

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



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| Centre name: | Centre 2 - Aras Attracta |
| Centre ID: | OSV-0004910 |
| Centre county: | Mayo |
| Type of centre: | The Health Service Executive |
| Registered provider: | Health Service Executive |
| Provider Nominee: | Mary Warde |
| Lead inspector: | Michael Keating |
| Support inspector(s): | Ann-Marie O'Neill; Florence Farrelly; Shane Walsh |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 27 |
| 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 notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

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|--------------------|--------------------|
| From: | To: |
| 12 July 2015 16:15 | 12 July 2015 18:00 |
| 13 July 2015 09:45 | 13 July 2015 19:00 |

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

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|---------------------------------------|
| Outcome 08: Safeguarding and Safety |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

Summary of findings from this inspection

Between July 2015 and March 2016 inspectors completed a series of inspections at the designated centre and found poor outcomes which had a significant impact on the safety and the quality of life of residents. In October 2015, HIQA required the provider to conduct their own audit of the safety and quality of life of residents to identify their own deficits and develop a remedial action plan.

Subsequent to this HIQA completed inspections in March 2016 to examine whether the actions of the provider had been effective in improving the safety and quality of life of residents. Inspectors found that significant improvements had been achieved and residents were experiencing more positive outcomes as a result. Although improvements have been made, there continues to be areas where further improvements are required and HIQA will continue to monitor compliance at the centre.

This inspection report relates to an inspection that occurred prior to HIQA requiring the provider to undertake their own audit.

This centre is one of three centres on a large campus, Centre 1, Centre 2 and Centre 3. The three centres were inspected during this visit and there are separate reports for each centre. This report refers to Centre 2. This was the third inspection of this designated centre to be carried out in 2015.

This was a triggered inspection following the receipt of a number of notifications

submitted to the Authority in relation to the safeguarding of residents.

Prior to the inspection, the provider was required to carry out a review of all notifications submitted and the investigation into two particular notifications regarding safeguarding. The provider was requested to attend a meeting with the Authority on the 29 June 2015 to discuss the three centres. At that meeting, the inspectors were not satisfied that the actions taken by the provider in response to an allegation of abuse were sufficient to safeguard residents.

In addition to that issue, inspectors also discussed specific concerns at the meeting relating to three main areas; namely governance and management, safeguarding and safety and inadequate staffing levels. During the meeting the provider and the person in charge were unable to provide adequate assurances that residents were being adequately safeguarded and protected, particularly from peer to peer altercations that were resulting in the injury of residents. Subsequent to the meeting the provider was required to submit a schedule of improvement actions to the Authority by Wednesday 8 July 2015 setting out how the provider proposed to address these concerns.

In that submission, the provider identified immediate actions that they stated had been taken including the allocation of additional staff and supports around identified residents. On this inspection, inspectors found that the provider had not implemented the immediate actions as stated in their submission. Because of the significant number of peer to peer assaults in the centre and the failure of the provider to implement their own action plan, inspectors required the provider to take immediate action to ensure the safety of residents. The immediate risk identified was mitigated before inspectors left the premises, and ongoing updates and reassurances are being sought from the provider in relation to this.

The other actions within the plan submitted by the provider included recruitment of staff, further reconfiguration of the centre and the appointment of additional management staff. The management posts outlined in the plan had been approved at the time the plan was submitted and interviews had been scheduled. However, plans and actions relating to the recruitment of additional staff and further reconfiguration of the centre were dependent upon approval from the Health Service Executive (HSE) at national level. This plan did not provide adequate reassurance and therefore an unannounced inspection was scheduled for 12 and 13 July 2015.

The concerns of the Authority were substantiated by the findings on inspection, and inspectors found that the provider had failed to sustain improvements that were noted during the inspection in April 2015. The inspection focused on governance and management, safeguarding and safety and staffing. The provider was found to have major non compliances in the four outcomes. In addition, the provider did not have a statement of purpose in the centre which accurately reflected the type of service and facilities provided in the centre, as required by the regulations. The findings are discussed in the body of the report and all non compliances are actioned at the end of this report.

