

**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 Autism Spectrum Disorder Initiatives
Centre ID:	ORG-0008257
Centre county:	Co. Dublin
Email address:	ted.bourke@asdi.ie
Registered provider:	Autism Spectrum Disorder Initiatives
Provider Nominee:	Amanda McDonald
Person in charge:	Edmond (Ted) Bourke
Lead inspector:	Linda Moore
Support inspector(s):	Julie Pryce;
Type of inspection	Announced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	3

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 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 April 2014 10:00	01 April 2014 19:30
02 April 2014 09:00	02 April 2014 12:00

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

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

This was an announced inspection of Autism Spectrum Disorders Initiatives to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. Autism Spectrum Disorders Initiatives comprises two designated centres, which are located in Dublin and Wicklow. Inspectors reviewed the documentation in the provider's main office in Newtown Mount Kennedy, Co. Wicklow. Inspectors then visited the two designated centres. This report pertains to the inspection findings of the inspection in the designated centre, in Dublin. The designated centre in Dublin includes three apartments. There were two residents, one resident and three residents accommodated at these addresses.

The inspector met with management, residents and staff members over the inspection. The inspector also spoke to relatives. The inspector observed practice and reviewed documentation such as personal care plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

Overall, the inspector found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met very effectively.

The centre was clean and had a warm, hospitable atmosphere and the inspector found that the residents were comfortable and confident in telling the inspector about their home. Residents were actively involved in planning their day. While evidence of good practice was found across all outcomes, areas of non compliance with the Regulations were identified. Areas for improvement included risk management practices and the documentation available to support practices. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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

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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

In general, the inspector found that resident's wellbeing and welfare was maintained by a high standard of evidence-based care and support. However, documentation required improvement. to ensure personal plans were outcome focussed rather than solely activity based. Some of the residents did not have goals defined in the plans. Each resident had a personal file and the inspector reviewed four of the files. These included risk assessments and individualised support plans, There was evidence of multidisciplinary involvement in the care of residents and some of the residents signed their support plans. Residents had an assessment in place, which in most instances was comprehensive and began prior to admission to the service.

The individual support needs of the resident was defined, and there was evidence of the participation of residents in the development of their support plans. However, the inspector found that they needed to be improved to detail resident's specific needs and guide practice. For example the residents personal care needs. There were no goals developed for two residents in their personal plans. There was a system to review the

residents on a monthly basis by the team and at the annual review meeting which was multidisciplinary and included the residents and relative where possible. This system could be further enhanced if the residents' personal plans were developed and evaluated at this meeting to ensure they are implemented and improve the outcomes for the residents.

While there were individualised risk assessments completed for residents to ensure continued safety of residents, these were not consistently completed for residents to include the actual risk and the control measures.

Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Some of the residents attended a day service and others enjoyed a person centred service which was tailored to meet the needs of residents. Residents enjoy a number of social and therapeutic activities such as , shopping, day trips and walks in the park. There were many examples of where residents were supported to be independent and develop skills within the home or learn leisure skills. The inspector found that the way in which staff supported residents showed their understanding of each person and the unique way that autism impacts on them individually.

There were examples where service user consultation and involvement was central to the development of the support provided by staff. The person in charge showed the inspector where residents living areas were designed to meet the changing needs of existing and new residents. This fob access had been replaced by a code to support a resident to access the living area.

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector generally found that the provider had put sufficient risk management measures in place however they needed to be improved. The systems for the identification, assessment, management, recording and investigation of risk required improvement.

There was a risk management policy in place however; many of the requirements of the risk management policy as set out in the Regulations were not contained within the policy including, self harm, accidental injury, aggression and violence. While the provider

and person in charge discussed the arrangements for identification, recording, investigation and learning from serious incidents, this was not set out in the policy. The provider said that training was planned for staff in the process of reviewing incidents.

