

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cluain Fhionnain
Centre ID:	OSV-0003361
Centre county:	Kerry
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Lucia Power
Lead inspector:	Mary Moore
Support inspector(s):	Geraldine Ryan
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	9

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 August 2016 09:00	10 August 2016 19:00
11 August 2016 08:45	11 August 2016 17:00

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

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

Summary of findings from this inspection

Background to the inspection:

This inspection was the sixth inspection of this service by the Health Information and Quality Authority (HIQA). A decision had been taken by the provider to close this centre and transition the residents to supported living in the community amongst the general population as envisioned in the national policy on moving on from congregated settings (generally settings where ten or more people with disabilities live).

Five of the inspections mentioned above were undertaken between June 2014 and December 2015. Inspectors had found a model of care that was institutionalised and medically focussed, an unreasonable level of restrictions placed on residents and significant non-compliance with regulatory requirements. Areas of repeat serious failings included the safeguarding of residents, governance and management and suitable staffing. On foot of these inspection findings regulatory actions taken by HIQA included the issuing of immediate action plans where the provider was required to immediately address significant inspection findings; a provider meeting was convened following the March 2015 inspection and the provider was issued with an improvement notice.

In April 2015 the implementation of the improvement notice and improvement was noted; in December 2015 there was evidence of continuing improvement.

The provider had also been requested by HIQA to submit monthly updates on the closure of the centre and residents transition to community living. In January 2016 it was expected that all residents would have transitioned by September 2016, in April 2016 the proposed transition date had moved to November 2016. The most recent monthly update received in July 2016 indicated that the closure of the centre was not now going to happen until March 2017. Based on this information and the pattern of notifications submitted to HIQA, this unannounced inspection was undertaken.

How we gathered our evidence:

Prior to the inspection inspectors reviewed the information held by HIQA. The first day of the inspection was facilitated by frontline staff as the person in charge was unavailable due to extenuating circumstances. The nominated provider was on annual leave but did come to the centre and met with the lead inspector. The person in charge was present for the second day of the inspection. Inspectors also met with members of the transition team (an external provider) who had been on-site since 2013 to support residents as they prepared to transition from an institutional medical model of care to a social model of supported living in the community.

In addition to speaking with the above, inspectors met with staff on duty in both units, inspectors reviewed and discussed records such as support plans, risk assessments, care records, fire and health and safety records, records of complaints, records of consultations held with residents and the findings of reviews of the service undertaken by the provider or commissioned to be undertaken on behalf of the provider.

Residents who resided in the open unit welcomed inspectors on their arrival to the centre. Inspectors conducted the inspection in the two units that compromised this centre. Inspectors met and communicated with all of the residents, sometimes this was verbal communication, at other times and as suited to each resident's needs and abilities the communication was non-verbal. The overriding theme of the verbal communications with residents was the transition to community living and when this was going to happen for them. This was clearly seen as a positive by some residents as they spoke of their hopes for greater independence and normality in their new homes. Some residents expressed a level of anxiety at to what was a significant life changing event for them. Some residents simply smiled and showed inspectors their rooms and personal belongings, a resident spoke of the distress that his behaviours caused him and one resident by gesture clearly demonstrated his desire for less restriction within the unit.

Description of the service:

This service was set up in 2001 to accommodate residents from a large local mental health facility; residents had a established history of institutionalised living.

The centre comprised of three single storey segregated buildings on a green-field site removed from the busy local town. Residents were living in two of these buildings; the buildings were separated from each other by a grassed area.

At the time of this inspection there were 21 residents living in this centre; nine in one unit and 12 in the other; the lives of eight of these 12 residents were highly restricted and they lived in two secure units within the main unit. Records seen indicated that residents had a dual diagnosis of intellectual disability and a mental health diagnosis.

The service remained under the auspices of and was staffed by the mental health services.

In 2013 the provider commissioned an external provider to work on site with residents and staff on the process of transition to community living; this transition team remained on site.

Overall findings:

The inspection findings are presented in the recognition that residents presented with a diverse range of needs and some residents whether living in the centre or in the community would always need support and a safe environment. However, the inspection findings were not good and while there was evidence that life had improved somewhat for some residents while they continued to live in the centre, it had not for a significant number of others. Overall quality of life had not improved for any resident in the context that the centre had not closed and residents continued to live in the congregated setting. It was difficult to reconcile the high level of environmental and personal restrictions evidenced with the commitment to transitioning residents to live in domestic type settings as part of a local community.

There was little evidence of the normal routines of daily living or how residents were prepared and ready for daily living in the community after over two years of a transition process. Many aspects of normal daily living were denied to residents such as access to kitchenettes, personal shopping and laundry, personal hygiene and shaving. Some residents had little choice and control over the life they lived in this centre or their right not to live in it.

Inspectors observed that there was a clear dichotomy between what residents experienced when with the transition team and when they returned to the centre in the afternoon. Both teams reported very different accounts of residents in relation to risks posed, behaviours that challenged and their potential.

