Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	The Bay
Name of provider:	Autism Initiatives Ireland Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	01 November 2018
Centre ID:	OSV-0003434
Fieldwork ID:	MON-0021785

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The provider describes the service as a respite service for ten male service users on a rolling basis. A maximum of four residents is accommodated at any one time. Support is provided for autistic spectrum conditions and other conditions including epilepsy and other complex needs. The centre is a three bedroom house and an attached apartment with two bedrooms for the sole use of one respite user. Two of the bedrooms in the main house have en-suite bathrooms and there are shared living and kitchen areas. The centre is close to the local town. The service aims to increase independent living skills and support integration while providing an overnight respite service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
01 November 2018	11:00hrs to 19:30hrs	Julie Pryce	Lead

Views of people who use the service

The inspector spent time with three residents and saw that they were comfortable and at home in the centre. Residents' views were elicited in various ways by staff members who were familiar with their preferred methods of communication.

Interactions between staff and residents were seen to be respectful and clearly took into account the detailed information relating to communication that was in each resident's personal plan.

Capacity and capability

There was a clearly defined management structure in place with clear lines of accountability. There were systems in place to ensure that the centre was regularly monitored. The person in charge was a regular presence in the centre, and was involved in implementing the monitoring systems that were in place to oversee the quality of life for residents in the centre.

There was an appropriately skilled, experienced and qualified person in charge in position at the time of the inspection. The person in charge demonstrated a detailed knowledge of the needs of residents, and had clear oversight of the care and support in the centre. She had specific skills relating to the needs of residents, for example was a staff trainer in some aspects of behaviour management.

A suite of audits was in place and had been regularly undertaken. Audits undertaken included audits of medication management and of information kept on residents, such as personal plans and medical information. There had also been unannounced visits on behalf of the provider every six months as required by the regulations. Actions required for improvement had been identified during these process, and those reviewed by the inspector had been implemented of were within their timeframe. Improvements for residents due to these actions included the introduction of new activities such as swimming, the updating of a personal evacuation plan and the review of some policies.

A series of regular meetings were held including management meetings, staff meetings and practice support team meetings. These meetings were based on clear terms of reference, and an agenda was set prior to each meeting. The first item at each of these meetings was a review of any actions agreed at the previous meeting.

The centre was adequately resourced to provide the required care and support in accordance with the needs of residents. There were appropriate staffing arrangements in place, and consistency of staff was managed by the use of a relief panel so that unfamiliar staff were not used.

Staff had received mandatory training, and training in specific areas pertinent to the needs of residents, for example an extensive training in autism was offered to all staff. There was regular structured supervision of staff which included performance management which was conducted on an eight weekly basis. While the inspector did not review the contents of staff files on this occasion, the human resources department had undertaken an audit of files which indicated that all files contained the information required by the regulations.

All the policies required by the regulations were in place and had been reviewed within the required time frame. There was a directory of residents in place as required.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, and had clear knowledge of the residents and oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff to meet the needs of residents, and consistency of care and continuity of staff was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, and additional training had been provided in accordance with the specific needs of residents.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and robust systems to monitor the quality of care delivered to residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Admissions of residents were well managed in accordance with their needs and preferences.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by the regulations, and described the service provided.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications were made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 4: Written policies and procedures

All the policies required under Schedule 5 of the regulations were in place.

Judgment: Compliant

Quality and safety

The provider had put arrangements in place to ensure the quality and safety of care and support of residents that residents who availed of respite care in the centre. However a particular challenging situation had arisen due to the deterioration of the mental health of one of the respite users, and the service were supporting this resident on a full time basis at the time of the inspection. The difficulties around this issue were immediately brought to the attention of the inspector and were reviewed during the course of the inspection.

While the situation was challenging, the provider had put in supports including staffing arrangements to support the needs of the resident. However in order to maintain the safety of the resident and staff, an additional restrictive intervention had been introduced. The implementation of this intervention was such that the resident was alone in their apartment for short periods of time, where they could not be observed by staff. This intervention was implemented when the resident's behaviour was at its most challenging. The inspector found that the provider had not fully considered and assessed the risk implications of this intervention. The provider took immediate steps at the time of inspection to introduce a method of observation and this was in place prior to the conclusion of the inspection. An appointment was made for the following day in relation to a determination as to whether the centre could continue to provide a service for this resident.

This situation did not affect any other residents, as the main house is separate from the apartment, and has a separate entrance and individual staffing. Three residents avail of a respite service at any one time in the main house, and there was a robust system of admissions in order to ensure a safe and compatible mix of residents. There was a detailed policy in place in relation to this process which required each resident to have a detailed assessment on which to base an individual support plan, in which compatibility needs and preferences were identified.