The provider, person in charge and staff took overall responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. The risk register was viewed by inspectors. This was in draft stage and was in the process of being developed. However, the inspector was not entirely satisfied that staff took a proactive role in the management of all risk in the centre. While staff had received training in risk, they were not sufficiently skilled in the development of risk assessments. For example, there were no risk assessments in place for a resident who resided alone. Risk assessments viewed by inspectors did not identify the risk and the control measures to minimise the risk. The inspector noted that there was no risk assessment in place for a resident whose behaviour may have placed staff at risk and this was developed during the inspection.

The inspector read the Health and Safety Statement for the centre, however this was not specific to this location. A health and safety committee was in place which met monthly, which included members of staff across all locations.

Residents commented that they felt the centre was safe and secure there was a staff member in the centre at all times.

A number of accident, incidents and near misses for 2014 were being recorded and these were reviewed by the person in charge. Inspectors noted that incident reports were maintained in resident's files. However, inspectors were of the understanding that not all incidents had been recorded. See outcome 8. The inspector noted that from a review of the accidents and incidents, that they were being submitted to and reviewed by the person in charge. However the system to review incidents and ensure learning was not robust as there was no system to trend this information for learning purposes. For example, there was no behaviour support plan in place to address a number of incidents which occurred from January 2014. The provider said that incidents would be reviewed at the senior management team and the quality committee going forward.

Inspectors found that while there was an emergency policy in place and alternative accommodation arrangements were discussed with inspectors, these were not set out in the policy.

All staff were trained in manual handling.

The procedures for the prevention and control of infection were satisfactory. There was an infection control policy in place which would guide practice.

Fire safety was well managed apart from fire safety training. There was evidence that regular fire drills had taken place, the records of the drills included the staff that were present or the learning outcomes. Staff were able to tell the inspector about what they would do if the fire alarm went off. Records reviewed by inspectors indicated that fire training had not been provided to all new staff and there were plans in place to address this. There were personal evacuation plans in place for all residents. While most of the

fire equipment was serviced regularly, as were fire alarms. However, there was no evidence of the servicing of emergency lighting. The inspector found that all fire exits were unobstructed on the day of the inspection.

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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However there were areas for improvement identified.

There was a policy in place which provided guidance to staff on how to respond to suspicions of abuse and was in accordance with the Regulations. Inspectors also read the easy to read version of the policy which was available to residents and staff. Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. However not all staff had received training on the protection of vulnerable adults and there was no dates to address this. While a designated person was appointed for staff to contact in the event of an allegation of abuse, there was evidence that this person had also not received any training in this area.

Throughout the inspection, the inspector noted that staff interacted with residents in a kind, caring, respectful and patient manner.

Residents confirmed that they felt safe and described the staff as being very kind and were able to tell the inspector about a number of staff whom they could talk to if they had a concern. Inspectors reviewed incidents and were informed that there were no current allegations of abuse in the centre. However inspectors were not satisfied that all incidents had been recorded. While there were appropriate risk assessments in place to protect a resident who had made a number of allegations, these incidents had not been recorded or responded too and this may have placed this resident at risk.

There was a system to manage residents personal finances, however the policy was not being used to guide practice. Inspectors noted that two signatures were not in place when staff accessed resident's finances, which contravened the policy. A new policy on the management of resident's finances was in draft format. A locked facility was provided in the office. There was a system to check residents' balances twice daily.

Overall restrictive practices were used infrequently in the centre. The inspector found that they needed to be improved in line with the Regulations. While staff had been provided with training in the management of behaviours that challenge, this training did not include the use of restrictive practices. The provider said this was being addressed in the next stage of the training. While residents had access to psychology and psychiatry services as required, there was no documentary evidence to demonstrate who initiated the restrictive practice, there were no risk assessments in place to include the alternatives that were tried prior to its use.

