

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005249
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kathleen Doherty
Lead inspector:	Jillian Connolly
Support inspector(s):	Thelma O'Neill
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
24 May 2016 13:00	24 May 2016 22:00
25 May 2016 12:00	25 May 2016 18:30

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the third inspection of this centre by the Health Information and Quality Authority. This inspection was conducted to follow up on significant failings identified in an announced inspection conducted in March 2016.

On that inspection, inspectors found serious failings in the governance and management of this centre which impacted on the quality and safety of care provided to residents. Inspection findings also demonstrated that residents had not been adequately safeguarded. There was limited evidence of on-going audit to inform and support decisions in regards to risk management. There were no arrangements in place to support, develop and performance manage staff and gaps were identified in the mandatory training provided to staff in regards to fire safety, the management of behaviour that challenges and the protection of vulnerable adults.

Following the inspection in March 2016, a regulatory meeting was held with senior management in the Health Service Executive and HIQA during which the serious risks and safeguarding issues were discussed. The provider responded to HIQA in writing, giving assurances that they had commissioned a team of external managers in quality improvement and risk management to review the service and to report back to HIQA on their findings and the actions taken to ensure that residents are safe.

An action plan was submitted to HIQA. As the time frame for completion of these actions had yet to expire, this inspection was conducted to review what immediate actions had been taken by the provider to safeguard residents.

The findings of this inspection demonstrated that disproportionate action had been taken by the provider to safeguard residents. The findings are presented under four outcomes, with major non-compliance identified in all.

Throughout this inspection, inspectors met with residents and staff, observed practice and reviewed documentation.

From the date of the last inspection, there had been a change in the management structure with the nomination of a new senior manager to oversee the operation of the centre and to act as a contact person for HIQA. This person commenced their role during the week of this inspection. While inspectors found that some action had been taken, overall there remained serious failings in the quality and safety of care provided in the centre. Key findings were that risk management was not effectively implemented in the centre and there remained an absence of review of the quality and safety of care delivered to residents. This resulted in an absence of appropriate supports being identified to safeguard residents. There also remained an absence of positive behaviour support for residents with a reliance of restrictive practices. Fire safety had not been adequately addressed and staffing levels were not consistent.

During the inspection, inspectors required the provider to take immediate action in relation to safeguarding, risk management, fire safety and governance and management. A notice of improvement was also issued to the provider following a regulatory meeting on 2 June 2016. This notice identified specific actions which the provider was required to take within 28 days.

The Action Plan at the end of the report identifies areas where significant improvements are required to comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 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:

Significant failings were identified in risk management during the inspection conducted in March 2016. Inspectors found on this inspection that the immediate actions taken by the provider were disproportionate to the level of risk identified in March 2016.

Inspectors found that the Health Service Executive risk management policy was not implemented in practice. As a result there was no comprehensive assessment of the environmental, operational and clinical risks within the designated centre. This resulted in an absence of appropriate control measures being identified and implemented to ensure the safety of residents residing in the centre. For example, Inspectors found that in some houses a review of accidents and incidents had commenced. However the outcomes of these reviews were not clear. Inspectors found that while quantitative information was identified, the review did not address a more fundamental factor which was the incompatibility of certain residents living together which resulted in some residents being physically assaulted by their peers.

Inspectors were informed that this had been identified by management and there were plans to move residents. However the actions taken to date did not mitigate the risk identified during the previous inspection. Furthermore, issues were not reported or escalated in line with national policy.

Of the risk assessments completed, the control measures identified either did not reduce the level of risks to residents or had not been implemented in practice.

Inspectors found that some efforts had been made to improve the safety of care delivered however overall the impact to residents was minimal. For example, while staffing levels had been increased at times, this was not consistent and had not been informed by a robust assessment of risk to residents. Of the risk assessments reviewed, inspectors found that they were incomplete and did not identify the actual level of risk to residents.

Through discussion and a review of relevant documentation, inspectors determined that persons participating in the management of the centre and staff did not have adequate knowledge of risk management. The provider was required to address this failing with immediate effect.

The centre consisted of seven houses in a campus setting. Inspectors were informed by management that in the event of a fire in one house, staff from all seven houses would provide assistance, if possible. Inspectors found, in March 2016, that the fire safety policies and procedures did not provide adequate guidance to support this practice. On this inspection, inspectors found that although the fire safety policy had been reviewed and updated, deficits remained. For example, the document referenced the role of the senior staff nurse. However it was not clear if that was the senior staff nurse for the entire campus or in each individual house.