No resident had transitioned from this service since December 2015. The provider nominee told inspectors that while it was hoped that five residents would transition to the community by November 2016, it was possible that no resident would transition in 2016 and the service would probably not be closed by March 2017 as insufficient funding was available. This was of concern to HIQA given these inspection findings but also given the level of expectation that residents had and have had for a considerable period of moving to "their own house".

There were repeat failings that were evident on the initial inspections of the centre by HIQA, these included; the management of complaints, the implementation of personal plans, systems for the assessment and management of risk, staff attendance at core training including fire safety, safeguarding, manual handling and

responding to behaviours that challenged and failure to evidence the incorporation of the preparation of residents for transition into each residents daily routine.

Of the eight Outcomes reviewed by inspectors the provider was judged to compliant in one and in substantial compliance with one. The provider was judged to be in Major non-compliance with the remaining six Outcomes; Residents Rights Dignity and Consultation, Safeguarding, Responsive Workforce, Health and Safety, Social Care Plans and the Governance and Management of the centre.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Over the course of inspections by HIQA life while they continued to live in the centre, had improved for some residents in terms of reduced limitations on their freedom and the level of choice and control that they had. Thirteen of the 21 residents now lived in what staff described as "open" units and were free to access the external grounds and the activation centre where the transition team were based.

Within the open units inspectors saw and residents confirmed that while their bedroom door was locked this was their choice and they had a key to their room that they kept on their person.

Mass was said in one unit during this inspection and residents told inspectors that they liked going to mass.

A new "people carrier" vehicle had been procured in March this year.

Members of the transition team confirmed that there had been and was a process of consultation with residents and their families in relation to the transition to community based living. The team confirmed that every resident had weekly input and an allocated key-worker from the transition team. The team also told inspectors that they had commenced working with and supporting residents who were anxious about moving to the community and who had said that they did not want to leave the centre. The team said that they had delayed earlier input with these residents given the uncertainty of closure and transition dates as they believed that their input may have only served to increase resident anxiety.

Inspectors saw records of residents meetings convened on a two-monthly basis; these were collective meetings where residents from both houses attended. Based on the records seen of these meetings the average number of residents in attendance was nine; approximately 43% of residents. It was clear from the records seen that residents participated and engaged with this process. The primary issues raised by residents were requests for more and specific activities and social outings and queries as to when they were to move to their new homes. Clearly actions arose from the contributions of residents at these meetings but actions, responsible persons and timeframes were not identified and there was no follow-up at the next meeting.

Over the course of this inspection residents who could spoke to inspectors about moving to the community to live and when it was going to happen. Some residents were emphatic that it was going to happen while others were unsure that it would happen as it was "going on" a long-time. The providers review conducted in October 2015 included consultation with residents. The overall finding of this consultation and feedback was that residents in general wanted to move and did not like living in the centre; residents wanted to go places, do things and have more independence. These residents who were consulted with at that time were all still living in the centre; records seen by inspectors on this HIQA inspection continued to reflect these themes. The term "if and when" was used in relation to transition records. Another record seen stated that the resident wanted to move, where they wanted to move to and that they felt they had been in the centre "for hundreds of years". It was difficult to see how residents' rights, choices and consultations were promoted and protected by the failure to expedite the transition.

Records of complaints were available for 2015 but not for 2016. Staff spoken with confirmed that they were not recording complaints received. One staff spoken with confirmed that they had received a complaint from a resident's relative but had not logged it.

The predominance of shared bedrooms had decreased, however, one shared bedroom was still in use on one secure unit and it was not clear that this was necessary.

There was ongoing evidence of institutional practice. In a number of instances, residents had made their preferences known to staff, but there was no apparent regard for their preferences. For example, the majority of resident records seen stated that residents received facial shaves and haircuts from staff; further to the inspection the provider clarified that the latter, while still undertaken in the centre were completed by a qualified hairdresser. It was recorded that residents hoped that they would and could access a barber in the community on transition. The provider said that this goal had been achieved for two residents who did attend the barber in the community.

Inspectors observed some staff showing kindness and a caring attitude towards residents. Some staff spoke kindly and respectfully of residents, their needs and required supports; it was clear from records seen that there were staff that residents liked to spend time with and felt comfortable speaking to. However, staff were unable to tell inspectors which resident was sleeping in a particular bed; one resident was spoken of and described to inspectors in the context of his behaviours that challenged and the one-to one supports "special" that were in place rather than by his given name.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

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

Findings:

Each resident was seen to have a plan that outlined their strengths and abilities and where support was required from staff; the plans seen were dated as reviewed in the second quarter of 2016. The plans were detailed and presented in a personalised manner. The support plan took account of and recorded resident's wishes, preferences and hopes for their future. However, as discussed in Outcome 8, there was evidence that some of the information provided in the compilation of the plans was either historical and no longer relevant or incorrect, particularly in relation to behaviours that challenged.

While the plans were detailed and personalised it was not evidenced how residents participated in the development and review of the plan; one plan seen by inspectors was signed by the resident.

While there was evidence that residents did have access to multi-disciplinary supports, there was no evidence that the review of the support plans was multi-disciplinary.

