Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Adults Services Palmerstown Designated Centre 1</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003897</td>
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<tr>
<td>Centre county:</td>
<td>Dublin 20</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Stewarts Care Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Brendan O'Connor</td>
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<tr>
<td>Lead inspector:</td>
<td>Caroline Vahey</td>
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<tr>
<td>Support inspector(s):</td>
<td>Thomas Hogan</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>20</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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</table>

Page 1 of 41
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 renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 03 July 2017 09:00
To: 03 July 2017 20:00
04 July 2017 10:00
04 July 2017 13:10

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
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</tbody>
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Summary of findings from this inspection
Background to the inspection.
This was the fifth inspection of the designated centre, the purpose of which to inform a registration renewal decision. This centre was recently subject to a triggered inspection in May 2017 following receipt of concerning information pertaining to safeguarding and safety. Inspectors identified concerns in the areas of safeguarding and safety, risk management and governance and management on the previous inspection.

This inspection focused on a more in-depth examination of the services provided in this centre. This was an announced inspection and 18 outcomes were planned to be inspected against. The findings on the first morning of the inspection identified such significant concerns that a decision was made to change the focus of this inspection to a risk based inspection. As a result eight outcomes were inspected against. Four of five units were visited as part of this inspection.

Description of the service.
The centre provided residential service for up to 21 adults on a campus based setting. There were 20 residents living in the centre on the day of inspection and both males and females could be accommodated. Two residents in the four units
visited had access to day services.

How the inspectors gathered evidence.
The inspectors spoke with four residents over the course of the inspection and observed practice for the first morning of inspection and at intervals for the remainder of the inspection. The inspectors met with the person in charge on the first day of inspection and spoke with ten staff members in relation to care and support of residents and facilities and services in the centre. The director of care also met with inspectors at intervals throughout the inspection. Relative or friend questionnaires received by HIQA were also reviewed, as well as documentation such as medication records, observational records, monitoring records, risk registers and risk assessments and health care plans.

Overall judgement of findings.
Major non compliances were identified in all eight outcomes inspected against. Residents had not been safeguarded against incidents of alleged abuse and adequate measures were not in place to safeguard residents, resulting in injury and negative experiences for residents. There was inappropriate use of restrictive practices, impacting on residents' rights, wellbeing and safety. Environmental risks were not identified or managed appropriately and identified control measures to mitigate risks not implemented. This had resulted in adverse incidents for residents and exposing residents and staff to known risks. Residents' healthcare needs were not consistently met and there was a lack of knowledge of residents' healthcare needs and supports identified.

Satisfactory medication management practices including administration and disposal were not found, to ensure residents received therapeutic interventions as prescribed. The provider had not ensured there were sufficient and consistent staffing arrangements to safely and comprehensively meet the needs of residents. As a result, an adverse incident had occurred and the appropriate care and support had not been provided to residents. There was evidence of institutional practices in the centre impacting on the rights of residents. The overall governance and management of the centre had failed to identify risks, ensure residents were safe and their needs were met, and to ensure residents' basic rights were upheld.

These findings are discussed in the main report and the regulations which are not been met in the Action Plan at the end of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
The inspectors found residents privacy and dignity was significantly compromised by practices in this centre. There was evidence of institutional practices in the centre, which seriously impacted on residents' rights, dignity and quality of life. The rights of residents' were found to be significantly compromised due to high levels of operational restrictive practices in this centre.

The inspectors spent a number of hours over the course of the inspection observing practice and reviewing facilities and support provided for residents.

Significant failings were identified in relation to residents' rights to privacy and dignity. The inspectors observed in one unit, a large, clear glass window was in situ whereby persons could observe a resident's bedroom from a kitchen area. Staff outlined this was used for observational purposes in the event of an environmental restrictive practice being applied in response to behaviours of concern. The inspectors observed a number of staff personnel accessed this kitchen including unit staff and household staff. Staff stated the resident liked it this way. It was not evident from a review of risk assessments and a review of restrictive practice prescriptions that the use of this window had been appropriately assessed or applied.

In this same unit the inspectors found the practice of checking of residents through covered viewing panels was not dignified and compromised residents' privacy. In addition, the inspectors found adequate care and support had not been provided to these residents. These checks consisted of either staff attending the unit for direct
contact, for a visit, or observing the resident through a viewing panel in the door at 15 minute intervals. These viewing panels were covered by a small curtain however, this curtain was only accessible for staff. Residents did not have a covering on viewing panels accessible from their apartments. Inspectors noted occasions when 15 minute checks were not being completed. This observational approach was found to be institutional by design and operation as opposed to being based on meaningful communication and engagement with residents. In a follow up review of the records maintained by staff of the completed checks, inspectors identified dates where residents had as little as 90 minutes of "constant" staff supervision. Outside of this staff would "visit" the apartments during which they would "enter apartment or observe through door window panel for sufficient time to assess status, engage momentarily with resident, provide an activity or other need". On another occasion one resident is recorded as having had no "constant" supervision in a 5 and a half hour period. No records were maintained for some dates and partial records maintained for other dates with "short staffed" entered on the records.

In addition, one resident told the inspectors, they had to lock their wardrobe as they said their peer frequently entered their bedroom uninvited and locks were used in order to prevent a peer from taking their possessions and throwing them out the window. A staff member also confirmed this was the case.

Significant concerns were identified in the use of restrictive practices and the impact this had on residents' rights to freely access their home, as well as fresh water.

Residents in one unit were all locked into their individual apartments and risk assessments outlined the reasons for these restrictions. On review of daily observational logs it was evident that the reasons for the application of these restrictions was not the presenting issue in the majority of cases. For example, over a six day period a resident did not present with defined behaviours however, the restriction was applied at all times. For another resident, no behaviours of concerns were recorded in observational records reviewed however, doors were also locked at all times.

**Judgment:**
Non Compliant - Major

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**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:
Inspectors found that the design and layout of two units of the designated centre was not suitable for the stated purpose and was not meeting the residents' individual and collective needs in a comfortable and homely way. While there were adequate private and communal accommodations for residents, the dining areas in three areas were found to be inappropriate in size and layout.