Inspectors also found that staff were conflicted on the procedure to be followed in the event of a fire. In one house staff stated that if there was a fire in the house next door they would evacuate. However, in the neighbouring house, staff told inspectors that they would evacuate residents to the house next door. Therefore, one house would be attempting to evacuate residents to a house which was also being evacuated. Staff had also provided conflicting information to inspectors in March 2016. Inspectors therefore determined that inadequate action had been taken by the provider in the interim period to ensure that staff were familiar with the procedure to be followed in the event of fire.

Inspectors reviewed a sample of personal evacuation plans and found that they did not provide sufficient information, in that they did not specify the number of staff required to support individual residents to evacuate. The records of completed fire drills, did not state the number of staff present or the method of evacuation used to support residents. Staff were unable to provide verbal assurances to inspectors that this was a documentation issue as they were not clear of what had occurred. Given the failings identified by inspectors, it was not possible to determine that residents could be safely evacuated in a timely manner and when the lowest numbers of staff were on duty.

Furthermore in March 2016, fire training records showed that 10 staff had not received an update in training in the prevention and management of fire. This was a failing previously identified on an inspection in July 2014. As of this inspection, four staff had not received this training. The provider was required to take immediate action to address this failing.

Inspectors observed that fire doors were no longer wedged open on this inspection and that of the sample of fire doors reviewed intumescent seals were in place. However, one fire door (office door) remained ineffective as it did not close properly.

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 were not assured that appropriate action had taken place to ensure all residents were protected from all forms of abuse. A repeated failing which had arisen in July 2014 and March 2016, where staff had not been provided with appropriate training in the prevention, detection and response to abuse. Inspectors also identified serious failings in the policies and practices of the centre to ensure residents were safeguarded in March 2016. Following on from this the provider identified 130 staff that required this training. As of this inspection, only 30 staff had received the training.

Inspectors found that while there had been an increase in the documentation of indicators of abuse such as unexplained bruising and verbal or physical aggression, staff remained unclear as to what constituted abuse and the procedure to be followed. For example, in one instance a staff member identified a behaviour which they considered an indicator of abuse. However, when asked by inspectors had they reported this, they confirmed they had not. On this inspection, inspectors observed a resident to engage in behaviours which posed a safeguarding issue for those residents that they shared a house with. This was not recognised as a safeguarding issue and therefore had not been investigated in line with National Policy. Documentation reviewed, and staff confirmed to inspectors that this behaviour occurred daily.

Inspectors reviewed copies of investigation reports into incidents which had occurred since the last inspection and found that they still did not provide assurances that safeguarding issues were being investigated appropriately. While immediate action had been taken to safeguard residents, inspectors found that not all parties involved were interviewed prior to the investigation being closed. Inspectors also found that line managers were not clear on their role on the procedure to be followed.

As a result, inspectors required the provider to take immediate action in arranging training on safeguarding for all staff.

Residents in the centre regularly engaged in behaviours that are challenging. In March 2016, inspectors found that staff had not received the appropriate training to respond to behaviours that challenge and to support residents to manage their behaviour.

Inspectors also found that all efforts had not been made to identify and alleviate the cause of residents' behaviour. This failing remained as of this inspection. Inspectors found that behaviour management plans were still being developed by staff who did not have the appropriate training or expertise. A review of the documents found that there was a primary reliance on restrictive interventions such as physical intervention by staff or medication. Staff described to inspectors the physical intervention used to prevent one resident from grabbing individuals' wrists. Inspectors were concerned that the intervention posed an unnecessary risk of serious injury to the resident and informed management of their concerns. The behaviour management plan for the resident was altered prior to the inspection concluding. However it was altered by a staff member who did not have the appropriate training or expertise. The reviewed plan still referenced the use of a high risk physical restraint. HIQA required the provider to cease with immediate effect all restrictive practices that present a risk of injury to residents.

Inspectors also found an instance in which a resident was administered PRN (as required) medication in response to verbal aggression by a fellow resident. Staff stated that this was an ongoing issue. Staff stated that they tried to separate the residents within the house as a preventative measure. However a review of staffing levels and incidents demonstrated that this was not effective. Furthermore inspectors were concerned regarding the need to try separate residents who resided together. Inspectors also found that there was an absence of review following the implementation of a restrictive practice. Therefore there was an absence of review of the incident to attempt to ascertain the cause of the behaviour or the appropriateness of the intervention. The provider was required to take immediate action and ensure that staff were appropriately trained in providing positive behavioural support to residents.