Some residents had access to off-site day services with other service providers and other supports such as personal assistants. Records seen indicated that residents enjoyed this and had good and established relationships with these services that they wished to continue post transition. Each resident had an individual daily planner and a key-worker from the transition team. Recorded activities undertaken included learning kitchen skills, literacy, table tennis and other sports/games and community access. During the inspection residents confirmed that they had been out for coffee, to a local shop and some had gone to a local annual fair.

Each resident had a person centred plan with identified goals. Based on the records seen this was an inconsistent process. Some goals in relation to moving out of the

centre were live since early in 2014; these were clearly not achieved. It was not clear whether other goals were achieved or not, it was not clear if there were two processes of goal setting for both teams (the transition team and the centre staff). For example one resident had five identified goals of a social and developmental nature to be achieved by May/June 2016 and no goal had a record of progression, achievement or if relevant, barriers to progression and achievement. Some goals while of significance and meaningful to residents were simple in terms of being met and would have had no evident barriers to their achievement; for example purchasing specific personal items, going for a walk or going to the beach. There was no clear link between goals and the transition plan so as to equip residents where possible with the required skills and learning for successful community and social integration.

There was an overriding theme in all of the support plans seen of a desire for greater independence in daily life, social inclusion and integration and enjoying social activities such as sports and visits to the cinema.

However, overall the evidence available to inspectors from written records, discussion with staff and observation of residents, suggested that the potential of residents and the support plan were not maximised and rehabilitation, social activities and engagement as listed above in paragraph 4, largely ceased when the transition team were not available. The person in charge confirmed this. Inspectors observed residents sitting on chairs or lying on couches without any stimulation other than television or radio or sitting outside watching the comings and goings to the unit.

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

Findings:
Inspectors were not reassured as to the robustness of systems for the identification, assessment, management and on-going review of risks. There was a link between this finding and the findings in Outcome 8 in relation to the predominance of restrictive practice and the inadequate multi-disciplinary supports in place to support residents in both preventing and managing their behaviours.

Plans were in place for identified risks, however, there was insufficient evidence of their relevance in practice and what impact they had if any on reducing or controlling risk.

Findings included:

- one risk assessment seen did not state what the actual risk was and what the resident was to “remain safe” from
- risks seen to be identified on a risk assessment template were not reflected in the support plan
- there was evidence that the process of risk assessment was not dynamic and subject to on-going review as required by Regulation 26 (2). On speaking with staff, staff confirmed that some identified risks were historical and had not been evidenced by staff for “years”
- as discussed in detail in Outcome 8 the provider did not adequately evidence that risk control measures (restrictive practices) were proportionate to the risk identified and that the adverse impact of these measures on residents’ rights and their quality of life had been meaningfully considered in a timely manner.

Conversely while there was evidence to support potentially disproportionate controls, there was also evidence of inadequate controls. Several residents were deemed to be at risk of absconding; some of these residents lived in the secure units others did not. Based on the notifications submitted to HIQA, there have been three instances where residents have left this centre and have not been noted to be missing by staff.

Inspectors reviewed the controls in place for two residents in an open unit, one with a history of absconding including a very recent incident, the other resident identified as at risk of absconding. When staff responsible for both of these residents were asked what controls were in place for the safety of the latter resident, they identified the first resident (with a history of absconding) as always observant and the person who would advise staff if the other resident was leaving the premises. Staff were not aware and records seen did not reflect that in addition to the most recent incident the resident had also previously left the premises in 2014 and was missing unnoticed by staff for 30 minutes.

Fire safety measures were in place including emergency lighting, an automated fire detection system and fire fighting equipment. Certificates were seen of the inspection and testing of the fire detection system in February and June 2016 and the fire fighting equipment in August 2015. However, there was no evidence available of the inspection and maintenance of the emergency lighting.

Some fire safety records had not been updated to reflect the reduced occupancy of the building and the current location of resident’s bedrooms.

Inspectors saw records that attested to the maintenance and servicing of vehicles; each vehicle had a safety/first-aid box.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Inspectors saw that on a daily basis a high level of restrictive practice applied to eight residents; five residents lived in one secure unit and three lived in the other secure unit, both units were sub-units within a larger unit. Inspectors saw that the main door to each unit was secured, then each bedroom door was locked and within each bedroom wardrobe doors were locked. These secure units were in of themselves compact and impoverished environments that lacked any semblance of homeliness and personalisation, and given the level of restriction compelled residents to live in close proximity to each other.

Inspectors reviewed a log that was maintained of restrictive practices. There was a generic repetitive theme to both the type of restrictive practices in place and the rationale for their use; for example; unit door locked, bedroom door locked, water in bedroom turned off, restricted access to the kitchen. Rationale provided were; to keep personal property safe, risk of absconding, poor safety awareness and drinks water excessively. The log stated that these restrictive practices were in place since 2001, were all authorised by the multi-disciplinary team and were reviewed by the restrictive practice committee between January and June 2016.