While some residents had positive intervention support plans, they were not in place for all residents and some resident's plans did not guide the staff. Inspectors noted that data on restrictive practices was collected monthly; however it did not include the detail of the interventions and supports required. Inspectors read the positive intervention policy and noted that it would not guide practice. There was no policy on behaviour support or the use of restrictive procedures to guide practice.

A rights committee had been established and included sixty percent volunteers and some residents, this committee had met nine times. The provider said that restrictive practices would be reviewed at this meeting going forward. One resident had been referred as a pilot project.

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that there were appropriate arrangements in place to support residents' health care issues as they arose. The inspector reviewed the records for residents and found that they had access to a general practitioner, including an out of hour's service. There was evidence that residents accessed other health professionals such as the physiotherapy services in house and arrangements were made to other support services if required. Inspectors saw evidence of an annual multidisciplinary

review of residents or more frequently if required. This review included service user, family, clinical team (occupational therapy, speech and language therapist, consultant psychologist and assistant psychologist). Relatives told inspectors that consent for treatment was obtained as required.

Health screening and Health assessments were in place for all residents and provided some valuable information for staff in the care of residents. However, these assessments did not include all aspects of the care required and there were no care plans in place for some residents to address the areas identified. For example, the care of a resident with epilepsy and those who remained at home alone. Hospital support plans were in place to support residents who may require hospital care.

The inspector was satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

There was a dining room in each of the apartments which were decorated to a high standard. Most residents choose to have their meals in the dining room. The inspector observed that meals were well presented and residents participated in the preparation as they wished.

Residents confirmed that they enjoyed the food particularly the choices and variety. Residents said they could make their own meal at any time of the day or night if they preferred and this was supported.

Photographs of foods for prompting were kept in the kitchen for residents to use to assist them in deciding what they wanted for dinner. The staff had arranged weekly meetings for residents in the centre as another way of supporting residents to communicate their views. The inspector reviewed the minutes and notes of some of these meetings and residents also told the inspector that they used the meetings to make decisions on what they wanted to eat during the week. Fresh fruit was available during the day which residents could access. There was evidence that residents and staff shopped for food for the house.

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found evidence of good medication management practices but there were areas for improvement.

There was a medication management policy in place which provided some guidance to staff, however this did not include the procedure for prescribing and administration of medications, including the use of medication for the management of seizures and self administration of medication. The management of medication errors was also not included in the policy. The inspector found that residents who required to have medication crushed were not individually prescribed. While individual medication management plans were in place, some of the information told to the inspector was not included in the plans. There was a system to check the balances of medication every evening and a discrepancy report was completed if deficits were noted.

Overall staff were knowledgeable about the procedure for the administration of regular medication and about checking the prescription, the medication description and that the correct medication was being administered. Staff had received training in the administration of medication and the administration of medication for the management of seizures. Staff knew about the procedures for reporting medication errors and the inspector noted that errors had been responded to and investigated by the person in charge.

Regular medication audits were undertaken and the use of blister packs was currently being trialled as result of a recent audit.

The inspector found that while there were medication error reports completed, they were stored off site and were not trended and used for learning in the centre.

While one of the residents were self administrating and there was evidence of an assessment being carried out, this did not include an assessment of capacity or a plan of care for this resident. While one resident's medication was being titrated to meet the residents needs and a diary was in place regarding the changes, there was no plan of care to guide this practice.

Staff and residents had access to pharmacists, who provided information to staff as required.

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

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The provider had established a management structure, and the roles of managers and staff were clearly set out and understood. The national director had recently retired. The provider now reported to the chief executive of Autism Initiatives in the UK in the absence of a national director.

The structure included supports for the person in charge to assist him to deliver a good quality service. These supports included the provider who reports to the board of directors on a quarterly basis. The executive management team met six weekly and the senior management team met weekly.

The quality committee recently established met six weekly. A quality assurance coordinator had been recently appointed who had received training in this area. The centre had received external accreditation in 2013 and had developed an action plan to address the findings. A resident's forum had been recently established and had two meetings, one of the agenda items had been the role of the Authority and the inspection process.