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:

Considering the significant failings identified in March 2016, inspectors determined that the poor governance and oversight arrangements in the centre had a direct, negative impact on the safety and quality of life of residents. Following on from the March 2016 inspection, a regulatory meeting was held with senior management of the Health Service Executive and HIQA. HIQA were provided with assurances that immediate action would be taken to ensure the safety of residents within the centre. This inspection was conducted to ascertain if the immediate actions taken were sufficient. Considering the findings of this inspection, inspectors determined that they were not.

Inspectors met with management at the beginning of the inspection who outlined the actions that had been taken following inspection. Examples provided included a review of a residents' living arrangements and plans to meet with external experts involved in the National Policy for Safeguarding. However inspectors found that the actions taken to date had only a minimal impact on the quality and safety of care for residents. Examples are as follows:

- The risk management systems in place were ineffective and the discussions/decisions by management were not informed by qualitative or quantitative evidence.
- There remained an absence of assessment of residents' individual and collective needs and therefore management/staff had failed to identify the supports individual residents required.
- Residents continued to engage in behaviours that challenge which had a negative impact on their own life and the lives of their fellow residents.
- Residents continued to spend large proportions of the day in their home.
- Staff training remained inadequate.
- There remained an absence of appropriate systems in place to review the annual review of the quality and safety of care.

Inspectors were informed that there were plans to separate the campus into four separate designated centres with four persons in charge. Inspectors met with the proposed persons in charge identified and found that they had not been provided with the appropriate training to fulfil the role.

The current person in charge informed inspectors that deficits had been escalated to management however it was unclear to inspectors who was responsible for addressing the deficits.

The provider was required to take immediate action to address the failings in the governance and management of the centre.

As a result, HIQA issued a notice of improvement to the Health Service Executive which identified the actions which were required to be taken within 28 days.

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:

In March 2016, inspectors found that the registered provider did not ensure that the number, qualifications and skill mix of staff on duty was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. Inspectors found on this inspection that this failing remained.

As stated previously, staffing had been increased in some areas of the centre which resulted in positive outcomes for residents. However this was not consistent. Staff rosters continued to show frequent gaps in staffing.

For example, there were residents residing in one house who required the following support:

- One resident required the support from two staff for mobility and intimate care
- One resident required the support of one staff due to a risk of falls
- One resident required the support of one to two staff at various times due to exhibiting physically assaultive behaviour
- One resident required two staff to be in the vicinity at all times due to a history of allegations against staff

Four staff were on duty from 08.00 hours to 20.00 hours. This reduced to two staff from 20.00 hours to 08.00 hours. Inspectors were in the house post 20.00 hours and observed that in practice two staff could not provide this support. Staff confirmed that residents were left unsupervised.

Inspectors also found that staffing levels continued to have a negative impact on resident's lives. Inspectors observed residents spending long periods of time in the house and daily records demonstrated that residents' activities were short and sporadic in nature depending on staffing levels.

Residents' individual and collective needs had not been reassessed following the inspection in March 2016, to ascertain the staffing levels actually required.

As identified in March 2016, the actual staff rota were still not reflective of the staff that worked in the centre. Frequently staff was rostered to work in one house, but were moved for short periods or full shifts to another house and this was not reflected on the staff roster. Inspectors found that it was not possible to accurately review the staff support provided to residents on a daily basis from the staff rosters maintained in the centre.

Staff training remained inadequate in regards to fire safety, safeguarding, risk management and positive behaviour support. Inspectors acknowledged that although some training had taken place, due to an absence of effective oversight, the training provided was not prioritised to ensure a safe service was delivered.

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:

Jillian Connolly
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:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005249
Date of Inspection:	24 May 2016
Date of response:	20 June 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 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:

The Health Service Executive has policies and procedures in place for the assessment, management and ongoing review of risk. Inspectors found that the policies and procedures were not implemented effectively in the designated centre. Inspectors determined that this resulted in an absence of safe services being provided to residents.