However, the provider did not demonstrate sufficient evidence to ensure that the requirement for and continued use of restrictive practices was in line with the requirements of Regulation 7(4) and (5) and guidance issued by HIQA. There was no evidence of risk based strategies to reduce the high level of restrictive practice seen in a more substantive and individualised manner in line with the plan to transition residents to life in domestic type settings. There was however, evidence available to inspectors that all restrictive practices may not have been justified; there was no evidence that alternative and less restrictive measures had been considered. For example the transition team confirmed that one resident attended day service and other social outings on a regular basis and never attempted to abscond and did not display inappropriate behaviour, yet this resident returned daily to a secure unit and a highly restricted environment. Centre based staff said that the resident had absconded "years back".

There was evidence of further restrictive practices that were not identified as such. This included the suppressive (chemical) approach to some reported behaviours. There was no evidence of the functional analysis of these or indeed any other behaviours, or the exploration of alternative measures. Staff spoken with said that these behaviours did not present any risk to others.

Residents did present with behaviours that challenged both themselves and others and it was clear that in any care context some residents would need staff supports and a safe environment. However, staff spoken with confirmed that some current records of behaviours were historical, no longer exhibited or incorrect. For example staff from the transition team said that they had not evidenced these behaviours in the time they had been working with residents. Centre based staff when shown some records said that they had not seen a resident demonstrate a particular behaviour "for years"; staff said that they had never seen a behaviour attributed to another resident to have been exhibited by that resident.

Inspectors were not reassured that residents were protected at all times from all forms of harm and abuse. Since March 2015 there had been 24 notifications of peer to peer physical interactions made to HIQA; reassurances provided to HIQA included positive behavioural interventions and supports. However, based on the records seen by inspectors there was a deficit of therapeutic behaviour support plans, not only in relation to peer to peer aggression but in relation to behaviours in general including behaviours learned over a long history of institutionalisation. This deficit supported the lack of evidence seen to support the high level of restrictions placed on residents on a daily basis.

There was reference in records seen to psychological referral and review, referral to other behavioural support services for advice and input but very little evidence of constructive outputs from this. It was not clear from these records who was responsible for the development of the plan (different agencies were referenced) or indeed if the plan had ever been developed. The person in charge told inspectors that staff had refused to engage with one agency in the development of positive behavioural support plans for residents. One very detailed positive behavioural plan was seen by inspectors but was confirmed by staff not to be implemented.

Staff said that there was currently two hours of psychology input available weekly and it was difficult to see how this was sufficient to meet the needs of residents and support their successful transition to community living.

Staff spoken with and records seen, indicated that residents exhibited very limited behaviours that challenged while with the transition team but behaviours escalated within the residential unit. Records including notifications submitted to HIQA stated that there were clear environmental triggers in the centre to behavioural incidents and that the failure to transition in a timely manner had resulted in heightened anxiety and frustration for some residents.

Staff confirmed that they did not maintain behaviour monitoring charts such as ABC (antecedent, behaviour, consequences) records as seen to be requested by the psychologist. Staff said and records seen indicated that incidents related to behaviours

were recorded in the daily narrative notes. It was therefore difficult to see how they were monitored and analysed so as to inform the evidenced based approach to behaviours that challenged.

There was an ongoing concerning deficit in staff attendance at training on preventing and responding to behaviours that challenged; this is addressed in Outcome 17.

There was evidence that residents were supported when they made an allegation of abuse against staff. Allegations of this nature had been notified as required to HIQA and their investigation by the provider was confirmed. The person in charge told inspectors that other than what had been notified to HIQA she was not aware of any further allegations made by residents about staff.

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 overall model of care was mental health. Staff were registered psychiatric nurses and the clinical director, the consultant psychiatrist visited the centre on a weekly basis.

The medical needs of residents were attended to by a local General Practitioner (GP) practice; staff said that a GP from this practice visited the centre on a daily basis Monday to Friday. Staff spoken with had a ready knowledge of residents healthcare needs and the supports in place to maintain health and well-being, for example any requirement for specific diet or a risk for falls.

Staff said and there was documentary evidence that staff monitored general health and well-being by monitoring body-weight and vital signs (temperature, pulse and blood-pressure). There was evidence of regular blood-profiling by the GP or suitably assessed nursing staff, for example for monitoring therapeutic levels of medicines.

Staff said and there was documentary evidence that as necessary residents were referred to the acute hospital services, such as the medical assessment unit for further investigation, and the out-of-hours medical service was contacted at weekends.

Staff said and there was documentary evidence that residents had access to other health service professionals including speech and language therapy, dietician, physiotherapy, chiropody, podiatry and dental care.

There was evidence of referrals for input from the psychologist and reviews by the psychologist. Staff spoken with said that this was limited and two hours were available on a weekly basis. In the context of the needs of residents it was difficult for inspectors to be reassured that this was sufficient to meet residents' needs in a consistent and effective manner; this has been discussed in Outcome 8.

Judgment:
Compliant

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 reviewed the management of medicines in one unit.

Medicines were supplied to residents by a community based pharmacy, in a compliance aid on a monthly basis.

Staff said that all medicines were checked on delivery by nursing staff and a further check was completed by staff from the pharmacy. There were no reported dispensing/supplying errors and this would concur with records seen.

