

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Lisrath
<b>Centre ID:</b>	OSV-0001517
<b>Centre county:</b>	Louth
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Peter Bradley Foundation Limited
<b>Provider Nominee:</b>	Donnchadh Whelan
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
14 February 2017 10:30	14 February 2017 19:30
15 February 2017 08:30	15 February 2017 14:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This was a follow up inspection to finalise and progress the registration status of the centre. The original registration inspection had taken place in November 2015. At that inspection one major non compliance was found in relation to fire safety. The provider had submitted an updated action plan in August 2016 which demonstrated that the actions had been addressed.

How we gathered our evidence:

The inspector met with and spoke with four residents. They expressed their satisfaction with the service and were very complimentary to the supports given to them by staff. They said they should "keep doing more of what they were doing". Residents said that staff had supported and motivated them to make adjustments enabled them to make changes and achieve long term plans. They did say that that the location was sometimes difficult as it is unsuitable for walking with wheelchairs and in some cases was far away from their local communities. They did however understand that this may not be possible to change and the staff did support them to access their own communities.

The inspector also met with the person in charge and staff, observed practices and reviewed the documentation such as personal plans, medical records, accident logs, policies and procedures and staff files.

All actions required following the previous inspection were reviewed and nine of the core outcomes were inspected against.

Description of the service:

The statement of purpose states that the centre is designated as a centre for adults, male and female with acquired brain injuries which will provide neuro rehabilitative support for people to live meaningful lives.

It is a single story dwelling in a rural location and suitably equipped and adapted to meet the residents' needs.

Summary of our Findings:

Overall, the inspector was not satisfied that systems were in place to ensure the suitability and safety of care despite the very positive findings in some outcomes. This resulted in a negative and potentially detrimental experience for residents, the details of which are described in the report.

The inspector found that significant improvement was required in safeguarding. An immediate action plan was issued to the provider on foot of these findings. This was discussed at length during the feedback meeting and the provider and person in charge acknowledged the significant nature of the findings.

As result of these findings improvements were also required in:

Governance systems and oversight of staff and practices which placed residents at potential risk (Outcome 14)

Risk management in relation to fire safety (outcome 7)

Continued good practice was found in:

Healthcare and medicines management which promoted residents wellbeing (Outcomes 11 & 12)

Consultation with resident and access to social actives was very good which supported residents' rights and lifestyles (Outcome 1 & 5).

The actions required to achieve compliance with the Health Act (Care and Support of Residents in Designated Centres (Children and Adults) With Disabilities Regulations 2013 are outlined 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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

There was evidence that residents were consulted regarding their wishes and plans and agreement was sought in relation to their rehabilitative goals and how to achieve them. Residents told the inspector about this but also indicated that at times decisions were made in regard to for example, what they spent their monies on when they did not consider this necessary. There were no complaints recorded at the time of this inspection but residents informed the inspector that they could and would voice their opinions and staff would address them.

Regular residents' meetings were held and the records showed that they discussed general routines in the centre and agreed the activities and plans for the week. Food choices were also agreed and facilitated.

The routines were primarily dictated by the residents own preferences, capacities and agreed rehabilitative plans where this was relevant. The staff and other supports required, such as adapted transport and mobility aids, to ensure this occurred were made available. Residents were registered to vote and participate in their community.

There was evidence that the residents were closely involved in their personal plans with a view to achieving day to day and longer term goals. The residents informed the inspector of this and also stated that their wishes were ascertained. Residents stated that staff provided them with information and clarity so that they understand their care needs and could make informed choices.

External independent advocacy and legal services had been sourced for a number of

residents where this was necessary.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that the social and healthcare needs of the residents were assessed and subject to review by relevant clinicians. There was evidence of good access to allied services and the recommendations of these clinicians informed the personal and rehabilitative plans for the residents. There was evidence on the records seen and from speaking with the residents that they and or their representatives, where appropriate, were involved and consulted in regard to their care, goals and rehabilitative needs.

In accordance with the assessed needs of the residents the personal plans provided details as to the capacity for the activities of daily living and the supports which each resident required to undertake this and develop to the best of their ability.

The plans were found to be concise and reviewed on a monthly basis. There was evidence that once outcomes were reached further plans and goals were identified in conjunction with the residents.

Residents social care needs were very well supported. They attended day care as appropriate, had regular and very good access to local community for shopping cinema and activities of their choosing. They were involved in sport and Special Olympics and also had regular familial access both in and out of the centre. There was evidence and residents confirmed that aids and assistive devices and technology were made available to support them to good effect.

**Judgment:**

Compliant

**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:**

The previous inspection found that fire safety management systems were inadequate. The provider had addressed this specific issue with the installation of satisfactory fire alarms, emergency lighting and extinguishers. Fire doors had also been installed in all rooms. However, the value of this work was negated by virtue of the fact that a number of significant fire doors were found to be wedged open. While this was undertaken to facilitate ease of access by residents with mobility needs systems such as self closures should have been installed. In addition, the alarms and emergency lighting had not been serviced quarterly as required. The services had commenced in February 2017 however.

Fire drills had been held regularly which included simulation of the reduced staffing levels at night. One staff however, was not familiar with how to use an evacuation aid identified for a resident and also what to do in the event of such evacuation. All staff had fire safety training according to the records reviewed.