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 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:

- HSE Risk Manager CHO 1 will undertake a comprehensive review of the operational, clinical and environmental risks in the designated centre.
- The Risk Manager CHO 1 in conjunction with staff in the designated centre will identify control measures which minimise the risk to residents.
- The Risk Manager CHO 1 will oversee a process to ensure that identified control measures will be implemented, monitored and reviewed.
- All Risks identified in Individual Screening tool will be fully risk assessed and risk managed. These will be reviewed on a quarterly basis by Named Nurses and monitored by PICS when required.
- A Programme of Risk Management Training will commence throughout the Service. 3 CNM's/PIC's attended the training on the 08/06/2016. The remaining CNM/PIC will attend on the 16/06/2016. A training schedule for all staff will be devised in conjunction with the HSE Risk Manager.
- Risk Register in each Designated Centre will be monitored by PICS on an on-going basis.
- Risks are escalated as appropriate to DOS level and Service Manager Level & senior management
- An Emergency Contingency Plan has been devised to plan evacuations from designated centre in the event of Fire, Loss of Water and Loss of electricity, a copy will be disseminated to each area.
- A member of staff has been identified in each designated centre to undertake Health & Safety Rep Training on the 20th, 21st & 27th/06/2016.
- Quality Safety & Risk governance group to be established within the designated centre and meet on a bi-monthly basis to monitor risk management systems.
- CNM's/PIC's will conduct an audit of staff sign off on Risk Management Policies.

Proposed Timescale: 27/06/2016

Theme: Effective Services

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

Of the sample of fire doors reviewed, one door did not close effectively.

2. Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

A review of all fire doors was carried out, one fire door required repair this was completed on the 20/06/2016.

Proposed Timescale: 20/06/2016

Theme: Effective Services

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

Inspectors were provided with conflicting accounts of the evacuation procedures. Fire drills did not provide assurances that all residents could be evacuated to a place of safety. Residents' personal evacuation plans did not provide sufficient information on the supports residents required.

3. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

- The Fire & Safety Officer, HSE Estates Department in conjunction with a third party contractor will carry out a comprehensive review of the fire management systems in the designated centre including environmental, clinical and operational factors.
- The Fire & Safety Officer, in conjunction with management of the designated centre will develop a Fire Management Policy which is reflective of the environmental, clinical and operational factors within the designated centre.
- Personal Emergency Evacuation Plans have been updated for all residents.
- All staff to have fire safety training on an annual basis.
- Fire drills in each house carried out in April 2016 and to continue on a rolling basis in future including day and night time drill.
- CNM's/PIC's will complete a record following each drill detailing how, when & where the drill took place, who was involved and length of time taken to evacuate each person.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

Not all staff had received fire safety training.

4. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

- All staff have completed regulatory Fire Safety Training with the exception of 3 staff that are on leave they will attend training prior to return to work.
- CNM's/PIC's will provide training for all staff on the Fire Management policy when

reviewed.

- Fire Management will become a standing item on the agenda of monthly staff meetings within the designated centre.
- CNM's/PIC's will conduct and document random checks with staff using the standardised template to consolidate knowledge of fire procedure.
- CNM's/PIC's will conduct an audit of staff sign off on Fire Management Policy
- All staff training to be tracked by the CNM/PIC for each centre.

Proposed Timescale: 17/06/2016

Theme: Effective Services

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

The fire policy was not clear and provided conflicting information.

5. 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 Officer from the local Fire Station attended the centre on the 13th of June to complete an independent review of fire procedures and provide a report following same.
- In the interim the PIC has updated the evacuation procedure & informed staff of same.
- The Fire & Safety Officer, in conjunction with management of the designated centre will develop a Fire Management Policy which is reflective of the environmental, clinical and operational factors within the designated centre.
- The policy will be review and updated every 2 years or more frequently if required.
- All staff will receive an update on the revised policy.

Proposed Timescale: 30/06/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff did not have the appropriate knowledge or skill set to support residents who engaged in behaviours that are challenging.

6. 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:

- A plan is in place to ensure all staff receives training on Managing Challenging Behaviour by the 24th of June 2016.
- To date (17.06.2016) 46 staff have completed the 5 modules required for this training, This includes the Director of Service and 4 CNM's/PIC's,
- Managing challenging behaviour will be a standing item on the agenda of monthly staff meetings.
- The behaviour support team will brief staff on behaviour support plans for residents in their care.

Proposed Timescale: 24/06/2016

Theme: Safe Services

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

Restrictive practices were not reviewed.