Inspectors saw that medicines were supplied on an individual resident basis and securely stored.

A refrigerator specifically for the purpose of storing medicines was in place; it was seen to contain only medicines and the temperature was checked twice daily.

The prescription was generated and maintained by the GP and the consultant psychiatrist; prescriptions seen were current and recently reviewed/rewritten. While the centre was nurse led, staff said that there was no transcribing of medicines undertaken by them.

Staff said that no medicines requiring stricter controls were in stock, no resident required their medication to be administered in an altered format (crushed) and there

was no covert administration of medicines. There were no reported medication errors.

No anomalies were noted between the prescription and administration records reviewed by inspectors.

Inspectors reviewed the report of a medicines management audit completed by the pharmacy in April 2016; no failings were identified.

Residents did have prescriptions for medicines to be administered on a p.r.n (as required) basis including medicines required as an adjunct to the management of behaviours that challenged. The maximum daily dosage was specified and records seen indicated that their administration was monitored on a quarterly basis.

However, one resident was seen to have three concurrent prescriptions for such medicines. Inspectors did not see and staff spoken with confirmed that there was no explicit administration protocol for these medicines to guide staff on which medicine or what combination of medicines to administer. Staff said that guidance was got from looking at what staff had previously administered.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Based on these inspection findings inspectors were not assured that there were management systems in place that ensured the consistent delivery of safe, quality, person-centred services to residents. While there was evidence of improved systems and processes, documentation, policies and procedures and systems of review it was not clear how these equated to maintaining ongoing improvement particularly in the quality of life experienced by residents. The evidence to support this judgement is presented below but also in each individual Outcome.

The person in charge articulated a clear commitment to the transition process; however she also clearly articulated challenges and obstacles and was uncertain that further improvement could be effected in the centre. There was little evidence of cohesion and the integration of the social model of care into the daily lives and routines of the residents.

The transition process had not been expedited and residents and staff did not have clear goals or definitive timeframes; this was a service without a clear vision or philosophy where residents experienced two divergent cultures of care; the mental health model and the social model. Staff said that the situation was frustrating and challenging, that some residents were continually pre-occupied with the transition while others were demonstrating disengagement with the process. This was evidenced by inspectors. Other staff said that there was little or no talk now of the transition.

Staffing arrangements did not support the consistent supervision of care and practice. The person in charge worked full-time Monday to Friday and had an office on the campus. The provider nominee said that she and the person in charge met weekly and spoke to each other as often as necessary. There were reported supportive and collaborative working relationships between local management and the transition team. There were two acting clinical nurse managers (CNM2); one was assigned to each unit.

However, staff said and the staff rota indicated that the CNM2 both worked the same shift, therefore the presence of managers was consolidated and not managed to ensure that a management presence was on duty at all times including weekends. Staff said that staff who worked the shift opposite to the CNM2 may never meet the CNM2. There was an on-call management rota but this was effectively an "on-call" rota for the local mental health services catchment area rather than an actual management/supervisory presence on site including at night-time.

Staff meetings were convened but nursing staff only attended these meetings; they were not inclusive of the staff employed as domestic staff but who were seen to interact with residents on a daily basis for example at mealtime.

The provider in October 2015 had commissioned an external person to complete an annual review of the service and the quality and safety of care and services provided to residents as required by Regulation 23 (1)(d). This review included consultation with residents and their relatives and the report was made available to inspectors. The findings of that review though completed over nine months ago were still reflected in these HIQA inspection findings and therefore evidence that the review did not result in significant meaningful change and improvement in the quality of life of residents. For example issues identified by that review included the requirement to expedite resident's transition plans, the restrictive nature of the environment, the need for meaningful engagement and activity for residents, the absence of safeguarding plans and inconsistent risk management practice.

The nominated provider had completed an unannounced inspection of one unit on 17 June 2016 the report of which had been made available to inspectors. This review also highlighted ongoing challenges in relation to resident choice, restrictive practice, activities and residents personal goals.

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:

Inspectors were not satisfied that staffing arrangements consistently met residents' needs, maximised their potential and supported their successful transition to community living.

The staff rota was not completed locally but was completed and finalised centrally within the mental health service. Any vacant shifts were filled centrally from a bank of overtime staff. The person in charge told inspectors that there were occasions when she did not know who was coming on duty until midday the day before when a vacant shift had to be filled from the bank of overtime staff. Staff spoken with said that staffing levels were maintained by staff on overtime; some of these staff were staff employed in the centre but staff from the local mental health catchment area were also utilised; this included staff required for "special" duty (a nurse assigned to provide one-to-one supervision for a particular resident). The provider stated that the latter occurred only in exceptional circumstances.

Inspectors were told that it was possible to meet a different nurse every day and that effective communication (exchange of information) was consequently an issue. Inspectors did meet staff who confirmed that they had not worked in the centre for some months prior to the inspection. A review of a sample of staff rotas by inspectors confirmed that there was significant reliance on both overtime and relief staff and that it would be possible to meet a different staff member on duty each day.