Inspectors were concerned with bathrooms in two units of the designated centre which were found to be of an unsatisfactory standard. There were no toilet seats on the toilets used by residents in these units. In addition, one bathroom had a lack of appropriate ventilation in place.

In one unit there was a lack of appropriate lighting and as a result the area appeared quite dark for residents. There was a noticeable lack of furniture across the majority of units in the designated centre, and in some instances furniture was damaged and of an unsatisfactory standard. In one individualised apartment area there was a dining table for a resident, however, there were no chairs on which the resident could sit to eat meals.

Three areas of the designated centre were found to be clinical and sterile in appearance. There was a lack of personalisation in these areas for residents with a lack of pictures or paintings hanging on walls, curtains on windows, and appropriate decoration of the environments.

In one unit of the designated centre a resident was observed being restricted from entering the hallway of the unit as it was not wheelchair accessible.

Recommendations arising from a review of a resident's needs by an external specialist, which included alterations to the living and garden environments for this resident, were found not to have been implemented.

In one area plaster was found to be falling from the wall, while in another unit inspectors found the plaster on a wall to be in a very poor state of repair. In addition, areas across the designated centre required painting with observations of paint chipping from walls.

Inspectors noted that improvements were made in one unit to a room following an issue identified on the last inspection in relation to risk.

Judgment:
Non Compliant - Major

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

Theme:
**Effective Services**

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

**Findings:**
The inspectors found measures had not been put in place in response, or to prevent adverse incidents involving residents. Residents were exposed to ongoing risk of harm.
Additional control measures outlined in risk management plans had not been implemented in order to reduce risks to residents and staff. There was evidence of environmental risks on the day of inspection. Appropriate arrangements were not in place to ensure residents could be evacuated from the centre and an immediate action was issued on the day of inspection. There were inadequate infection control measures in place to protect residents and an immediate action was also issued for this non-compliance. Assurances were provided by the end of the inspection in relation to the matters raised, outlining the measures the provider was taking to mitigate identified risks.

The inspectors reviewed records of incidents in one unit for 2017 and a welfare plan developed by the provider. The provider had recently undertaken a review of incidents in the centre following concerns that peer to peer incidents had not been appropriately reported, investigated or responded to in order to reduce risks to residents. Despite safeguarding plans developed recently, incidents of assault continued to occur in one unit and the inspectors were not assured that risks were mitigated. From review of safeguarding risk assessments, incident records and the centre’s welfare plan, there was a total of 36 incidents peer to peer incidents including physical and verbal aggression, intimidation, and of peers’ behaviour impacting on residents’ anxiety levels and sleep. While some measures had been taken in one unit, adequate measures were not in place to mitigate immediate risks to residents in another unit.

The inspectors also found the measures in place to mitigate risks were not consistently implemented. For example, the provider had failed to ensure consistent familiar staff were provided in a unit, resulting in an unexplained absence of a resident. In addition, additional control measures outlined in risk management plans were not implemented in order to further reduce risks.

The inspectors reviewed fire precautions in the centre. On the day of inspection, a number of routes in two units did not have adequate escape available. An immediate action was issued and the provider made arrangements to ensure these risks were mitigated. The inspectors also observed there was no emergency lighting in a final exit route in one unit. A fire door did not have a seal in situ, to ensure adequate containment of fire.

Poor practice was found in relation to infection control. Residents in one unit did not have handsoap or handtowels provided in toilet facilities which did not promote hand hygiene. In addition, there was a failure to ensure personal furnishings were kept in a hygienic state. An immediate action was issued in relation to infection control regarding
Environmental risks had not been identified and as such rectified to mitigate risks. A perspex screen fell off a television cabinet at the time of the inspection. The inspectors issued an instruction to staff to rectify this issue. In addition, an external stairwell used as the main entrance and exit for a resident had a build up of moss and leaves

**Judgment:**
Non Compliant - Major

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### 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.*

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### Theme:
Safe Services

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

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

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### Findings:

Inspectors found that sufficient measures were not in place to protect residents from being harmed or suffering abuse. Appropriate action was not taken in response to allegations or incidents of abuse. In addition, inspectors found the centre was operated in a restrictive manner for the residents who lived there.

On the day of inspection, inspectors found there was an absence of identification or recognition of incidents of potential abuse and appropriate response to incidents including peer to peer incidents and inappropriate sexualised behaviour. Evidence was not available to confirm all incidents were investigated or notified to the appropriate agencies in line with national policy. The inspectors were told this was an oversight and that a process was now underway to review all historical incidents in the designated centre. At the time of inspection, this review had been completed for a retrospective period of a four month period for two units in the designated centre, and for a six month period in one other unit of the designated centre.

Inspectors observed one resident engaging in inappropriate sexualised behaviours in a shared living room area and inspectors had to request staff attention to address this. In a follow up discussion, the staff member stated that this incident was not a safeguarding concern and would not be recorded as an incident. Another resident was observed to be removing their clothing throughout the period of the inspection and staff redressed them
on five occasions in front of those present in the living room area.

Staff outlined an incident of peer to peer physical abuse which occurred in the days preceding the inspection, during which one resident was observed to be biting another resident. Inspectors found an absence of response to this incident with no incident form available in the unit, or safeguarding plan addressing the measures taken to reduce or eliminate the possibility of reoccurrence.

Inspectors reviewed 'Safeguarding Adults Risk Assessment Tool' documents which had been completed for residents whom had previously been subject to alleged abusive incidents. In the case of one resident there were 15 incidents listed on the document relating to June 2017 with an additional statement of: "familiar incidents recorded as far back as 2014". 14 of the incidents listed related to alleged psychological abuse and reactions to other residents' "vocalisations" and "shouting and screaming". While the provider acknowledged the high level of risk exposure for the resident, the safeguarding plan did not outline any measures to reduce or eliminate the risks of reoccurrence.