7. 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:

- Following a HIQA directive all restrictive practice in the designated centre ceased at 1700 hours on the 31.05.2016 pending review by competent person.
- A Multidisciplinary Team review of all behaviour support plans commenced 26.05.2016 and concluded 02.06.2016.
- This review identified 10 residents as having a restrictive practice listed in their behaviour support plan.
- An audit was conducted to determine the frequency of use of restrictive practices in the previous 12 months for all 10 residents.
- The MDT agreed a protocol based on clinical criteria for the prescribing of restrictive practices where a resident's behaviour necessitates intervention as a last resort.
- This protocol includes a system for ;
- Assessment and prescribing of restrictive practice.
- Record of each instance of restrictive practice.
- Record of debriefing following each instance of restrictive practice.
- Record of MDT review following each instance of restrictive practice to identify the learning that can be applied. (The review will involve the resident and /or their representative where appropriate).
- Using the above protocol the MDT approved and prescribed restrictive reactive strategies for 9 residents in the designated centre based on agreed clinical criteria.
- CNM's have identified residents in the centre who may require a restrictive procedure for the purpose of a medical or health need. These cases will be reviewed by the MDT using the above protocol on the 20.06.2016.

Proposed Timescale: 20/06/2016

Theme: Safe Services

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

Inspectors found that there was a primary reliance on restrictive practice.

8. 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:

- An appropriately trained staff member and a psychology assistant have been enlisted to complete an assessment of each resident who requires support to manage their behaviour on week commencing 15.06.2016.
- A team of staff who have completed the Multi Element Behaviour Support programme will be identified to support this process.
- The most appropriate framework for positive behaviour support will be agreed and implemented.
- A Clinical Psychologist has been identified to provide oversight.
- Restrictive practices will only be prescribed by the MDT as a last resort and for the shortest duration necessary when all alternative measures considered have been exhausted.
- Resident's Positive behaviour Support Plans will be reviewed in conjunction with resident, family/ representative where possible and MDT and individual risk assessments will be carried out. These plans will be reviewed on a quarterly basis or more frequently if required.
- An education/training programme is being provided to all staff in relation to managing behaviours of concern and will include de-escalation techniques.
- Managing behaviour will be a standing item on the agenda of monthly staff meetings
- The Service is in the process of reviewing alternatives to Care & Responsibility.
- The Acting Service Manager/Provider Nominee has contacted Studio 3 to provide training where it is deemed necessary. When appropriate staff has received Studio 3 training, the use of Care & Responsibility / Breakaway techniques will cease in Donegal Intellectual Services.

Proposed Timescale: 24/06/2016

Theme: Safe Services

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

Inspectors identified a safeguarding issue which had not been addressed.

9. 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:

- A Behaviour Therapist met with the resident & relevant staff on the 10/06/2016 to devise a programme to address the above issue and provide ongoing support & guidance.
- Staffs first priority on receipt of an allegation of abuse is to ensure that the Resident is protected and safety is maintained.
- All allegations of abuse will be dealt with under the National policy for Safeguarding of Vulnerable Persons at Risk of Abuse.
- Safeguarding Training for designated Officers will be delivered to all PICs/CNM's when dates have been secured.
- All Allegations will be notified to HIQA, CHO1 Safeguarding Team & on the National Incident Management Forms.
- All Allegations will be thoroughly investigated using HSE National Policies of Safeguarding Vulnerable Persons at Risk of Abuse and Trust in Care.
- Monthly MDT meetings are scheduled to monitor safeguarding concerns – Commenced on the 14th of April 2016 and ongoing.
- Social Worker for adults with Intellectual Disability commenced meetings with service users on 20th April, 2016 providing them with support using easy read guides on safeguarding
- A meeting between the Designated Officers and the Donegal Safeguarding Team commenced on 15/06/2016 to monitor issues and share learning, to held bi monthly.
- All PIC's will track and trend safeguarding issues on a monthly basis and these will be reviewed at Local Quality Safety & Risk Committee quarterly.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

Investigations of abuse were not robust.

10. 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:

- All Allegations will be thoroughly investigated using HSE National Policies of Safeguarding Vulnerable Persons at Risk of Abuse and Trust in Care.
- The necessary NIMS, Safeguarding and HIQA NF06 forms will be completed & submitted within the required timeframes.
- Onward referrals to MDT will be made where appropriate.
- A meeting between the Designated Officers and the Donegal Safeguarding Team was convened on 15/06/2016 to monitor issues and share learning, meetings to be held bi

monthly.