As a result of the findings from this, and previous inspections the Chief Inspector

deemed it necessary to request the registered provider to enhance their own governance and management monitoring as a formal requirement. They were requested to carry out a programme of auditing in accordance with Regulation 23 (2). This places a legislative responsibility on the provider to carry out unannounced visits to the centre to monitor the safety and quality of care and support provided and as required, to put a plan in place to address any concerns identified during the visit.

The registered provider was also required to prepare a written governance and management report of the visit and to make this report available to the Chief Inspector and on request to relatives and residents. The Authority provided a report template for this purpose and at the time of publication of this report, the registered provider has been requested to complete the unannounced visit and subsequent report on a quarterly basis. One such report has been provided to the chief inspector as requested on 27 October 2015. This plan provided reassurances that noncompliance identified in this report were actively being addressed.

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 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

Inspectors found that the provider and person in charge had not put adequate arrangements in place to safeguard residents from being harmed by peer to peer incidents of aggression and from behaviours that challenge.

Individual residents were found to be regularly targeted by other identified residents. The provider and person in charge had failed to put adequate arrangements in place to ensure the protection of residents from incidents of aggression and these incidents were occurring frequently. Staff stated this was the case and documentation including accident/incident report forms and nursing notes confirmed this to be the case.

The behavioural support guidelines highlighted the requirement for staff to be appropriately trained in a specified course on managing behaviour that is challenging including de-escalation and intervention techniques. The inspectors were particularly concerned that one staff member working in this highly challenging environment had not yet received training in this area, in addition other staff could not recall when they had received training. Nursing notes documented several incidents where staff had been injured by physically intervening in order to protect other residents who were regularly targeted. Information provided to inspectors both verbally and in documentation stated that staff members had to physically intervene on a daily basis to prevent altercations between identified residents and also between residents and staff.

During the inspection, the inspectors witnessed an incident where three male staff had to intervene during an intense physical altercation. While this appeared to be well managed, some of these staff members were not trained in the specified interventions.

In addition, this staffing level was not available on the previous day, when only two staff, one of each gender, were available. The stated staff complement for the centre was five staff.

Inspectors also found that many incidents of aggression were not being reported in accordance with the organisation's policy. This meant that the actual level of incidence was significantly higher than the provider's overview records indicated. On several occasions during the inspection, there had been incidents and "near misses" between residents which were noted in the daily nursing notes, but were not reported through the incident reporting procedures. When questioned why this was the case, staff stated that these incidents occur so frequently that that would be constantly filling in these reports.

Behavioural support plans were in place however, sufficient efforts were not being made to identify and alleviate the cause of individual resident(s) challenging behaviour. The supports required for individual residents as identified in the plans were not provided. For example one resident's plan stated the resident required 2:1 staffing levels between 08:00 hours and 20:30 hours and this was not being consistently provided. In addition, the behaviour plan identified the reduction in staffing levels during staff break times as a significant trigger to challenging behaviour. While this report was dated September 2014 this issue had not been addressed. The wishes of individuals not to live in a particular environment, while known, were not addressed. This was causing increased anxiety and stress leading to a need to use restrictive techniques on a frequent basis.

Individual behavioural support guidelines had been developed by a clinical nurse specialist in challenging behaviour with the assistance of a specialised training programme led by a clinical psychologist. However, the quality of the plans was inconsistent and they did not always provide clear guidance for staff. For example, while one resident's plan was clear, concise and provided good guidance to staff members, another residents' was found to be unclear with conflicting information and lack of clarity on which set of guidelines should be followed. This resident's plan contained several lengthy and complex reports and documents, six of which were reviewed by the inspector. However, there was no single summary document, to provide clarity to staff on how to manage difficult behaviour.

Given the intensely challenging environment in this centre, the inspectors noted the respectful interactions between staff and residents, and noted the efforts made by staff to provide and promote personalised intimate care practices, as documented within care plans.

Some staff did not demonstrate a sufficient knowledge and understanding in relation to what constitutes abuse. In addition, training records indicated that a number of staff had not completed safeguarding training. However, staff spoken with during the inspection confirmed that they had completed training in the safeguarding and protection of vulnerable adults.