In the same unit during the period of inspection, an incident involving behaviours which challenge took place. As a result of this, two residents were left with no option but to retreat to their bedrooms to maintain personal safety. Inspectors were advised not to leave the locked office of the unit during this time. Staff member told the inspectors residents felt afraid. The 'Behaviour Support Plan' for the resident involved in this incident listed unfamiliar staff and noise (along with others) as triggers for behaviours of concern, however, inspectors found that unfamiliar staff were regularly rostered to work in the unit and at the time of inspection noise levels were very high and potentially contributing to increased arousal levels in the unit. The inspectors found suitable arrangements were not in place to support some residents mental health needs and residents with identified risks of high arousal were exposed to ongoing elevated arousal levels. In another unit, appropriate support was provided in order to implement the support outlined in a behaviour support plan.

The measures taken by the provider in one unit in response to safeguarding concerns were raised by both a staff member and the person in charge. The staff member outlined to inspectors that supervisory measures were impacting negatively on residents availing of the services of the unit.

Inspectors were concerned at the level of restrictive procedures in place in the designated centre. This applied to three of four areas of the centre visited by inspectors. While the person in charge acknowledged that there were environmental and physical restrictive procedures in place in some areas of the centre, the extent of these and the use of chemical restraint was not recognised. Examples of environmental restraints in use included locked doors (internal and external), locked garden gates, locked wardrobes, and key operated light switches. With regards to physical restraint procedures, a 'denim suit' was used on occasions for one resident in response to the inappropriate removal of clothing; and a 'half body suit' was used at night for another resident who engaged in behaviours of a sensory nature.

There were specific concerns in relation to restrictive procedures in one unit of the designated centre. This area consisted of a two story building with four individual
Apartments, each of which was home to one resident. Three residents were present at the time of inspection while one was attending a day service programme. The freedom of movement of each of the three residents was limited at the time of inspection. The external doors, and internal doors which allowed access into each of the apartments were locked and residents could not independently leave these areas. There was an absence of defined behaviours for use of some of these restrictions, for example, the locking of doors was indicated due to a risk of aggression. However, records confirmed there was no indication of this behaviour in some cases. Window restrictors were observed to be in place which prevented the unobstructed opening of windows.

During a discussion held on the first day of inspection between the recently appointed Head of Care, the person in charge for the centre, and the inspectors, the Head of Care stated that safeguarding systems were not adequate to protect residents in one unit of the designated centre.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

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

**Findings:**
The inspectors found residents' healthcare needs were not met. Issues were identified in relation to staff knowledge and in plans in place to guide practice. Reviews with healthcare professionals were not consistently followed up. Suitable arrangements were in place for the provision of drinking water and accurate fluid records were not maintained. Nutritional needs were not met for a resident in line with recommendations. Food and drinks for residents were not appropriately prepared and handled.

The inspectors spoke to staff members and reviewed identified healthcare needs of residents. Inspectors found some staff did not have sufficient knowledge of residents' healthcare needs and supports, for example, identified healthcare needs and signs which would indicate a deterioration in these conditions. While some staff could demonstrate appropriate knowledge, staff to whom the responsibility for overseeing care was assigned, did not have sufficient knowledge.

Contemporaneous fluid records were not maintained for residents with specific fluid requirements. The inspectors reviewed corresponding healthcare plans, however, these plans did not guide practice and in the absence of satisfactory staff knowledge, the
inspectors were not assured a resident's healthcare needs could be safely met. An immediate action was issued on the first day of the inspection regarding this issue. By the end of the second day of inspection, the provider had outlined the actions they were taking to mitigate these risks.

The inspectors found that for a resident with specific nutritional needs, prescribed supplements were not consistently provided to the resident and records were not maintained on the medication administration sheet as to the reason behind this omission. Inspectors were not satisfied with resident access to water on this inspection. On the first morning of inspection, the inspectors observed a resident drinking from a bathroom sink and while a staff member did attend to the resident it was not evident during the period of observation that any fluids were offered to this resident post incident. The inspectors identified two residents could not freely access water in a unit and the measures the staff outlined for one resident to access drinks were not implemented. Adequate hydration was not provided to one of these residents and appropriate alternatives had not been provided following the implementation of water restrictors in this unit. For example, staff outlined the resident's fluids were recorded in meal records in order to provide assurances the resident received sufficient hydration. However, the inspectors found the resident had not been provided with sufficient fluids at all times. In addition, the inspectors were shown a bell by the staff, who specified this could be used for the resident to alert staff, if they were not in the apartment, to the fact they required a drink.

The inspectors found reviews with external healthcare professional had not been followed up for two residents. For example, a resident's external appointment was rescheduled to May 2017 from September 2016. The clinical nurse manager outlined to inspectors that written confirmation of the appointment was due to be received in March 2017 however, to date no correspondence was received and there was no follow up action by the provider to pursue this matter. In addition, a recent audit of residents' healthcare needs identified a referral to an external health provider, in response to a resident's elevated blood levels, had not been appropriately followed up. This audit identified that while a written referral was made in December 2016, it was unknown to whom this letter was sent.

Improvements were required in the provision of food and drinks and in the mealtime experience for residents. The inspectors observed food was handled by staff inappropriately. Tea for residents was prepared with milk added to the teapot prior to serving to residents. Overall the inspectors observed the mealtime was rushed for residents and there was a lack of positive social engagement with residents. With the exception of one resident, staff did not sit with residents throughout the mealtime and there was limited conversation with residents. The inspectors observed the experience was task orientated, with courses of meals quickly replaced by the next course. Despite an expressed wish, one resident had not been supported to prepare their own drinks. Staff outlined there was a risk of burn to the resident due to the weight of the large industrial type kettle, however, staff confirmed a more suitable size kettle had not been trialled.

Judgment:
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):
No actions were required from the previous inspection.

Findings:
Inspectors found that residents were not protected by the procedures in place for medication management. Medications prescribed to three residents on the day of inspection had not been administered including anticholinergic medications and prescribed nutritional supplements. In addition, inspectors found that in some instances prescribed supplements were not administered in the prescribed timeframe.

An immediate action was issued to the person in charge which sought assurances that a review of all medications would be completed. An audit completed by the person in charge in response to the immediate action highlighted regular errors and omissions of medications, which included anti epilepsy medications, neuroleptic medications, anticholinergic medication and antibiotic medication.