There was corroborated evidence available to inspectors that a staffing presence was not maintained at all times on at least one of the two secure units. The reasons given to inspectors for this was in response to an incident on another unit, staff breaks and the administration of medicines to residents at night-time as two staff completed this together.

There was further evidence that residents did not have access to staff at all times. Inspectors found the office door on one unit locked while two staff were present in the office; the window was occluded with paper so that the staff occupants could not be seen. This was brought to the attention of the person in charge who addressed this matter. Inspectors were told that a resident had also complained that he was unable on one occasion to access staff at night so as to request pain-relief, due to a locked door .

Training records dated August 2016 of training completed by staff did not provide evidence that all staff who worked in the centre had the required mandatory training, training that was also directly relevant to the assessed needs of this cohort of residents.

Firstly all staff listed on the staff rota were not included in the training records; approximately 13 staff. Secondly of the staff listed in the training records;

- Five staff were identified as requiring staff training in protection/safeguarding
- 18 staff were identified as requiring manual handling training
- 21 staff were identified as requiring PMVA (Professional Management of Aggression and Violence) training
- 18 staff were identified as requiring training in positive behavioural supports.

This is of particular concern given the findings in Outcome 8 in relation to restrictive practice and behaviours that challenged. This has been a repeat finding on inspections.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Cluain Fhionnain
Centre ID:	OSV-0003361
Date of Inspection:	10 August 2016
Date of response:	25 September 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Actions arose from the contributions of residents at resident meetings but actions, responsible persons and timeframes were not identified and there was no follow-up at the next meeting.

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

1. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

The resident's forum meetings will take place in each unit and not collectively in one unit for both houses. This will ensure that all residents have the opportunity to attend. The meetings will take place during the normal working week, each Friday, on a monthly basis so that residents attending day service can attend as they are on a half day and the Person in Charge can be present. The format of the minutes will identify the action to be taken, the person responsible for supporting the resident, time lines for completion and result of the action taken. Any further follow up will be included and the support plan updated. The overall responsibility for carrying out this action will be taken by the CNMII and identified resident. Progress reports to be furnished to the PIC.

Proposed Timescale: 14/10/2016

Theme: Individualised Supports and Care

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

One shared bedroom was still in use on one secure unit and it was not clear that this was necessary.

There was ongoing evidence of institutional practice with the majority of resident records stating that they received facial shaves from staff and haircuts onsite in the centre, yet it was hoped that residents could access a barber in the community on transition.

Staff were unable to tell inspectors which resident was sleeping in a particular bed; one resident was spoken of and described in the context of his behaviours that challenged and the one-to one supports that were in place rather than by his name.

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:

In keeping with each resident's preference as outlined in their Support Plan a detailed personal care plan will be compiled to ensure that preferences in relation intimate and personal care are met. In Archview residents who wish to attend a barber do so. In Bridgeview a hairdresser comes in every six weeks or sooner if required. In consultation with each resident their preference in relation to hair cutting and shaving will be documented so that all staff can meet individual preferences. Options to carry out independent personal care will be explored and supported by all staff members and monitored by the Key Worker.

The resident who is currently sharing a room will move to a single bedroom as part of a larger move to reduce restrictive practices, enable more meaningful preparation for transition and improve each individual's privacy.

Proposed Timescale: 21/10/2016

Theme: Individualised Supports and Care

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

Residents' rights, choices and consultations were not promoted by the failure to expedite the transition.

3. Action Required:

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

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

Ongoing 1-1 meetings between the key worker and the resident will take place on a monthly basis to ensure that supports are put in place with participation and consent from the resident to enable him to decide the level and type of support and care they require. Any new decisions will be updated in the Support plan and intimate care plan as required.

Discussion with PIC and advocate to take place so as to ensure that the rights of people are being exercised and recommendations are followed through and issues brought up at the advocacy meetings are addressed

A consistent approach will be required when discussing the transition for each individual.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

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

Records of complaints were available for 2015 but not for 2016. Staff spoken with confirmed that they were not recording complaints received.

4. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and

whether or not the resident was satisfied.

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

Staff have been advised that any complaints from a resident or relative need to be documented on the complaint form to include actions taken and further actions required. They will also advise the resident /relative of the complaints procedure and forward a copy of the complaint to the complaints manager and the Person in Charge as per policy.

The PIC will issue a memo to all staff flagging the complaints procedures and the role and responsibility of all staff to comply with this.

Proposed Timescale: 30/09/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

There was evidence that some of the information provided in the compilation of the support plans was either historical and no longer relevant or incorrect, particularly in relation to behaviours that challenged.

5. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The person in Charge with the CNMII and transition Team Manager will go through each support plan to ensure that they are reflective of any changes of circumstances or needs. A robust system will be put in place to ensure that the plan is reviewed on a monthly basis and that this is recorded.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

There was no evidence that the review of the support plans was multi-disciplinary

6. Action Required:

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

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

The key worker will review and feed back to the CNMII any changes or updates since last review. The person in Charge with the CNMII and Transition Team Manager will go through each support plan to ensure that they are reflective of any changes of circumstances or needs.

