office of the person in charge

in the centre and make the centre the sole area of responsibility of the person in charge. The person in charge had established experience within the organisation, in the supervision of staff and the delivery of supports to service-users. The person in charge participated in the education and training programme facilitated by the provider.

A new team-leader who was also a nominated PPIM (person participating in management), was in post since late January 2016. This was the team leader's first supervisory role but he was seen by inspectors to apply himself to the role and its responsibilities and he facilitated the inspection with openness and confidence.

All staff spoken with articulated their support for the new management structure and acknowledged the improvements made and the requirement for change.

The person in charge had ready access as required to the regional manager and formal regional meetings were convened on a monthly basis. In addition the regional manager said that she attended staff meetings in the centre as necessary with three such meetings convened since August 2015.

Staff were aware of the out-of-hours on-call rota and it was clearly displayed in the administration office.

The provider had arranged for both and annual review and unannounced visit to the centre as required by Regulation 23 (1) and (2). This process involved consultation with representatives and reports were available for inspection. The unannounced visit had been undertaken on the 10 February 2016 and the report had only issued on the 15 February, one week prior to this inspection. The report indicated that a substantial number of deficits were identified. The inspector reviewed the report of the annual review completed in May 2015 and saw that similar and substantial deficits had been identified. These deficits included deficits in medication management, support plans and consultation with residents; a total of 33 actions issued.

However, no quality improvement action plan was evidenced. Given these inspection findings and the similarity of the findings of the two internal audits it was difficult to evidence how or if the provider monitored the progress of the implementation of the required actions to ensure the quality and safety of the supports and services provided to residents in the centre.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The provider was aware of and had in the past exercised its responsibility to notify the Chief Inspector of any absence of the person in charge and the arrangements for the management of the centre during this absence. The current unexpected absence of the person in charge was discussed with the regional manager who committed to provide support to the team leader and update the Authority once the proposed length of absence was ascertained.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
There was no evidence available to inspectors to indicate that the service was not sufficiently resourced. The regional manager confirmed that the required resources were available.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
Staff spoken with confirmed that the maintenance of adequate staffing levels was a daily challenge due to planned and unplanned staff absence. The agreed staffing levels were maintained with each service user in receipt of the agreed one to one staff support with one additional "floating" staff. Night time staffing consisted of one "waking" staff member and one sleepover staff. The regional manager confirmed that staffing arrangements were increased and/or altered as necessary in response to residents' needs.

While inspectors were satisfied that staffing numbers were maintained this was dependent of the use of both relief and agency staff. A review of the staff rota from the 1 to the 28 February 2016 indicated that an average of eight regular staff inputted into the rota but this was augmented over this period by seven different relief staff and eight different agency staff. Residents presented with differing and complex needs as reflected in the agreed staff to resident ratio. However, staff spoken with expressed concerns in relation to the over reliance on relief and agency staff and the impact of this on residents in terms of lack of consistency and the challenge for regular staff to ensure that staff not employed on a regular and consistent basis were informed and updated on residents' needs and support plans including behaviour support plans. Inspectors noted that behaviour management guidelines specified the requirement to "minimise staff changes" and concerns had been raised with the provider and with the Authority by families surveyed as to frequent changes in staff.

These staffing arrangements posed further challenges in relation to ensuring that all staff working in the centre had the required training necessary to meet the needs of the residents. Training records indicated that staff had in 2014, 2015 and 2016 received training in manual handling, fire safety, safeguarding, the management of actual and potential aggression (MAPA), medication management including medications requiring specific administration techniques, first aid, person-centred planning and report-writing. However, staff spoken with including staff not employed directly by the provider told inspectors that they had not completed MAPA training. This was of concern to inspectors given their role in the centre and the supports required by residents in this specific area. The regional manager was requested to address this as a matter of priority and confirmed for the Authority that MAPA training was scheduled from the 1-3 March for all staff, including agency staff, who had not yet received this training and who were supporting residents. Refresher training for the remaining staff was scheduled to be completed by June 2016. The regional manager also committed to meet with staff to ascertain any additional supports staff may require in relation to MAPA and provide support/training as required.

Staff files were made available for the purpose of inspection; a random sample of four was reviewed by the inspector. Only one of the four files contained all of the information specified in Schedule 2; missing information across the remaining three included documentary evidence of relevant qualifications, proof of identity in a format that was sufficient to verify identity and evidence of Garda Síochána vetting.

The statement of purpose referenced a commitment to staff training and development in the area of autism, yet this was not reflected in the staff training records or in the staff files.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Overall inspector's were satisfied that the records listed in part 6 of the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place and were retrieved as requested by inspectors.