Inspectors found that storage arrangements in place for medications in the designated centre was appropriate.

Procedures for the disposal of medication or return of medication to the community pharmacy were not in compliance with the centre's policy on medication management. A clinical nurse manager confirmed that there were no records being maintained for return of medications as required in the centre's policy.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

**Findings:**
The inspectors found the management systems in place had not ensured the service provided was safe, appropriate to residents' needs and consistent. There were ineffective monitoring systems in place in order to provide assurances on the quality and safety of care and support. Major non compliances were identified in all eight outcomes inspected against and the impact of these failings had significantly compromised the safety, wellbeing and rights of residents living in the centre. Lines of accountability were not clear. The arrangements for the person in charge to manage two designated centres did not ensure the effective governance and operational management of the centre. The inspectors found the person in charge did not demonstrate sufficient knowledge of residents' needs, staffing arrangements, and of safeguarding issues and indicators. Adequate support was not provided to managers in the centre and these managers did not have protected time allocated for certain functions.

Significant failings were identified across all outcomes inspected against. Both the person in charge and the director of care stated residents were not safe in the centre. Four immediate actions were issued in relation to healthcare needs, medication management, fire precautions and infection control and by the end of the inspection the provider outlined the measures they were taking to mitigate the risks. The inspectors also issued a further instruction in relation to risk management on the day of inspection. The provider had not protected residents from incidents of alleged abuse and there was inadequate safeguarding measures put in place in to protect residents.

The rights of residents had not been protected in the use of restrictive practices and these practices significantly compromised residents' basic human rights. There was evidence of institutional practices compromising residents' privacy and dignity.

Residents' healthcare needs were not fully met, and staff to whom the provider had delegated responsibility for the provision of care were not knowledgeable on these needs and supports. Safe medication management practices were not implemented. Adequate fire safety arrangements were not in place and poor infection control practices were also found. The identification and response to risk had not ensured residents were safe. The provider did not have sufficient or consistent staffing arrangements in place in order to meet residents' need and to ensure their safety and wellbeing.

There was inadequate monitoring of the services provided in the centre. The inspectors reviewed reports post inspection of six monthly unannounced inspections carried out by the provider in three of five units since November 2016. The provider was requested to submit all reports of all unannounced visits since the registration inspection however, these were not received by the inspectors up to the time of writing this report. Four of
these unannounced visits had not reviewed adverse incidents, despite incidents forming part of the specified review process. While the provider had initiated a review of safeguarding issues in the past number of weeks, on the day of inspection the inspectors found adequate measures had not been implemented to issues highlighted as a result of this review.

Lines of accountability were not clear. The person in charge had no budgetary oversight in relation to the centre and it was unclear from discussion with the person in charge how decisions in relation to day to day budgetary requirements were made. In addition, the person in charge did not have any oversight in relation to day activity staff assigned to the centre.

The person in charge was responsible for two designated centres comprising ten units however, given the failings identified during this inspection, it was evident this arrangement did not ensure the effective governance and operational management of the centre. The inspectors met with the person in charge and found the person in charge did not have sufficient knowledge and insight into residents' healthcare needs, staffing arrangements in the centre and safeguarding indicators, and had not initiated appropriate responses to safeguarding concerns within the centre. The person in charge told the inspectors, the lack of response in relation to safeguarding concerns was an oversight.

There were three clinical nurse managers working in units in the centre however, these nurse managers formed part of the daily complement of nursing staff and did not have protected time assigned. Two of these clinical nurse managers were also assigned to an additional one unit each.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Overall inspectors found that the number, and skill mix of staff on duty was not
appropriate to the number and assessed needs of residents.

The person in charge stated that they could not identify the number of days in the two weeks preceding the inspection where the required minimum staffing levels were in place for the designated centre.

Clinical nurse managers and staff spoken with throughout the inspection identified that staff shortages occurred on a regular basis and this had a negative impact on residents. When asked, one member of staff stated that staffing levels were a factor in maintaining safety in the unit.

There was a reliance on relief and unfamiliar staff within the centre which also impacted on residents. Staff described how this resulted in incidents occurring. One staff member informed inspectors that they were moved within the centre as a result of the inspection taking place. Another staff member highlighted that on one occasion there were three unfamiliar staff rostered to work in a unit and that this resulted in a resident absconding from the area.

There an absence of an effective system in place for the planning and management of staff absences including annual leave and sick leave. In one case a day activities staff member was absent from the designated centre on nine weeks planned leave and the person in charge was not aware of this. Despite the leave having commenced at the time of inspection it was not clear if cover would be provided for this absence or not.

The person in charge confirmed that there were at least 2.69 whole time equivalent posts unfilled in the designated centre at the time of inspection.

Staff files or staff supervision records were not reviewed as part of this inspection.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

Action Plan

Provider’s response to inspection report

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<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Limited</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003897</td>
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<tr>
<td>Date of Inspection:</td>
<td>03 &amp; 04 July 2017</td>
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<tr>
<td>Date of response:</td>
<td>02 October 2017</td>
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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:
Inspectors found that institutional practices in this centre were not based on a rights based approach to practice in upholding residents' rights.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

**Please state the actions you have taken or are planning to take:**
Full transition plans are being put in place to move the current residents from the unit identified in this action.

Full multidisciplinary reviews of the unit identified took place on the 24/4/17 and the 19/6/17.

A full review of restrictive measures took place on the 19/6/17. A full psychiatric review in June 2017 was undertaken and recommendations regarding the unsuitability of the environment and ideas for possible improvements were put forward. The Director of Care is in the process of implementing the changes required.

A new Person in Charge will be in place from the 4/9/17. This new post will have responsibility for the unit in this designated centre that currently requires.

A programme of training will be introduced for all staff to increase awareness around institutional practices.

<table>
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<tr>
<th>Proposed Timescale: 04/09/2017</th>
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<tr>
<td>Theme: Individualised Supports and Care</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents' privacy and dignity were compromised in this centre.

2. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
Full transition plans are being put in place to move the current residents from the units identified in this action. Additional accommodation is being sought and specialised units are being converted to meet the needs of the residents. The first of these specialist units is now complete.