The person in charge meets the provider weekly to plan the service and discuss any issues. The provider was available daily if required.

The inspector found that the person in charge was appropriately qualified and had continued his professional development. He had sufficient experience in supervision and management of the service. He was reasonably knowledgeable about the requirements of the Regulations and Standards, and had very clear knowledge about the needs of each resident. He was in the process of completing a diploma in management. The inspector observed that he had a person-centred approach with residents and staff through his open and friendly interaction with them. He demonstrated strong leadership and good communication with his team. He was frequently observed meeting with residents and staff and ensured good supervision to all staff. He was an organised manager and all documentation requested by the inspector was readily available.

Inspectors found that there were appropriate deputising arrangements in place. There were robust on call arrangements in place, staff had received training on the provision of on call support. There was a system in place to review the quality of care and experience of residents. A Peer review had commenced between services with a view of improving the service provided. The person in charge from the designated centre in Wicklow was in the process of developing a resident's forum and there were plans to include residents from the Dublin centre.

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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that there were appropriate levels of staff on the day of inspection to meet residents' needs and the layout of the premises. The person in charge used a complexity of need document along with his clinical judgment and feedback from staff and residents to inform decisions about staffing levels. Additional staff were provided as required to meet residents needs. All staff and residents agreed that there were adequate staff on duty.

Staff files were reviewed and they did not fully contain all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Written references were in place for all staff members. There was no evidence of the person's identity, including a recent photograph on staff files. The provider was in the process of addressing this. The inspector found that all existing staff had vetting and this was applied for three yearly. While vetting had been received from an external agency for some new staff members, this was not documented in the appropriate format as required by the Regulations.

There were appropriate arrangements in place to ensure that all staff receive formal supervision on an ongoing basis. The inspectors read the individual performance reviews and noted that the outcomes of these reviews were linked to a continuous professional development programme. All staff engaged in continuous supervision on a six weekly basis, the minutes were reviewed by inspectors. The supervision provided improved practice and accountability. While education and training was provided to enable staff to provide care that reflects evidence based practice, there were areas for improvement.

Inspectors found that some staff had received training in the UK in areas specific to the provision of Autism services and provided this training to other staff, the training included, autism awareness, good autism practice, board maker training, cognitive distortions, sensory integration, anxiety training, the management of behaviours that

challenge training. A number of staff received training staff on the National Standards. As previously stated, all staff had not received fire or safe guarding training. There was currently no plan to address this.

The inspector found that residents' privacy and dignity was respected by staff. The inspector observed staff knocking on the doors of occupied rooms and waiting for permission to enter. Staff interacted with residents in a courteous manner and addressing them by their preferred names. The inspector observed good interactions between staff and residents who chatted with each other in a comfortable way. Residents received assistance, interventions and care in a respectful, timely and safe manner.

Inspectors found that volunteers were supported and supervised, however the details of vetted were not as per the requirements of the Regulations and the roles and responsibilities were not set out in writing.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Linda 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:	A designated centre for people with disabilities operated by Autism Spectrum Disorder Initiatives
Centre ID:	ORG-0008257
Date of Inspection:	01 April 2014
Date of response:	15 May 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

The personal plans did not fully reflect the assessed needs of residents.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

- Service users will be consulted as part of the assessment process, at a level at which they can experience success. Where it is difficult for service users to contribute to this process, people who know the service user well, including family and staff will share

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

opinions of a service user's strengths and needs. All views and agreed outcomes for the service via this process of assessment will culminate in the completion of a service summary.

- Pre-admission the Sector Managers and the Clinic Team will review all assessments from admission, clearly identifying service users assessed needs in liaison with Team Leaders and keyworkers.
- All service users will have a support plan within a time period of 28 days of admission.
- Working file documentation will be completed including support plan goals to meet assessed needs of individual service users.
- Improvements to this process will include review of and the updating of the assessment process.