Judgment:
Compliant

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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002648
Date of Inspection:	22 February 2016
Date of response:	30 March 2016

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:
Staff confirmed that residents' religious and/or spiritual beliefs were not facilitated in the centre.

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

1. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
Staff will actively engage with service users, their families and circle of support will explore the reintroduction of attending mass; a social story will be developed to support the individuals to make an informed choice

Proposed Timescale: 21/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff confirmed that the availability or accessibly of advocacy had not been explored with residents or their representatives.

2. 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.

Please state the actions you have taken or are planning to take:
The service will reconfirm with service users and their families of their right to independent advocacy services.

This will be communicated through written correspondence to families and through the development of social stories for Service Users during key working meetings.

Internal and External Advocacy information will be displayed in the service.

The service will make contact with the National Advocacy Service to identify Advocacy Officer for the area. Advocacy Officer will be invited to visit to meet service users and families and inform them of the services external advocates can provide.

Proposed Timescale: 21/04/2016

Theme: Individualised Supports and Care

The is failing to comply with a regulatory requirement in the following respect:
Staff spoken with conceded that much of the routine within the centre was based on information from families, from the day resource and staff knowledge of residents that had developed over time rather that a process of structured consultation with residents that was clearly evidenced.

Staff spoken with described a rigid staff-led element to the ethos of the centre described as somewhat "institutional".

3. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
Planned review meetings will continue with families and key workers, clear actions and outcomes will be discussed and developed in these meetings and incorporated into individual support plans and activity planners.

The involvement and participation of service users in these meetings will be encouraged and promoted through the use of social stories and visual schedules.

Proposed Timescale: 21/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was limited detail of the actions taken in response to complaints and whether these were sufficient to address the matters complained of and satisfy the complainant. Given the repeat pattern it is reasonable to assume that they were not sufficient.

4. 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:
Measures have been put in place to ensure complaints have been responded to; the service will continue to log complaints and ensure that actions taken to address complaints are clearly documented as per organisational policies and procedures this includes recording confirmation when the complainant is satisfied with the outcome. The organisations complaints officer will attend a team meeting on the 27th April 2016 to discuss and review the complaints procedure with staff.

Proposed Timescale: 21/03/2016 & 24/04/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff spoken with confirmed that all of the supportive communication interventions highlighted in the support plans including the PECS and the communication diary were not in routine use.

5. Action Required:
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

Please state the actions you have taken or are planning to take:
Support Plans for each service user will be reviewed and updated with the appropriate and preferred means of communication clearly identified.

The use of communication strategies for each service user will be discussed through team meetings and individual meetings to ensure required supports are provided in a consistent manner.

Proposed Timescale: 21/04/2016

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted from the communication log a repeat pattern of dissatisfaction raised by families in relation to staff failure to communicate with them as agreed and to not having informed them of changes.

6. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
Communication agreements in place will be reviewed and discussed with staff team and families.

The responsibility of communicating with families will be assigned to a staff / staff members for each shift on the shift planner.

Agreed communication with families will be discussed with the staff team in staff meetings and through individual supervisions to ensure communication is maintained with families as per the agreement. All family communications will continue to be recorded in communication logs.

Proposed Timescale: 21/04/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no contract seen for one of the four residents currently living in the centre.

7. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Contract of care to be completed and added to Service User's file. The service user's family will be provided with a copy and will be requested to sign on the service user's behalf once they have read and are in agreement with the terms as outlined in the contract.

Proposed Timescale: 26/03/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The support/personal plan was not available in a format that was meaningful and accessible to residents.

8. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
Support Plans will be made available to each Service User in an accessible format.

Proposed Timescale: 02/05/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of the personal plan was not multi-disciplinary (MDT), as required by the Regulations and as appropriate to residents' needs and the MDT supports that they were in receipt of.

9. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
All external professional who are actively involved will be invited to attend annual review meetings. If unable to attend the PIC will request a report which will inform the support plan

The service will lead on a formal annual review of each resident's needs assessment and support plan. Input into this review will be sought from professionals as required; the review of the plan will be informed by all relevant individuals on an ongoing basis.

Proposed Timescale: 31/07/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not clear that the support/personal review process ensured that supports and the effectiveness of the plan were monitored or that the plan clearly reflected residents' current needs.

10. 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:
As confirmed above a formal annual review of each support plan will be facilitated. On an ongoing basis the support plan will be updated and maintained as changes in resident's support needs are identified through interaction with residents, meetings with families, consultations with medical and other allied health professionals.

As part of this process residents will be supported to identify goals they require support to achieve, this will be a rolling process. It will be documented on an Action Plan, with responsibilities and timeframes assigned. As residents achieve their desired goals they will be supported to identify new goals, this will be an evolving process.