Consultation with residents was managed on both an individual and a group basis, and there were various service user forums including an advocacy forum. There was an ethos of promoting the rights of residents, and residents meetings included a discussion around a 'tree of rights' which had been designed by one of the service users.

Each resident had a personal plan in place and they had been involved in the development of these plans which were regularly reviewed. A futures planning meeting was held each year for each resident which was attended by the resident, their family, the staff and key-worker and any members of the multi disciplinary team who were involved with the residents. Each plan was reviewed monthly including review of goals and progress towards achievement of goals.

Personal plans also included positive behaviour support plans where residents required support in this area. These plans were very detailed, and were supported by the practice support team

There were systems in place in relation to the safeguarding of residents, and a clear process under which to follow up any allegations of abuse or complaints. All notifications had been made to HIQA as required. There was a policy in relation to protection of vulnerable adults and staff had received training. There were robust systems in place in relation to residents' personal money and in the management of household finances.

There was a detailed risk register in place in which all identified risks were recorded and risk rated. Corporate risks, environmental risks and individual risks were all recorded in the register. A detailed health and safety statement was in place, and there was a robust system of recording and reporting of accidents and incidents, and of trending and oversight of incidents.

Detailed risk assessments were also in place, both environmental and individual risk assessments. Each identified individual risk assessment had an associated risk management plan. There was carefully managed positive risk taking, for example some activities which held some risk for residents were assessed, risk rated and had an associated risk management plan.

There was appropriate fire safety equipment throughout the centre, including extinguishers, fire blankets, emergency lighting and self closing fire doors throughout. Regular fire drills had been conducted, and the person in charge ensured that all residents and staff were involved in fire drills. Each resident had a detailed emergency evacuation plan, and there was an emergency bag which contained items that might encourage residents to evacuate the building gin the event of an emergency.

Regulation 10: Communication

There was detailed guidance for staff in relation ot communication, and all interactions observed were in accordance with this guidance.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to meet the needs of the residents and had sufficient communal and private spaces.

Judgment: Compliant

Regulation 20: Information for residents

Information for residents was readily available in an accessible format.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk register in place including risk ratings, and a detailed risk assessment for each risk identified and robust oversight of risk within the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and evidence that residents could be evacuated quickly in the event of an emergency

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident in sufficient detail as to guide practice, which had been regularly reviewed with the involvement of the residents and their families.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were detailed behaviour support plans in place, based on individual assessments. However the use of restrictive practices recently implemented did not safeguard the resident.

Judgment: Not compliant

Regulation 8: Protection
Systems and processes were in place ot protect residents from abuse.
Judgment: Compliant
Regulation 9: Residents' rights
There was an ethos of upholding the rights of residents.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Bay OSV-0003434

Inspection ID: MON-0021785

Date of inspection: 01/11/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Immediate action involved the installing of visual monitors to ensure staff could observe service user at all times. In conjunction with these monitors we introduced guidelines for staff and a protocol for the use of the monitors, ensuring respect and dignity of the service user at all times. A risk assessment was in put in place to support these guidelines also.

An observation chart was put in place to ensure staff were monitoring and recording the service users wellbeing at all times.

Staff ratio was increased to two staff 24 hours 7 days per week.

An emergency meeting was held on Friday 2nd November 2018.Persons in Attendance were Psychiatrist, Parents, PIC, Staff of The Bay, National Director (Provider).

Discussed at the meeting was an involuntary admission to a psychiatric facility. This was agreed by all parties present to be the best course of action for the service user, however, his GP refused this admission on grounds of service users suitability to the available facility.

The outcome of that decision meant that the service user remains resident at The Bay.

An increase of anti-psychotic medication has been prescribed and administered since that date. These multi-disciplinary meeting continue on a weekly basis.

We have reviewed and updated the Restrictive Practice Reduction Plan, with a view to decreasing and eventually removing the restrictive practice (locked door).

This is only in place when the service user is displaying behaviors of concern and when there is a high risk of harm to himself and others.

When the restrictive practice is in place there is a staff member constantly monitoring the service user on the monitor and recording on the observation chart.

We have identified other factors that may contribute to increased behaviors of concern such as physical health. The service user experiences extreme constipation which is linked to an increase in behaviors of concern. In order to support the service user with this, we have introduced a high fibre diet, laxatives and a bowel movement chart in conjunction with his medical team.

The use of the restrictive practice (locked door) has been decreasing over the last month, but is wholly dependent on the mental state of the service user and the level of

risk posed to both himself and to staff.
We are unable to provide a time frame by which the restrictive practice will be fully removed. We have sought guidance from the service user's Psychiatrist on this issue but a clear answer can not be given due to the fragile nature of the service user's illness.

10/01/2019

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	10/01/2019