Judgment:
Non Compliant - Major

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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):

Findings:
A centre specific statement of purpose which provided all of the information required by the regulations and which accurately described the service and facilities provided in the centre was not available to inspector during the inspection or to residents or their representatives.

This centre comprises five bungalows. Inspectors asked for a statement of purpose in four of these bungalows. In two bungalows, inspectors were provided with an old statement of purpose referring to the service provided across the campus. In the other two bungalows, a statement of purpose was not provided.

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):
No actions were required from the previous inspection.

Findings:
Management systems in place were found to be ineffective to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored. The management system in place had failed to address the ongoing risk to residents

and staff due to inappropriate staffing levels and failure to put measures in place to adequately protect residents.

An immediate action was issued to the provider nominee in this regard. An immediate response was requested before the inspection was completed to address the specific risk(s) identified. The inspectors were satisfied that these measures provided the adequate protection to residents and staff on a short-term basis. However, concerns remain in relation to the sustainability of these measures as they relate to reassurance around the provision of additional staff on an ongoing basis. Previous reassurances in relation to increased staffing levels provided to the authority following previous inspections, provider meetings and contained within commitments provided through notifications had not been met. Therefore, ongoing updates have been requested from the nominee provider in relation to the measures taken to address the particular risk referred to within the immediate action.

The inspectors were concerned with this level of noncompliance demonstrated by the provider in relation to previous commitments and assurance provided to the Authority. Following a meeting with the provider on 29 June 2015, the provider submitted a plan outlining how concerns raised in relation to safeguarding residents would be addressed. Inspectors found that the provider had failed to implement specific commitments given in this plan. For example, the provider stated that specific arrangements had been put in place for a named resident in this centre but inspectors found that this had not been adequately implemented and as a result, residents continued to be the target of attempted assaults and had been subjected to injury at times.

There were found to be inadequate governance and management arrangements over the weekend of 11 and 12 July. The clinical nurse manager assigned responsibility for the centre was unable to provide appropriate governance or supervision across the centre comprising five bungalows due to low staffing levels and her need to stay in one bungalow as a staff member. She was unsure of staffing levels throughout the centre over the weekend. For example the numbers of staff and the actual individuals working in specific bungalows were not known in some cases and the rota did not identify who was working in each bungalow at certain periods of time.

Inspectors found that the provider's audit of quality and safety was not robust and was not identifying issues of significant concern relating to the welfare and protection of all residents.

The provider nominee had carried out an unannounced visit to the centre two days prior to the inspection on Friday 10 June 2015 in line with her legal obligations under Regulation 23(2)(a) & (b). A copy of the subsequent draft report on the quality of care and support provided in the centre was provided to the inspectors following the inspection. A number of findings in this report were found to be inadequately cross-checked against supporting documentation. For example, this report states that there was an 'incident report completed for all incidents'. However, inspectors found that this was not the case.

Other findings found to be inaccurate within this report included:

- 'all staff had completed training in safeguarding': training records provided to

inspectors showed this was not the case

- 'CNM2 affirmed that staff are more vigilant and there is a heightened awareness on safeguarding issues': findings on this inspection was that residents were not adequately safeguarded

- 'planned and actual staff rosters available in centre 2': inspectors found that while these rosters were available, they were not accurate and did not reflect the actual staff working in each centre at all times.

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:

The provider had identified and informed inspectors of the staffing levels and skill mix required in this centre to meet the specific needs of a resident with complex care and support needs and to provide support to other residents. Inspectors found that the provider was failing to provide those staffing arrangements and failing to ensure a safe level of staffing in the centre. This was of particular concern, given the level and frequency of behaviours that challenge in the centre.

Inspectors reviewed accident and incident report logs and identified specific days in which the numbers of accidents/injuries increased significantly when the centre was short staffed. Three individual examples during the month of June were identified and discussed with senior management.

Inadequate staffing levels were found to be high risk during specific periods. For example on the day before the inspection (Saturday 11 July 2015) one specific unit within the centre, identified as requiring 5 staff to ensure the safe delivery of support and care only had two staff on duty between 19:00 hours and 20:30 hours. While there were five staff on duty in this bungalow during the inspection, it was noted that across the centre (5 Bungalows) over the following seven days, the centre only had its required allocation of staff on two of these days. The planned rota identified the centre was short three staff on four days and two on one day. The provider nominee stated efforts were

being made to fill these positions with agency staff but this was proving difficult.