A timetable to review each support plan will be compiled and a robust system put in place to ensure compliance.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Some goals in relation to moving out of the centre were live since early in 2014; these were clearly not achieved.

It was not clear whether other goals were achieved or not, it was not clear who was responsible for the progression of the goals (the transition team or the centre staff), it was not clear if there were two processes of goal setting for both teams. One resident had five identified goals of a social and developmental nature to be achieved by May/June 2016 and no goal had a record of progression and/or achievement.

7. Action Required:

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

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

A review of the PCP will take place and a progress report for each resident to be completed by the end of November. This review will incorporate both the transition team and nursing staff to ensure approach is consistent. An agreed action review plan will be put in place to monitor goal attainment that is SMART.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

There was no clear link at times between goals and the transition plan so as to equip residents where possible with the required skills and learning for successful community and social integration.

There was an overriding theme in all of the support plans seen of a desire for greater independence in daily life, social inclusion and integration and enjoying social activities

such as sports and visits to the cinema. However, the evidence available to inspectors from written records, discussion with staff and observation of residents, suggested that the potential of residents and the support plan were not maximised and rehabilitation, social activities and engagement largely ceased when the transition team were not available.

8. Action Required:

Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

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

Currently life skills training takes place with the transition team, we acknowledge that there is lack of consistency in relation to the transition process between both staff groups and as part of a review a structured system will be put in place so there is a clearer understanding of the process in relation to preparation for transition. Individual goals will be identified with the resident when reviewing the support plans and will be time lined to capture and target dates for achievement. On a daily basis a nurse will be identified from each area to assist each resident to achieve these goals in conjunction with the activity and learning programmes already in place with the transition team.

Proposed Timescale: 30/11/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was an absence of evidence to support that risk control measures were proportionate to the risk identified and that the adverse impact of these measures on residents' rights and their quality of life had been meaningfully considered in a timely manner.

9. Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

A review of this regulation will take place with the risk and patient safety advisor so as to ensure compliance. Both the risk management policy and practice will be reviewed in line with the policy to ensure that protocols are being adhered to.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

While there was evidence to support potentially disproportionate controls, there was also evidence of inadequate risk control measures.

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:

The policy contains the management of emergencies and risk assessments are reviewed every three months including the restrictive practices. A review of this regulation will take place with the risk and patient safety advisor so as to ensure compliance to policy is reflected in practice.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

There was no evidence available of the inspection and maintenance of the emergency lighting.

Some fire safety records had not been updated to reflect the reduced occupancy of the building and the current location of resident's bedrooms.

11. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

The fire safety statement reflects the bed numbers but did not have provision for the number of residents this has been corrected. There is an emergency light Log book in all areas which was not found on the day of the inspection. This has been signed by Allied Fire Protection as having been tested on the 24/06/2016. On discussion with the Maintenance Manager a certificate will be issued for the emergency lighting inspection.

Proposed Timescale: 31/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was an ongoing concern concerning deficit in staff attendance at training on preventing and responding to behaviours that challenged.

Staff confirmed that they did not maintain behaviour monitoring charts such as ABC (antecedent, behaviour, consequences) records.

12. Action Required:

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

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

This will be included on the risk register and escalated as a red risk. Notices have been sent out to each individual staff member including those that do overtime/occasional replacement on the unit informing them to comply with attendance at mandatory training. Staff not attached to the unit have been requested to submit full training records. A request has been sent to an external provider for the provision of further training and the Quality Improvement Division HSE have been asked to source other facilitators who could provide training.

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

There was a high incidence of restrictive practice. The provider failed to demonstrate evidence of the requirement for this level of restriction. The provider failed to demonstrate why such a high level of restrictive practice had not been reduced in a more substantive and individualised manner.

There was evidence available to inspectors that all restrictive practices may not have been justified.

There was evidence of other restrictive practices that were not identified as such.

13. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The restrictive practices in place are reviewed with the restrictive practice committee whose role is to reduce this practice. Over the last year a number of restrictive practices have been reduced and this is on-going. Given the current environment of one of the units this has proven more difficult and discussions are currently in place to move residents so as to reduce the restrictive practice.

In relation to chemical restraint the psychiatrist will be asked to review all these measures and make recommendations taking into account the complexities of each resident

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

There was no evidence of the functional analysis of behaviours. There was little or no evidence of the exploration of alternative management strategies other than restriction.

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:

The Restrictive Practice Committee will review each resident and the individual restrictive measures in place. This multi-disciplinary review will look at each resident with a view to minimising the current Environmental restrictive practices and to fully review chemical restraints. Where a restrictive practice is in place the reason as to why will be clearly documented and continued to be reviewed as is the committees protocol.

A timetable had been circulated to all staff detailing the planned dates for the Safeguarding of Vulnerable Person's Awareness Training Programme. This training will take place on site.

21/10/2016 training commences. Review 30/11/2016

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Based on the records seen by inspectors there was a deficit of therapeutic behaviour support plans, not only in relation to peer to peer aggression but in relation to behaviours in general including behaviours learned over a long history of institutionalisation.