Full multidisciplinary reviews of the unit identified took place on the 24/4/17 and the 19/6/17.

A full multidisciplinary review of restrictive measures took place on the 19/6/17.

The level of staffing across the designated centres has been reviewed in line with the
safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across the Designated Centre each day to ensure that sick and other leave can be covered.

All environments are being assessed for their appropriateness. Remedial works are being undertaken where possible to improve privacy.

A programme of training will be introduced for all staff to increase awareness around institutional practices.

**Proposed Timescale:** 18/09/2017

**Theme:** Individualised Supports and Care

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

Adequate care and support was not provided to residents in one unit in accordance with their needs.

3. **Action Required:**

   Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

   Full transition plans are being put in place to move the current residents from the unit identified in this action. The first resident will move by the 14/10/17.

   The unit identified will be closed within 6 months. Meetings will be held with all residents and their families to explain the process of transitioning. The first meeting took place on the 28/9/17.

   Immediate remedial works have been carried out to ensure that rights and privacy issues have been addressed, this included the removal of viewing panels. This also includes access to water at all times for all residents.

   A new Person in Charge will be in place from the 4/9/17. This new post will have responsibility for a much smaller number of residents.

   A new rights committee has been put in place chaired by the independent external chair.

   Weekly multidisciplinary meetings are being held (including the families and advocates) to monitor the levels of care and support provided.

   Full safeguarding plans have been put in place for all residents. These safeguarding plans are being overseen by the HSE safeguarding teams.
**Proposed Timescale:** 01/04/2018

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

1. Inspectors observed an area of the designated centre where plaster was falling from the wall, and in another area the plaster covering was in a poor state of repair.

2. Areas of the designated centre required repainting and there were walls with paint chipped or damaged.

3. There were no toilet seats available for residents on toilets in two units inspected.

4. Overall there was a lack of furniture available to residents, and some furniture which was in place was damaged and not of a satisfactory standard. In one case a leather seat was ripped and the padding had fallen from the interior of the seat.

5. Recommendations outlined in an assessment by an external specialist for environmental improvements in the living space and garden areas of one unit had not been implemented.

**4. Action Required:**

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

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

A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

1. Plaster work has been repaired.
2. A schedule for painting has been put in place. Costing have been presented to the HSE for agreement.
3. Appropriate toilet seats will be sourced that will be robust enough to stay in place.
4. New furniture has been sourced that is robust but not institutional in design.
5. The garden will be developed so that it can be used by residents.

The recommendations of the external specialist will be included in the transition plan for the individual identified. This includes making safe access to the garden possible.

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**Proposed Timescale:** 18/10/2017

**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of one unit within the designated centre was not appropriate to meet the needs or the number of residents being supported.

5. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
Full transition plans are being put in place to move the current residents from the unit identified in this action.

A new Person in Charge will be in place from the 4/9/17.

A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

Immediate works were carried out to resolve issues relating to privacy and dignity. Additional measures were also put in place to ensure access to water at all times.

The recommendations of the external specialist will be included in the transition plan for the individual identified.

Proposed Timescale: 04/09/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In one area of the designated centre a resident was unable to gain entry to the entire living space as a hallway did not have the necessary wheelchair access.

6. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
A planned programme of remedial maintenance work is in place. 3 magnetic door hold open devices were fitted in one of the units to ensure that residents can access all areas.
A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

Full transition plans are being put in place to move the current residents from the unit identified in this action.

**Proposed Timescale:** 18/09/2017  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
1. There was insufficient lighting available in one unit which resulted in a dark living environment for residents.

2. There was insufficient ventilation in the bathroom area of one unit.

**7. 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:**
A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

1. Additional lighting will be installed.
2. All bathrooms have been assessed to ensure there is sufficient ventilation. Where required additional ventilation has been fitted.

**Proposed Timescale:** 18/10/2017  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed that areas of the designated centre were clinical and sterile in nature. These areas were not suitably decorated to create a homely environment for residents. In some units there were no curtains in place on windows or pictures hanging on the walls.

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

Please state the actions you have taken or are planning to take:
A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

Keyworkers have regular meeting to determine the wishes of the residents in relation to the décor and furnishing of the homes. This includes poster and pictures as well as soft furnishings.

Alternatives to standard furnishings are being sought where an individual’s behaviour means that standard furnishings are not robust enough.

Curtain poles and pictures will be put in place. Where curtain poles are not tolerated alternative fastenings will be put in place.

All areas will be repainted by the middle of November 2017.

Proposed Timescale: 18/11/2017

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:
Adverse incidents involving residents were not appropriately reported or responded to in order to mitigate risks.

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

Please state the actions you have taken or are planning to take:
A new system of risk management has been introduced. Risk registers in relation to healthcare and safeguarding have been introduced. A new fulltime admin assistant has been employed to manage the risk registers and to ensure they are up to date. The risk registers are stored on a shared drive and all relevant staff have access to it. This started on the 28/6/17.

Twice weekly triage meetings are held between the Director of Care - Residents, the Director of Nursing and the Risk manager. All incidents are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.
All risks rated as high are reviewed daily in the MDT Care Planning meeting. This started on the 28/6/17.

An MDT approach is being taken with the safeguarding and healthcare risk registers, each clinician has responsibility for the risk ratings within their area of expertise. This has commenced.

All incident reports are now uploaded onto SURA to allow for easier access and monitoring. This started on the 28/6/17.

**Proposed Timescale:** 04/09/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Appropriate measures were not in place to mitigate risks.

Additional control measures, outlined in risk management plans were not implemented in practice.

A risk to a resident, in relation to a broken television perspex screen, had not been attended to.

The external stairwell used as the main exit route for a resident had a build up of moss and leaves, and was not safe for the resident.

**10. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
A new system of risk management has been introduced. Risk registers in relation to healthcare and safeguarding have been introduced. A new fulltime admin assistant has been employed to manage the risk registers and to ensure they are up to date. The risk registers are stored on a shared drive and all relevant staff have access to it. This started on the 28/6/17.

Twice weekly triage meetings are held between the Director of Care - Residents, the Director of Nursing and the Risk manager. All incidents are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.