Any changes to support requirements will be communicated to the staff team during, shift handover, supervision and team meetings.

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was some limited evidence of goals and objectives but it was not clear that personal goals were based on a current assessment of residents' health, personal development and social care needs and abilities. It was not clear how goals were progressed, by whom and if not why not.

11. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
Each individual's assessment will be updated on an annual basis. Any changes to required supports will be identified and reflected in the individuals support plan.
This will then inform future goals and objectives which will be discussed at key worker and review meetings

Proposed Timescale: 30/05/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Review was required to ensure that the premises met both the individual and collective needs of the residents. One shower enclosure that was raised above floor level and did not allow sufficient space for staff assistance was not accessible and therefore not suited to the needs of the resident. Other modifications had been required to manage behaviours that posed a risk to residents and therefore at the time of this inspection there was only one functioning bath and one functioning shower, both in the same room, used by all four residents.

12. 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:
The service has sought a full OT review which will include a review of all en-suite bathrooms. The PPIM of the service will explore a suitable solution to reinstating the upstairs shower which will not present risk to any service user.

Proposed Timescale: 30/05/2016

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 there was evidence of investigation by the provider of adverse events and of action taken, it was difficult for inspectors to be reassured that there was sufficient learning and monitoring to prevent a reoccurrence.

13. 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:
Behaviour support plan reviewed by behavioural therapist, and specific techniques to de-escalate an incident have been identified in the behaviour management guidelines and communicated to staff and families. This approach has now been implemented and there is ongoing review and support being provided by the behaviour therapist. A psychological assessment has been completed and the service is currently awaiting the report. The organisation's Risk Specialist attended the service and conducted a review of all risk assessments in the service.

Matters raised by the inspectors in relation to an investigation conducted by the organisation have been discussed with senior management. Feedback highlighting areas of improvement have been acknowledged and will inform future learning.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Given the robustness required in this centre some of the identified risk management controls were broad and vague; there was duplication of risk assessments, and inconsistency of both assessment and control implementation.

14. 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 organisation's Risk Specialist attended the service on 16/3/16 to review all risk assessments and controls. The risk specialist will prepare a report which will be furnished to the service with recommendations; the recommendations will be implemented with oversight of the PIC. Any recommendations will be discussed with the staff team in team meetings, families and relevant professionals.

Proposed Timescale: 21/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Only one escape route was clearly indicated on the day of inspection; two were noted on the diagrammatic plan of the building.

Internal doors had door closures and some had automatic hold open and release devices, however inspectors also noted the use of door wedges, one door was wedged open with a retail catalogue.

15. 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:
Signage will be placed at both exits in line with the diagrammatic plan of the building.

A risk assessment has identified the requirement to have fire doors open for certain service users. The risk assessment includes control measures that fire doors must remain closed at night when service users are sleeping.

The service is exploring options with the organisation's Property Department for door closures which will enable doors to remain open and will close in the event of a fire.

Proposed Timescale: 30/06/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff working in this centre on a less than full-time basis had not received MAPA training. As a result, not all staff had the required knowledge and skills to equip them to respond appropriately and safely to behaviour that was challenging and to support residents to manage their behaviour.

16. 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:
All staff who required MAPA training completed training on the 6th & 7th March 2016. Staff will receive MAPA refresher training when required and prior to renewal dates.

Matters raised by the inspectors pertaining to unapproved and potentially unsafe interventions utilised during an incident have been discussed with the behaviour therapist and the staff team to ensure only agreed and approved interventions/distraction techniques are utilised. The behaviour management guidelines have been updated which reflect specific interventions/distraction techniques to be utilised during any event of behaviour that challenges.

Proposed Timescale: 31/03/16 & 30/06/16

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings, it was not demonstrated that all alternative measures were considered before a restrictive practice was used.

17. 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:
Behaviour support plans (BSP) are currently being reviewed by the Behaviour Therapist in conjunction with the team.

The review will ensure that within all BSPs provisions are in place to enable all possible alternative measures be considered before a restrictive practice is used.

Implementation of revised BSPs will ensure that all alternative measures are considered before a restrictive practice is used and that when the use of a restrictive practice is required the least restrictive procedure for the shortest duration is used.

This will be communicated to the staff team in team meetings and monitored through ongoing review in line with the organisation's Restrictive Practice Policy.

Proposed Timescale: 30/06/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Individual behaviour support plans did not provide clear specific guidance for staff with respect to what physical restraint was approved for use.

All restrictive practices in use had not been identified.