Notifications submitted to HIQA stated that there were clear environmental triggers to behavioural incidents and that the failure to transition in a timely manner had resulted in heightened anxiety and frustration for some residents.

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:

As per agreed internal procedures the provider was afforded two opportunities to submit a satisfactory response to the action plan. HIQA did not agree the response to this action and has taken the decision to not to publish that response.

Proposed Timescale:

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:

There was no explicit administration protocol for p.r.n medicines to guide staff on which medicine or what combination of medicines to administer.

16. 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:

The medication policy outlines the protocols in relation to the ordering, collection, storage and administration of all medication including PRN. Qualified nurses should know how much PRN medication is required following their assessment of each individual event and the presentation of the resident. To avoid any error in judgement we have commenced a full review of each resident's PRN medication. An individual protocol will be put in place for each resident currently prescribed PRN. This will be completed and signed off by nursing staff and the Consultant Psychiatrist.

Proposed Timescale: 31/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Systems of review did not result in significant meaningful change and improvement in the quality of life of residents.

17. 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) A Regulation 23 was carried out on the 4th of October 2016 which will be written up and forwarded to HIQA. An action plan will be put in place to effect change and improve deficits in outcomes inspected with defined responsibility and specific timelines to achieve the actions. This will also be completed for all unannounced inspections and annual reviews. 30th November 2016

B) An annual review (unannounced) will take place to review change and implementation, this will be reviewed by the Management and Governance Committee. 16/12/16

Proposed Timescale: 16/12/2016

Theme: Leadership, Governance and Management

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

Based on these inspection findings inspectors were not assured that there were management systems in place that ensured the consistent delivery of safe, quality, person-centred services to all residents at all times.

18. 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:

o The registered provider has put together a closure plan so as to move all residents to community houses. The HSE are having intensive negotiations to secure revenue for the transition of all residents. Houses have been identified in the community in accordance with preference. Ongoing

- o The two CNMIIs are now on different rosters to provide Clinical Governance on both sides of the roster to include on site weekend cover with the on call service provided. Complete
- o The restrictive nature of the environment will continue to be reviewed on an individual basis for each resident by the Restrictive Practice Committee. Proposals which were put forward to move some residents to less restrictive areas have been challenged by Unions and staff. This has been put on the risk register as a red risk. Ongoing
- o A full review of all safeguarding plans will be undertaken by the multidisciplinary team to ensure that identified risk is appropriately managed. 30/11/2016
- o A PCP outcome summary of all individual goals achieved will be compiled by the Transition team
- o An Independent Living Skills Assessment document will be introduced to be completed by the resident with both staff groups so that all DLS can be assessed across the 24hr period. 30th November 2016
- o A signing sheet for all nursing staff in the 24hr residential service will be introduced to confirm that they have read the Support Plan, PCP and the above document for all residents. This will be done immediately and after that on annual basis following the multidisciplinary review. Any changes in the intervening period will be communicated by the Transition team in the communication book and a copy of the monthly resident and nurse key worker review meeting sheet will be given to the Transition team. 30th November 2016.

Proposed Timescale: 30/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staff rota was not completed locally but was completed and finalised centrally within the mental health service. Any vacant shifts were filled centrally from a bank of overtime staff.

There was corroborated evidence available to inspectors that a staffing presence was not maintained at all times on at least one of the two secure units.

There was evidence that residents did not have access to staff at all times

19. 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 current staffing levels are adequate and even with the reduction with resident numbers they have remained the same as if with full compliment. A review will take place with senior management with regard to the rostering system and the level of supervision currently being provided in each unit. The movement of residents to open units would ensure that with only one locked unit remaining that all residents would have access to staff at all times and full supervision. The opposition by Unions and staff has for now delayed this proposal. A meeting with the Management Governance Group has been called for the 13th of October to discuss how this situation can be resolved.

Proposed Timescale: 31/10/2016

Theme: Responsive Workforce

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

All staff listed on the staff rota were not included in the training records; approximately 13 staff. Secondly of the staff listed in the training records;

- Five staff were identified as requiring staff training in protection/safeguarding
- 18 staff were identified as requiring manual handling training
- 21 staff were identified as requiring PMVA (Professional Management of Aggression and Violence) training
- 18 staff were identified as requiring training in positive behavioural supports.

This is of particular concern given the findings in Outcome 8 in relation to restrictive practice and behaviours that challenged. This has been a repeat finding on inspections.

20. Action Required:

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

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

A detailed letter has been forwarded to all staff who have access to the overtime list and who have been assigned or may be assigned to the service to fill vacancies, informing them of the required mandatory training and with a request to furnish details of their current training records. This cohort of staff will be maintained on a separate training register from staff currently assigned to the service.

For staff assigned to the service further written requests to attend mandatory training have been issued with a time table of planned training dates to include Safeguarding Vulnerable Persons Awareness Programme.

An assessment of the capacity of the service to release staff for training will be discussed at the Management Governance Group meeting

The PIC is liaising with a training service provider and the Quality Improvement Division of the HSE to provide further training in Positive Behavioural Supports Programmes.

Correspondence Complete. Training - ongoing

Proposed Timescale: 07/10/2016