All risks rated as high are reviewed daily in the MDT Care Planning meeting. This started on the 28/6/17.
An MDT approach is being taken with the safeguarding and healthcare risk registers, each clinician has responsibility for the risk ratings within their area of expertise. This has commenced.

All incident reports are now uploaded onto SURA to allow for easier access and monitoring. This started on the 28/6/17.

A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

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<th>Proposed Timescale: 18/09/2017</th>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not provided with hand soap or handtowels in order to promote hand hygiene.

There was a failure to ensure personal furnishings were kept in a hygienic state.

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

**Please state the actions you have taken or are planning to take:**
Hand soap and disposable towels are available in all areas.

In areas where residents are unable to tolerate soap dispenser or paper towel dispenser alternatives have been trialled.

Furnishings have been repaired or replaced as required.

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<th>Proposed Timescale: 07/08/2017</th>
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<td><strong>Theme:</strong> Effective Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no emergency lighting in place in a final exit route from one unit. Exit routes did not have adequate means of escape.
12. **Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

Systems are in place such as, daily fire safety checks, fire drills, fire alarm, emergency lighting in protected escape routes and staff training in evacuation procedures.

Where required emergency lighting and signage will be installed.

Fire evacuation plans will be reviewed to ensure that there are adequate means of escape.

Additional staff training and practice fire drills will be conducted to ensure staff and residents can be safely evacuated in the event of a fire.

**Proposed Timescale:** 18/10/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The seal on a fire door was not in place.

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

**Please state the actions you have taken or are planning to take:**
A planned programme of remedial maintenance work is in place. A senior member of the local service improvement team is responsible for liaising with the technical services team and ensuring that the plan is implemented. Regular audits are undertaken to ensure that remedial works have been completed and that any new issues are highlighted.

Fire checklists have been amended to include the checking of door seals.

**Proposed Timescale:** 18/09/2017

**Outcome 08: Safeguarding and Safety**
**Theme:** Safe Services

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

All alternative measures were not considered before the implementation of restrictive procedures. In addition the least restrictive procedure for the shortest duration was not used in practice.

Residents were exposed to known triggers such as elevated noise levels.

**14. 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:

Measures have been put in place to ensure restrictive practices are applied in accordance with the assessed needs of residents, and their use is appropriately applied and monitored.

A full review of restrictive measures took place on the 19/6/17. A full psychiatric review in June 2017 was undertaken and recommendations regarding the unsuitability of the environment and ideas for possible improvements were put forward. The Director of Care is in the process of implementing the changes required.

Measures have been put in place to ensure restrictive practices are applied in accordance with the assessed needs of residents, and their use is appropriately applied and monitored.

All areas have been audited in line with best practice and the HIQA Guidance document to ensure that all existing restrictive measures in use have been implemented in line with the regulations and best practice. This now complete.

Examination of environment and practice to identify the use of any unauthorised restrictive measures has been undertaken. A number of restrictive measures that where not previously detected as such have been identified and appropriate plans put in place. Support has been sought from the appropriate clinicians in respect to this. The restrictive measures policy is also being rewritten as a stand-alone document instead of a part of the managing Behaviour Policy. This is now complete with the exception of the new policy which is awaiting approval.

Enhanced monitoring of restrictive measures through the new compliance document set will increase oversight and understanding. This will allow for the effectiveness and necessity of measures to be monitored and evaluated. This will start on the 14/8/17.

The protocols and other guidance in relation to the use of PRN medication has not always been clear. This is being addressed with new protocols being put in place where necessary. The protocols are being written in such a way that they clearly guide...
practice. This will be completed by the 14/8/17.

**Proposed Timescale:** 14/08/2017  
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Inspectors found that residents were not protected from peer to peer abuse within the designated centre. Measures which were in place to protect residents from abuse were not effective.

**15. 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 following measures have been put in place to ensure residents are protected from abuse and to ensure systems identify and allow appropriate responses to risks in order to ensure residents are protected from abuse.

All resident records have been audited by the local service improvement team to determine if any safeguarding issues have been unreported and/or inappropriately managed. This is now complete.

Safeguarding risk assessments have been completed for all residents who were highlighted as being at risk by the Person in Charge. Safeguarding plans have been implemented as required. This has led to a reduction in the number of negative peer to peer incidents with no further incidents reported from those deemed to be presenting the highest level of risk. It has also highlighted that some residents are inappropriately placed and transition plans have been put in place as required. Some groups of residents within particular units are incompatible and additional staff resources are required to fully implement safety plans.

Three individual apartments have been constructed to allow for the residents who are causing difficulties for others to be safely managed. These apartments will be stand alone with their own staff team and Person in Charge. This will allow for residents to be supported with the appropriate levels of staff until a transition to a permanent, alternative placement can be organised. This measure will safeguard both the individuals who are moved and those who were previously at risk of harm.

The risk assessments have been entered into the safeguarding risk register by the Director of Care - Residents. This has allowed for areas of priority to be identified across the service. Key risks include; the use of unapproved restrictive measures, incompatible peer groups, staff that are unfamiliar with residents needs and in some areas insufficient staff to meet the needs of residents.

The safeguarding risk register is now monitored daily by the Director of Care - Residents and the effectiveness of safety plans is assessed and changes made as
Residents who require urgent intervention are identified at the 9.00am MDT Care Planning meeting and resources are deployed accordingly. This commenced on the 28/6/17.

The Safeguarding Risk Register is the responsibility of the Director of Care - Residents until the 3/8/17 when a new Principal Social Worker with responsibility for safeguarding commences in post. Daily reports are also made to the CEO of any areas of high risk.

Any internal notification of suspected abuse must be accompanied with an immediate safety plan which sets out what actions frontline staff have taken to ensure safety. This is a change from existing practice where the Designated Officer completed the safety plan. This has proved to be very effective and emphasised to frontline staff that safeguarding is the responsibility of everyone and has allowed for a much quicker response. This commenced on the 28/7/17.

No new care or treatment plans will be implemented until the author has ensured that all staff are aware of the plan and are clear on how the plan should be implemented. This has led to a change in practice and ensured that safeguarding measures are consistently applied. This is being introduced on a phased basis and commenced on the 3/7/17.