The staff rota did not identify all staff who had worked in the centre as agency staff and twilight staff were not listed. In addition, the common practice of moving staff around the centre (between bungalows) or between the three designated centres within the campus was not been appropriately recorded and reflected within the staff rota(s). Reviews of a number of previous rotas with a number of different clinical nurse managers and the inspector found incidences when they were unable to identify who had worked in a specific centre or bungalow. This also meant that there was no evidence to demonstrate if adequate staffing levels were maintained at all times in specific bungalows.

As had been discussed previously, staff members were not provided with appropriate training in managing challenging behaviour and some staff had not completed safeguarding training. The training records maintained were poorly managed, for example some staff listed had retired and were no longer working in the centre, the records were not centre specific, and the reliability of the documentation was questionable as clinical nurse managers spoken with stated some staff members had received safeguarding training however, this was not reflected in the training records.

Staff were inadequately supervised and supported at weekends as the clinical nurse manager assigned management responsibility was not supernumerary and was based as a front line nurse in one bungalow throughout the weekend.

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:

Michael Keating
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 report¹

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| Centre name: | A designated centre for people with disabilities operated by Health Service Executive |
| Centre ID: | OSV-0004910 |
| Date of Inspection: | 12 & 13 July 2015 |
| Date of response: | 31 July 2015 |

Requirements

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

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

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all staff were appropriately trained with up to date knowledge and skills as assessed as required within support plans to respond to behaviour that is challenging and to support residents to manage their behaviour.

1. Action Required:

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

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:

Since March 2015, the Service has changed its philosophy of training in the management of behaviour that challenge including de-escalation and intervention techniques. To a low less restrictive arousal approach.

Staff training is planned for August 31st, 01st and 02nd of September 2015 and 15, 16th and 17th September. Further training is being planned for October, November and December 2015, dates to be confirmed. Three staff are being trained as Train the Trainers in Studio3 to deliver ongoing training and provide support in the development and implementation of behavioural support plans. Once all staff are trained, one day refresher training will be provided.

Experts in the management of challenging behaviour are onsite each month to review behavioural support plans, and to support staff and Clinical Nurse Managers in the low arousal approach. Additional support is being provided from 17th to 19th August 2015.

Proposed Timescale: 31/12/2015

Theme: Safe Services

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

Sufficient efforts were not being made to identify and alleviate the cause of individual resident(s) behaviours. Known triggers to escalated behaviour were not being addressed such as reduced staff numbers during break times; and the wish to not live in a particular environment, while known were not addressed. This was causing increased anxiety and stress leading to a need to use restrictive techniques on a frequent basis.

2. 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:

Additional staffing resources have been put in place to ensure that there are consistent numbers of staff during meal breaks, 7 days per week. This is being supported Psychology Project Workers and the Activation Team in this Centre.

One Resident is being accommodated in an independent self contained unit and supported by staff at all times from 8am to 12midnight. He is supported by one staff from 12midnight to 8am when he is usually sleeping. This service is resident led and he is supported with a range of activities as per his activation assessment. Behaviour support plans are being reviewed and updated to provide clear and consistent guidance

to staff.

The implementation of his behaviour support plan is being supported by Clinical Nurse Specialist in Behaviours that Challenge and Psychology Project Workers

Proposed Timescale: 11/08/2015

Theme: Safe Services

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

Residents were not adequately protected from all forms of abuse as adequate safeguarding and safety measures assessed as required were not provided.

3. 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 service is committed to the protection of vulnerable adults. A significant number of additional staffing resources have been put in place to support residents to live in self contained units with 1:1 or 2:1 staffing supports with one resident who has moved to a self contained apartment. Plans are in place to reduce numbers in bungalows by opening additional services as soon as the appropriate staff can be deployed to the service. There is no impediment to the recruitment of staff at either a local or national level other than the availability of candidates.