- An independent external company who specialise in safeguarding will carry out a review of Safeguarding Arrangements in HSE Residential Units for People with Disabilities in Donegal to commence in June and be completed by 31st July 2016.
- The review will identify and highlight areas of good safeguarding practices in units and promote the continuation of those practices. In addition, the review will identify areas of below standard safeguarding practice and highlight these to management with suggested actions to address such standards.

Proposed Timescale: 05/08/2016

Theme: Safe Services

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

Staff had not received training in the prevention, detection and response to abuse.

11. Action Required:

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

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

- A programme of Safeguarding Awareness training has been rolled out by the CHO 1 Safeguarding Team to ensure that all staff (101 in total) in the designated centre are aware of the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (December 2014).
- As of 13/06/2016 all 101 staff has received Safeguarding Awareness training.
- The Acting Service Manager/Provider Nominee has issued a memorandum (09.06.2016) to all staff reinforcing the requirement for staff to read and sign off on the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (December 2014) and the Donegal Intellectual Disability Service Guideline for the Reporting of Concerns Regarding Vulnerable Persons at risk of Abuse (February 2016) to ensure they are familiar with the categories and indicators of abuse and the procedures to be followed in the event of an allegation or suspicion of abuse.
- A Staff Questionnaire has been developed to be completed randomly with staff at all levels in order to consolidate staff knowledge of safeguarding processes.
- Staff have been formally notified in writing of all contact details of Confidential Recipient, Designated Officers outside the centre and the Adult Social Work Team in Donegal. Details of the Good Faith Reporting Process, Protected Disclosure Policy were also provided to all staff members on 25th March 2016.

Proposed Timescale: 30/06/2016

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:

The management structures in place did not identify the individuals responsible for ensuring all areas of service provision were safe and effective.

12. 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:

- In order to meet regulation 23(1) (b) A clearly defined management structure has been put in place that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.
- This has been communicated to all staff, residents and/or their family/representative.

Proposed Timescale: 11/05/2016

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 did not ensure that the services provided were safe and effective. Inspectors identified that disproportionate action had occurred following the previous inspection.

13. 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:

- The management structure reflects the reconfiguration of the designated centre into 4 designated centres with a PIC identified for each and the Director of Services identified as the PPIM in order to ensure that the service provided is consistent and effectively monitored.
- A review took place of the compatibility of residents sharing accommodation and a phased plan for transition will be put in place by the 31st of July 2016 to relocate residents within the service to ensure the service provided is safe and appropriate to residents' needs.
- The transition has commenced and will be ongoing and reviewed monthly or as required in consultation with the residents, families/representatives and the Multidisciplinary Team.
- There will be 3 monthly unannounced provider visits and reports of same will be

forwarded to HIQA

- The Provider Nominee will meet with PIC's following inspections to discuss required action plans and agree dates for completion of same.
- There will be annual provider visit to the Centres and reports of same forwarded to HIQA.
- An Audit system is being developed by the provider nominee and will be introduced by Sept 1st 2016

Proposed Timescale: 01/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was an absence of appropriate assessment to ascertain the supports residents required. Therefore the registered provider failed to ensure that there were sufficient staff with the appropriate skill and qualifications to meet the needs of residents.

14. 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:

- Staff have been allocated to each designated centre as part of the management structure to promote consistent staffing within designated centres.
- The Keith Hurst Dependency Assessment was completed for all service users to inform staffing levels on the 13th of May 2016 this was implemented with immediate effect.
- The four designated centres will have a statement of Purpose which will reflect the new configuration of service delivery within this Designated Centre and will be forwarded to HIQA on completion.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Rosters remained inaccurate.

15. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

- An allocation of staffing has been identified for each designated centre 11.05.2016
- Each PIC will have responsibility for maintaining the planned and actual roster in each designated centre and ensuring the required staff /skill mix are rostered. This will be updated daily in the designated centres by the PIC
- The Director of Services will monitor staff rosters to ensure Regulation 15 (1) is met.

Proposed Timescale: 20/06/2016

Theme: Responsive Workforce

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

Staff training remained inadequate as evidenced throughout this report.

16. 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:

- Personal development planning will commence for all Staff by PICS & PPIM.
- A Training Needs Analysis has been completed to formulate staff training.
- A rolling schedule for refreshers in mandatory training will be developed and maintained by CNM's/PIC's and PPIM.
- CNM's/PIC's and PPIM will be responsible for ensuring staff attends training.
- Director of Services will conduct a quarterly audit to ensure identified training is sourced and staff has attended training as allocated.

Proposed Timescale: 30/09/2016