**Proposed Timescale:** 03/08/2017

**Theme:** Safe Services

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

Incidents and allegations of abuse that occurred in the designated centre were not appropriately investigated or followed up on.

**16. Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
The following measures have been put in place to ensure residents are protected from abuse and to ensure systems identify and allow appropriate responses to risks in order to ensure residents are protected from abuse.

All resident records have been audited by the local service improvement team to determine if any safeguarding issues have been unreported and/or inappropriately managed. This is now complete.

Safeguarding risk assessments have been completed for all residents who were highlighted as being at risk by the Person in Charge. Safeguarding plans have been implemented as required. This has led to a reduction in the number of negative peer to peer incidents with no further incidents reported from those deemed to be presenting
the highest level of risk. It has also highlighted that some residents are inappropriately placed and transition plans have been put in place as required. Three residents cannot be safely managed within their current accommodation (across all six designated centres) and alternative accommodation has been sourced and these residents will move by mid-August (subject to registration and successful consultation with the residents and their families). Some groups of residents within particular units are incompatible and additional staff resources are required to fully implement safety plans.

Three individual apartments have been constructed to allow for the residents who are causing difficulties for others to be safely managed. These apartments will be stand alone with their own staff team and Person in Charge. This will allow for residents to be supported with the appropriate levels of staff until a transition to a permanent, alternative placement can be organised. This measure will safeguard both the individuals who are moved and those who were previously at risk of harm.

The risk assessments have been entered into the safeguarding risk register by the Director of Care - Residents. This has allowed for areas of priority to be identified across the service. Key risks include; the use of unapproved restrictive measures, incompatible peer groups, staff that are unfamiliar with residents needs and in some areas insufficient staff to meet the needs of residents.

The safeguarding risk register is now monitored daily by the Director of Care - Residents and the effectiveness of safety plans is assessed and changes made as required. Residents who require urgent intervention are identified at the 9.00am MDT Care Planning meeting and resources are deployed accordingly. This commenced on the 28/6/17.

The Safeguarding Risk Register is the responsibility of the Director of Care - Residents until the 3/8/17 when a new Principal Social Worker with responsibility for safeguarding commences in post. Daily reports are also made to the CEO of any areas of high risk.

Any internal notification of suspected abuse must be accompanied with an immediate safety plan which sets out what actions frontline staff have taken to ensure safety. This is a change from existing practice where the Designated Officer completed the safety plan. This has proved to be very effective and emphasised to frontline staff that safeguarding is the responsibility of everyone and has allowed for a much quicker response. This commenced on the 28/7/17.

No new care or treatment plans will be implemented until the author of the plan has ensured that all staff are aware of the plan and are clear on how the plan should be implemented. This has led to a change in practice and ensured that safeguarding measures are consistently applied. This is being introduced on a phased basis and commenced on the 3/7/17.

**Proposed Timescale:** 03/08/2017

**Theme:** Safe Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed a staff member attending to the personal needs of a resident whom required repeated assistance. This was completed in a common living room area and was not carried out in a manner which respected the resident's dignity.

17. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Staff in the area have been retrained in the delivery of care in a way that maintains the resident’s dignity.

Two additional staff trainers have been appointed. In addition to providing induction these staff will work alongside staff to model good practice and the appropriate implementation of care plans.

Proposed Timescale: 08/08/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The persons responsible for daily supervision and provision of care were not knowledgeable on residents’ healthcare needs and interventions.

Healthcare plans did not guide practice.

Contemporaneous fluid intake records were not maintained for a resident. Nutritional supplements were not provided to a resident with specific nutritional needs as prescribed.

Adequate hydration was not provided for a resident, which was further compromised by the use of a restrictive practice.

Residents had not been appropriately supported in relation to out patients appointment.

18. 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:
The existing Designated Centre will be split into three new centres from the 4/9/17.
Each new Designated Centre will have its own Person in Charge.

This will allow the Person in Charge to effective manage the centre. The induction for the new Person in Charge will commence on the 14/8/17.

From the 20/7/17 additional supports have been put in place for nurses who may be moved to an unfamiliar area or who are engaged through an agency.

A member of the nurse education team carries out a face to face induction and is available throughout the day to offer advice and support. This has already had a positive impact on practice. This started on the 20/7/17.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17.

An additional resource is now in place to ensure that when care staff are moved to new or unfamiliar areas or are engaged through an agency that they are suitably trained and inducted to the area.. This started on the 20/7/17.

Performance management plans are in place for a number of staff who have been detected as lacking skills and competence which they would be expected to have. This has commenced.

The competency matrix will ensure that staff will only be deployed to areas in which they are deemed competent.

Healthcare plans are being rewritten by the nurse in charge of the area to ensure that they contain sufficient detail to guide practice. All restrictions in relation to access to water have been discontinued following a review by the Director of Care.

Measures have been put in place to ensure that residents have appropriate access to hydration. Full access to drinking water is maintained at all times.

Fluid intake is currently recorded in both the mealtime diary and the fluid in/out chart. This is being simplified to just recording in one place. This will increase the accuracy of the records. All records are checked by the Person in Charge to ensure that any concerns are picked up and acted upon.

**Proposed Timescale:** 18/09/2017

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Support had not been implemented for a resident to allow them to prepare their own
hot drinks.

19. **Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
Where appropriate residents will have access to facilities to allow them to make hot drinks.

Assessments will be undertaken to determine the levels of support required by each resident.

**Proposed Timescale:** 04/09/2017

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Hot drinks for residents were not appropriately prepared.
Staff did not appropriately handle food, in order to be assured the practice was hygienic.

20. **Action Required:**
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

**Please state the actions you have taken or are planning to take:**
Hot drinks will be served in a way that meets the identified preferences of the residents.

Staff will be retrained in hygienic food production.

**Proposed Timescale:** 04/09/2017

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The mealtime for residents was rushed and did not promote a social and positive experience.

21. **Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

**Please state the actions you have taken or are planning to take:**
An audit of mealtimes has taken place across all of the homes within the designated centre by the service improvement team.