The service has employed a fulltime Social Worker, who is now the Designated Person to undertake a preliminary screen independent investigation and draw up and review a safeguarding plan in line with Safeguarding Vulnerable Adults at risk of Abuse National Policy and procedures published by the HSE in December 2014. This Social Worker is being supported by a Principal Social Worker and is undergoing National HSE Training for Designated Officers commencing 10th August 2015, following which she will provide onsite ongoing refresher training to staff.

A Safeguarding Register is maintained and reviewed on a weekly basis with the Social Worker and Clinical Nurse Managers. The Register outlines the Safeguarding issues identified and the safeguarding plan from the screening of the investigation process. The purpose of these weekly meetings are to ensure that all recommendations from safeguarding investigations are being adhered to.

15 minute behaviour sampling has commenced for one resident with severe challenging behaviour who is currently residing in a self contained apartment with staffing supports at all times. Detailed records will be maintained of his behaviour and interaction with staff for one week period and reviewed thereafter.

Proposed Timescale: Complete and ongoing and 31st December 2015

Proposed Timescale: 31/12/2015

Theme: Safe Services

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

Not all staff had been provided with appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

4. Action Required:

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

Please state the actions you have taken or are planning to take:

At the time of the inspection three staff had not undertaken training in the protection of vulnerable adults. As an interim measure, the Clinical Nurse Manager and Social Worker is meeting with the staff identified to review the Safeguarding Policy with these three staff. The Service has scheduled Safeguarding Training for 24th August for outstanding training for new staff to the Centre 2

Proposed Timescale: 24/08/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

There was no statement of purpose available to residents or their representatives.

5. Action Required:

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:

The Statement of Purpose had been removed for updating. Going Forward The Statement of Purpose will only now be removed from the Unit on the replacement with an updated version. Updated version is now available in all areas of Centre 2.

Proposed Timescale: 11/08/2015

Theme: Leadership, Governance and Management

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

There was no centre specific statement of purpose available to inspectors during the

inspection.

6. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

The Statement of Purpose had been removed for updating. Going Forward the Statement of Purpose will only now be removed from the Unit on the replacement with an updated version. Updated version is now available in all areas of Centre 2.

Proposed Timescale: 11/08/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The written report on the safety and quality of care and support provided in the centre was found not to be accurate or robust in several areas as outlined in the body of this outcome.

7. 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:

A more robust method of inspection will be utilised to meet the regulatory requirements. More time will be assigned to the inspection process to allow for in-depth critical analysis of information and systems. Additional external inspectors will be nominated by the provider to carry out a more robust inspection.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

There were ineffective arrangements in place to support, supervise and performance manage all members of the workforce due to poor management levels at set times of the week.

8. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015.

Interviews conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July with three external successful candidates identified These will be additional management posts, with one Clinical Nurse Manager 3 dedicated to Centre 2 due to commence on 01st September 2015. This manager will work with current managers in the Centre and provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 2 only. This will provide a more robust management and supervision system at Centre level.

The current PIC is supernumerary and contactable at all times.

Clinical Nurse Manager 2 is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff.

Staff are being recruited through National Recruitment Service with approval for 25 additional Whole Time Equivalents. These actions will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times. There is no impediment to the recruitment of staff at either a local or national level other than the availability of candidates.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

Management structures in the designated centre were not adequate, particularly at weekends. The clinical nurse manger assigned responsibility for oversight of the centre was working as part of the rota, assigned to a specific bungalow within the centre and could not be accountable for the service provision in the other four bungalows.

9. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015.

Interviews conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July with three external successful candidates identified. These will be additional management posts, with one Clinical Nurse Manager 3 dedicated to Centre 2 due to commence on 01st September 2015. This manager will work with current managers in the Centre to provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 2 only.

The current PIC is supernumerary and contactable at all times.

Clinical Nurse Manager 2 is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff. Staff are being recruited through National Recruitment Service with approval for 25 additional Whole Time Equivalents. These actions will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times. There is no impediment to the recruitment of staff at either a local or national level other than the availability of candidates.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

Ongoing risk of injury to residents and staff members was identified due to inappropriate staffing levels and lack of adequate management systems to ensure the safe and appropriate delivery of care to residents.