Proposed Timescale: 01/08/2014

Theme: Effective Services

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

There was no system to evaluate residents plans to ensure they were implemented, effective and improve the outcomes for the residents.

Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- Working file audits have been introduced to review documentation including support plan goals/risk assessments as part of the Monthly Review Form.
- Working file documents are revised monthly and are adapted for each service user to reflect changes in circumstances and new developments.
- Support plan goals will also be evaluated daily within the daily records and reviewed monthly by keyworkers, and subsequently three monthly to ensure progress in achieving goals.
- Service user plans will be discussed at team meetings, during consultation with service users, annual review meetings and multidisciplinary meetings.
- Sector Managers will monitor and supervise that these goals are clearly communicated at annual review meetings and multi-disciplinary support meetings.
- Service users will have a clear poster or any other way of raising their awareness to remind them of their goals which will be accessible to them, i.e. poster on bedroom/prompt card or any other preference by the service user to prompt or clarify their goals.
- Internal peer to peer auditing will focus on individual working files, risk assessments and support plans, which will take place monthly.

Proposed Timescale: 01/08/2014

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 risk management policy did not meet the requirements of the Regulations.

Action Required:

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

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

- The Risk Management Register is currently being reviewed together with a new 'Positive Behaviour Support' policy. This will ensure that the register will meet regulations.
- Staff will undertake a process of review following incidents, improving outcomes in risk management. An incident review team comprising of the Sector Manager, Clinic Team, Team Leader, SCIP Trainer & Key Worker representative will meet monthly to review incidents. This will ensure a process of learning from incidents, identifying trends, frequency, learning and outcomes.

Proposed Timescale: 01/08/2014

Theme: Effective Services

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

The systems to assess and manage risk required improvement.

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 risk management policy is currently under review together with the risk register to; identify hazards and evaluate the risk and will include responding to emergencies and identify emergency accommodation.
- Health and safety risk analysis form will be completed for each activity. The degree of risk will be identified for each hazard by estimating hazard severity by probability.
- All risk assessments will be monitored and evaluated monthly and correspond with the support plan in reducing the risk while enabling service users to attain their goals.
- An 'allegation' review form is now in place.

Proposed Timescale: 01/08/2014

Theme: Effective Services

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

Not all staff had received fire training.

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 will be trained to Fire Warden/Marshal level
- Dates are booked with an accredited company.

Fire Warden/Marshal

- 30th June 2014
- 23rd July 2014
- 28th August 2014
- 24th September 2014

Proposed Timescale: 25/09/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive procedures were not applied in accordance with evidence-based practice and the requirements of the Regulations.

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:

- All staff are currently receiving training in PROACT SCIPr. This is a BILD accredited behaviour support programme.
- The 'Positive behaviour support' policy is being revised and will include the levels of restrictions.
- All restrictive practices are being recorded and monitored monthly (Audit of Restrictive Practice) by Team Leaders and logged at Newtownmountkennedy Offices. Sector Manager and the Quality Assurance Coordinator will evaluate and monitor.
- Quarterly summary reports will be submitted to HIQA as per legal requirements by Sector Manager.
- Any restrictive practices will have an assessment in place and determined as a last

resort. All restrictive practices will be reviewed to reduce restrictions in accordance with national policy, current legislation and evidenced best.

- Restrictive practices can be referred to the 'Rights Enhancement Committee' for review and evaluation for appropriateness of use and recommend alternative, removal, reduction of use of restrictive practice.

Proposed Timescale: 01/08/2014

Theme: Safe Services

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

Some of the staff had not received training in relation to safeguarding residents.

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:

- All staff will undergo Safeguarding training.
- Two staff have been identified to facilitate training for all staff, both of whom have completed the Train the Trainer course.
- Safeguarding training (Protection and Safeguarding) will be part of the training provided to staff.