Areas of deficiency have been identified and remedial action plans have been put in place. Named staff have been made responsible for implementation.

The local service improvement team is now working alongside staff members to assist in the development of good practice. The initial focus is to increase the competence and knowledge of the nursing and care staff. This started on the 28/6/17.

**Proposed Timescale:** 08/08/2017

### 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:**

Inspectors found through documentation review that prescribed medications had not been administered to residents on the day of inspection and on previous days. In addition, prescribed medication were not administered in the appropriate timeframe.

**22. Action Required:**

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

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

Food supplements are prescribed to be given at certain times however the resident may require the supplement at times either before or after the given time. The prescribing Doctor has confirmed to staff that that the nutritional supplements are not medication and it is safe and appropriate for them to be given at other times.

From the 20/7/17 additional supports have been put in place for nurses. A member of the nurse education team carries out a face to face supervision and is available throughout the day to offer advice and support. This has already had a positive impact on practice.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17.

Analysis of medication audits has led to staff performance improvement plans being put in place as required.
Proposed Timescale: 08/08/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The practice of disposing of medication was found not to be in line with the designated centre's policy which required a record of receipt of medication returned to the community pharmacy by staff. A clinical nurse manager confirmed that the required procedures were not in place.

23. Action Required:
Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
The required procedures have been put in place and are monitored by the Director of Nursing.

Proposed Timescale: 08/08/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was not knowledgeable on resident's healthcare needs, staffing levels in the centre, and on safeguarding indicators. The person in charge had not initiated appropriate responses to safeguarding concerns.

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

Please state the actions you have taken or are planning to take:
The Director of Care - Residential meets with members of the Service Improvement Team, key MDT staff and the Persons in Charge at 9.00am each morning to review risk registers and staffing deployment. Priorities are identified and resources deployed as appropriate under the clear direction of the Director of Care.
The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

This will allow the Persons in Charge to effective manage the centre. The induction for the new Persons in charge will commence on the 14/8/17.

**Proposed Timescale:** 14/08/2017

**Theme:** Leadership, Governance and Management

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

The arrangement for the person in charge to manage two designated centres comprising ten units was not appropriate and had not ensured the effective governance and operational management of the centre.

25. **Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

**Proposed Timescale:** 04/09/2017

**Theme:** Leadership, Governance and Management

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

The management systems in place had not ensured the service provided was safe and appropriate to residents' needs.

The management systems had not ensures a consistent service for residents.

The service in place was not effectively monitored in order to ensure the service was safe and met the needs of resident in an appropriate manner.

26. **Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
Please state the actions you have taken or are planning to take:
A new system of risk management has been introduced. Risk registers in relation to healthcare and safeguarding have been introduced. A new fulltime admin assistant has been employed to manage the risk registers and to ensure they are up to date. The risk registers are stored on a shared drive and all relevant staff have access to it. This started on the 28/6/17.

Twice weekly triage meetings are held between the Director of Care - Residents, the Director of Nursing and the Risk manager. All incidents are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.

All risks rated as high are reviewed daily in the MDT Care Planning meeting. This started on the 28/6/17.

An MDT approach is being taken with the safeguarding and healthcare risk registers, each clinician has responsibility for the risk ratings within their area of expertise. This has commenced.

All incident reports are now uploaded onto SURA to allow for easier access and monitoring. This started on the 28/6/17.

Proposed Timescale: 08/08/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unannounced visits had not considered all areas within the centre on a six monthly basis. A comprehensive audit of the quality and safety of the care and support provided was not completed as part of these unannounced visits and issues in relation to safeguarding and incident management were not reviewed as part of six monthly unannounced provider visits.

27. 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 programme of unannounced visits commenced on the 30/6/17, each unit will be visited within the regulatory timescales.

Audits of safeguarding and incident management form part of the unannounced provider visits. The findings of the audits are evaluated and remedial action plans put in place as required.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lines of accountability for all levels of service provision were not clear. The person in charge did not have any budgetary oversight in relation to the centre and was unclear on the decision making process for day to day budgetary requirements.

The person in charge did not have oversight in relation to day activity staff assigned to the centre. The person in charge had not been made aware of the extended absence of a staff member within a reasonable timeframe.

28. 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 Director of Care - Residential meets with members of the Service Improvement Team and key MDT staff at 9.00am each morning to review risk registers and staffing deployment. Priorities are identified and resources deployed as appropriate under the clear direction of the Director of Care.

Clear lines of accountability are now in place. A new management structure will be introduced from the 4/9/17.

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate support was not in place for clinical nurse managers to manage units. Some clinical nurse manager were assigned to two units however, they did not have protected time either to attend to these units or to complete assigned administrative duties.

29. 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 existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

From the 20/7/17 additional supports have been put in place for nurses who may be moved to an unfamiliar area or who are engaged through an agency. A member of the nurse education team carries out a face to face induction and is available throughout the day to offer advice and support. This has already had a positive impact on practice.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17.

An additional resource is now in place to ensure that when care staff are moved to new or unfamiliar areas or are engaged through an agency. This started on the 20/7/17.

Performance management plans are in place for a number of staff who have been detected as lacking skills and competence.

**Proposed Timescale:** 08/08/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that there was an absence of an effective system in place to manage staff absences such as annual leave and sick leave.

**30. 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:**
The level of staffing across the designated centres has been reviewed in line with the safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across the Designated Centre each day to ensure that sick and other leave can be covered.

Further to this a full review of the scope of the services provided and the level of resources and structures required to maintain the service is being undertaken. This work will be undertaken by an external consultant and will inform future developments. This will be completed by the end of October 2017.
**Proposed Timescale:** 18/09/2017

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that the number and skill mix of staff was not appropriate to the number and assessed needs of residents.

**31. 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 level of staffing across the designated centres has been reviewed in line with the safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across the Designated Centre each day to ensure that sick and other leave can be covered.

Further to this a full review of the scope of the services provided and the level of resources and structures required to maintain the service is being undertaken. This work will be undertaken by an external consultant and will inform future developments. This will be completed by the end of October 2017.

**Proposed Timescale:** 18/09/2017