10. 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:

Staffing levels and governance structures are being addressed by ongoing recruitment of staff through National Recruitment Service. National approval has been granted to recruit 33 WTE Care Assistants into the service to reduce reliance on Agency and provide consistency of care. This recruitment process along with the recruitment of 23 Social Care Workers is underway. The Social Care Workers will facilitate the opening of two transitional living bungalows for 8 residents reducing the numbers residing in current bungalows, thus enhancing safeguarding. This also supports the transition from an institutional setting to community living in line with the principles of the Service Review being conducted.

As an interim measure the service is working with Agency to secure consistent staffing.

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015.

Interviews conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July with three external successful candidates identified. These will be additional management posts, with one manager dedicated to Centre 2. This manager will work with current managers in the Centre and provide supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 2 only. This will provide a more robust management and supervision system at Centre level. Clinical Nurse Manager 2 is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff.

The Staff being recruited through National Recruitment Service will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times. There is no impediment to the recruitment of staff at either a local or national level other than the availability of candidates.

Proposed Timescale: The Authority was not satisfied with the timescale proposed under this action

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staff rota did not include all staff who had worked, twilight staff were not listed. In addition, the common practice of moving staff around the centre (between bungalows) or between the three designated centres within the campus was not being appropriately recorded and reflected within the staff rota(s).

11. 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:

Since the Inspection, all rosters have been reviewed. All staff and the shifts they are working are identified on the roster. In addition, their locations of work is identified on the roster. The policy on Roster Guidelines has been redrafted and has been sent for peer review.

Proposed Timescale: 11/08/2015

Theme: Responsive Workforce

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

The provider had identified the number and skill mix of staff required to provide a safe level of service in this centre but had failed to provide that level of staffing.

12. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

The action plan submitted by the provider does not satisfactorily address the failing identified under this outcome. The Authority has taken the decision not to publish this action and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Responsive Workforce

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

Staff were not provided with access to appropriate training in relation to the specialist challenging behaviour programmes assessed as required for all staff.

13. Action Required:

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

Please state the actions you have taken or are planning to take:

The service has changed its approach to the management of challenging behaviours and is retraining staff in a less restrictive low arousal approach in the management of challenging behaviour.

Staff training in the management of challenging behaviour is ongoing and is planned for August 31st, 01st and 02nd of September 2015 and 15, 16th and 17th September. Further training is being planned for October, November and December 2015, dates to be confirmed.

Three staff are being trained as Train the Trainers in Studio3 to deliver ongoing training and provide support in the development and implementation of behavioural support plans. Once all staff are trained, one day refresher training will be provided in the low arousal approach.

Practitioners are providing onsite support to Clinical Nurse Specialist in Behaviours that Challenge in the management of challenging behaviour. Additional Support is being provided in the month of August

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

Staff were inadequately supervised and supported at weekends as the clinical nurse manger assigned management responsibility was not supernumerary and was based in one bungalow throughout the weekend.

14. 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:

The Governance structure is under development. A dedicated Director of Services has been appointed to the Service and has taken up position from 13th July 2015. Interviews conducted by external experts for Clinical Nurse Managers, Grade 3 took place on 23rd and 24th July with three external successful candidates identified These will be additional management posts, with one Clinical Nurse Manager 3 dedicated to Centre 2 due to commence on 01st September 2015. This manager will work with current two Clinical Nurse Managers, Grade 2 and Clinical Nurse Manager, Grade 1 in the Centre to provide robust management supervision and governance. The Clinical Nurse Manager 3 will become the PIC for Centre 2 only.

The current PIC is supernumerary and contactable at all times.

Clinical Nurse Manager 2 is only included in the roster, following a risk assessment to provide safe staffing, as part of the roster the CNM 2 will continue to provide supervision to staff.

Staff are being recruited through National Recruitment Service with approval for 25 additional Whole Time Equivalents. These actions will ameliorate the aforementioned risk and allow CNM2 to remain supernumerary at all times. There is no impediment to the recruitment of staff at either a local or national level other than the availability of candidates.

Proposed Timescale: 30/09/2015