Inspectors reviewed incident records and saw that other unapproved and potentially unsafe interventions had been used by staff. Inspectors were not satisfied that this had been satisfactorily explored by the provider to provide adequate re-assurance that unapproved and unsafe interventions were not and would not be used in the centre.

A detailed log of every episode of restraint or use of a restrictive procedure that included details of the reason, type and duration of restraint and/or restrictive procedure used was not available in the centre to inspectors.

18. 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:
Behaviour support plans (BSP) are currently under review by the Behaviour Therapist.

Implementation of revised BSPs will ensure that all alternative measures are considered before a restrictive practice is used and that when the use of a restrictive practice is required the least restrictive procedure for the shortest duration is used.

BSP's will clearly identify what restrictive practices are sanctioned to be utilised, how it is to be utilised and when. All internal documentation will be completed following any planned and unplanned restrictive practice in line with organisational policy.

A detailed log of restrictive practices will be maintained which will include reason, type and duration of restrictive practice. The restrictive practice log will be reviewed and discussed on an ongoing basis in team meetings.

Proposed Timescale: 30/06/2016

Outcome 09: Notification of Incidents
Theme: Safe Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Any and all occasions where a physical restrictive procedure was used had not been notified as required by Regulation 31 (3)(a). **19. Action Required:** Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. **Please state the actions you have taken or are planning to take:** Any occasion on which a restrictive practice is used will be reported to the Chief Inspector at the end of each quarter.
Proposed Timescale: 30/04/2016

Outcome 11. Healthcare Needs
Theme: Health and Development **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Several blanks were noted in a food intake record and there were no records available for inspection of the monitoring of residents' body weight. **20. 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:** Food intake records will be completed on a daily basis for the resident requiring this support. A Dietician has been sourced and will attend the service to provide advice and guidance. Weight records will be taken weekly to monitor the resident's weight.
Proposed Timescale: 25/03/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied as to the timeliness of all referrals to and reviews by other disciplines including psychology, behavioural therapy and occupational therapy.

21. 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:
Referrals will continue to be made as and when required. The person in charge will ensure each referral is followed up in a timely manner. If appointments are not available within an acceptable timeline appropriate alternatives will be sourced in consultation with the Health Service Executive.

Proposed Timescale: 21/03/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As discussed in the body of Outcome 12 inspectors were not reassured that medication management systems were conducive to safe medication management practice.

22. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
•Blister packs are being explored and have been implemented for one resident since the 21/03/16.
•New storage systems for the safe storage of medication have been ordered and delivery is expected by 7/04/16
•All medications will be clearly labelled and replaced if the label becomes illegible.
•Any controlled medication in use will be stored and controlled within legislative requirements.
•All medication will be transported as per the organisations safe administration of medication policy. This issue has been highlighted in the context of the current review of policy. The safe administration of medication policy is currently being reviewed.
•Medication errors/events will be reviewed and discussed at team meetings and individual supervisions to ensure learning.

Proposed Timescale: 30/05/2016

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:** There was no quality improvement action plan evidenced. Given these inspection findings and the similarity of the findings of the two internal audits it was difficult to evidence how or if the provider monitored the progress of the implementation of the required actions to ensure the quality and safety of the supports and services provided to residents in the centre. **23. 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 report from the most recent internal audit will be used as an operational action/improvement plan. •The actions identified will be worked on and document will be maintained by the PIC to demonstrate progress until each of the actions are complete. •Review of the action plan will form part of the agenda for team meetings and supervision sessions with the PIC and Regional Manager. •The Action Plan will be discussed at team meetings and will be a regular agenda item until all actions are closed off.
Proposed Timescale: 30/04/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Only one of four staff files reviewed contained all of the required information. **24. 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:** All staff files will be updated and include all documentation as required in schedule 2.

Proposed Timescale: 31/03/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff spoken with and families surveyed expressed concerns in relation to the over reliance on relief and agency staff and the impact of this on residents in terms of lack of consistency and the challenge for regular staff to ensure that staff not employed on a regular and consistent basis were informed and updated on residents' needs and support plans.

25. 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:
Due to the high level of absenteeism currently in the service there is a requirement to utilise relief and agency staff. The service has regularised the number of agency and relief staff utilised. This has been achieved by identifying regular agency and relief staff who are familiar with the residents' needs and support plans.

Proposed Timescale: 30/03/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The statement of purpose referenced a commitment to staff training and development in the area of autism, yet this was not reflected in the staff training records or in the staff files.

26. 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:
Statement of purpose and function will be updated to reflect actual training provided. The PIC and PPIM's in consultation with the organisations learning and development department are exploring suitable training options for the staff team. One staff member is currently undergoing a diploma in Autism studies which is being supported by the organisation.

Proposed Timescale: 31/12/2016