Scheduled dates:

- Monday 23rd June 2014, 9:30am-5pm
- Wednesday 16th July 2014, 9:30am-5pm
- Tuesday 12th August 2014, 9:30am-5pm
- Wednesday 17th September 2014, 9:30am-5pm
- Tuesday 14th October 2014, 9:30am-5pm
- Tuesday 18th November 2014, 9:30am-5pm
- Monday 8th December 2014, 9:30am-5pm

Proposed Timescale: 08/12/2014

Theme: Safe Services

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

All incidents had not been recorded or responded too.

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:

- Understanding autism training includes incident report practice and introduces awareness of restrictive practices/Mental Capacity Bill (currently under review)
- All incidents will be recorded on an incident form, signed by staff, Team Leader and Sector Manager.
- A positive intervention support plan will be developed for each service user where applicable to ensure an agreed consistent approach is adopted to support behaviour.
- A 'glossary' has been introduced which identifies service user language references i.e. names, places, people, situations.
- An 'allegation review form' has been designed and will be implemented to record all allegations with immediate review post-incident utilising a clearly defined steps.

Proposed Timescale: 06/05/2014

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:

The medication management policy did not guide practice.

Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

- The current medication policy is being reviewed to reflect an action plan for the 'titration' of medication with corresponding, photo, calendar time-line, rationale and possible side effects. All staff to be familiar with this program.
- All prescribing will be specific to each medication, i.e. crushable, liquid administration, taken with service users preferred administration and this will be emphasised in the policy.
- A new epilepsy policy is being introduced together with a buccal/prn protocol which will be recorded in the individual medication management plan (IMMP) and the health record.

Proposed Timescale: 01/08/2014

Theme: Health and Development

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

The risk assessment for residents self administering medications did not include an assessment of capacity or a plan of care for this resident.

Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and

assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

- The health record form is being reviewed to include a capacity plan regarding a service users 'self-administration' of medications.
- A self-medication assessment tool will be introduced to determine the level of ability/capacity for a service user to self-administer their medication. This will form part of their support plan and will be risk assessed. This will be continually monitored and reviewed.

Proposed Timescale: 01/08/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staff files did not meet the requirements of the Regulations.

Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Staff Files will include:

Two references (Employment/Character), proof of eligibility, Person's Identity – Photographs will be attached to all files as part of the identification process and proof of relevant qualifications.

Garda Vetting – All staff files will have their own individual Garda vetting form stamped by the Garda vetting agency.

Performance reviews and supervision notes are held on the personnel files in the HR office

Proposed Timescale: 01/08/2014

Theme: Responsive Workforce

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

Staff did not have access to appropriate training as discussed in Outcome 17.

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:

• All staff will receive relevant mandatory training as follows:
Manual Handling (max 12 per session-refresher every 2 years)

- 20th June 2014
- 15th July 2014
- 6th August 2014
- 16th September 2014

Fire Warden/Marshal (max 12 per session-yearly refresher)

- 30th June 2014
- 23rd July 2014
- 28th August 2014
- 24th September 2014

Occupational First Aid Refresher (max 10-refresher every 2 years) (existing OFA Trained staff only)

- 9th July 2014

Emergency First Aid (max 12-refresher every 2 years) (new staff and OFA Trained staff who go out of date)

- 9th June 2014
- 31st July 2014
- 20th August 2014
- 30th September 2014

As discussed re Safeguarding and Protection next meeting 12th May to confirm content. Training dates agreed early June.

Proposed Timescale: 01/10/2014

Theme: Responsive Workforce

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

The roles and responsibilities of the volunteer were not set out in writing as required by the Regulations.

Action Required:

Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

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

- The roles and responsibilities of the volunteer will be set out in writing as required by the Regulations.
- Volunteers – Any volunteers within AI will have clear roles and responsibilities as well as individually stamped Garda vetting forms.