Each resident had a risk assessment completed which governed a number of issues such as medical needs, building hazards and activities of daily living. The assessments focused on individual residents' needs for example, issues with medication, potential for falls or choking incident risks. There were strategies in place to mediate the risk. Portable bells were also available so that resident could access staff if needed.

A risk management policy, local risk register, and emergency plan were devised and suitable. Equipment used for residents was serviced as required and vehicles were seen to have evidence of road worthiness and up to date insurance.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

From a review of behaviour support and rehabilitative plans, incidents and daily records and speaking with staff, the inspector found that significant improvements were required in fundamental safeguarding and support systems for residents. The inspector found that remedial action was required at the time of inspection and an immediate action was issued to the provider.

This finding was influenced primarily by the manner in which rehabilitative plans and behavior support plans were being implemented, interpreted and overseen. These were devised by the clinical staff with the support of the key workers and team leader.

From a review of specific documentation and also from speaking with staff it was apparent that in some instances residents' wellbeing and dignity were compromised by this systemic process. The plans involved completion of tasks in an incremental manner in order to develop residents' skills and independence. However the process as documented and described by staff was implemented in an overly robust manner.

This rigorous implementation as recorded in the documentation resulted in failure to assist with mobility following a fall and potential injury, failure to assist when basic self care tasks were taking inordinate lengths of time and causing distress, and the use of language in spoken and written form which was unkind and unsupportive. The evidence of this was presented to the person in charge in detail.

The inspector fully acknowledges the complexity of the circumstances involved. However, the procedures as implemented did not demonstrate that the organic nature of the behaviours presented and the subsequent physical and psychological need for support was adequately understood by staff.

The inspector also acknowledges preceding the inspection it had been decided to revert to a programme which was more supportive while awaiting further assessment. However, while this referral had been made there was no system whereby the provider could access such assessment speedily as they were dependant on the public health services for this. Given the nature of this service, such access may be required frequently and speedily. This was discussed this with the provider.

It was of concern that these issues were not identified by management or if identified were not acted upon sooner. Staff acknowledged that the practices were used as the programmes had to be followed rigorously. Some staff also said they were not always comfortable in doing so however. An immediate action plan was issued to the provider in regard to these findings.

The policy on safeguarding of vulnerable adults was not complete but the provider informed the inspector that this was in the process of being revised to ensure it was in accordance with the national guidelines.

The inspector found that there was a lack of clarity and knowledge in relation to procedures for managing safeguarding incidents and the parameters and responsibilities imposed by certain legal orders.

This was demonstrated by the following;

A safeguarding matter had arisen in relation to circumstances external to the centre. Immediate action was taken to protect the resident. However the process for screening and reporting was not followed satisfactorily. The incident was only recorded on email, no safeguarding plan was documented, it was not reported to the organisations designated officer but to another professional, and there was a significant delay in plans being made to satisfactorily screen the matter. In the interim the person in charge was not clear on what actions to take to continue to safeguard the resident or parameters of a legal order.

Neither the person in charge or the team leader had adequate training in their roles in safeguarding to guide their practice. The inspector was informed that this was to be scheduled.

The inspector reviewed details of previous incidents of extremely challenging behaviours. Safeguarding measures had been implemented and the decision was correctly taken that suitable care could not be provided in the service. However, it was apparent that some incidents required a level of direct intervention which staff were not trained or equipped to implement despite their best efforts.

Staff had training in challenging behaviours but not in safe systems for physical intervention and therefore could not do so. The need for physical intervention was not, however, a routine feature of this service.

There was no p.r.n.(as required) medication being used at the time of this inspection to manage behaviours . Restrictive practices were not a feature of the service. The practices of restricting access to food storage areas were used. The rationale was clear and the action was reasonable for the safety of those concerned. However the risk assessment for its use and impact had not been satisfactorily completed. The inspector was satisfied however that this was a documentary deficit only.

Residents were assessed as not requiring support to manage their own monies. The record maintained was satisfactory and monitored.

There were personal intimate care guidelines available for the residents.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the residents received a good standard of healthcare.

There was access to both general practitioners (GP) services and a range of allied health services appropriate to the residents' needs. Residents confirmed that they can attend their GPs either in the surgery or in the centre. Records of these appointments and outcomes were maintained.

There was evidence of referral and consultation with allied services as required by the residents' needs, including occupational therapy physiotherapy, neurology dentistry and opticians. Residents told the inspectors of the benefit of their physiotherapy and the importance of doing their exercises with staff support. Support plans for residents identified healthcare needs including nutrition and skin integrity and were implemented as required. Specialist equipment and additional nutritional supports were seen to be available and used.

There were strategies in place to encourage healthy eating, diets and health promotion with staff and residents agreeing on food choices. The residents informed the inspector of this and it was clear that staff were helping them to be informed on their overall health needs. Residents prepared meals with staff support as necessary.

**Judgment:**

Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

The inspector found there was a suitable medicines management policy in place to guide practice which staff adhered to. The care staff were trained to administer medications as required including emergency medication.

Systems for prescribing administering and storage and return of medicines were satisfactory. Resident were assessed to fully or partially self administer medicines with staff support. There were systems for monitoring this and for the reconciliation of such medicines. There were audits of administration practises undertaken.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The statement of purpose was revised as required to reflect the changes to the organisational structure. Care practices and admissions were found to be congruent with the statement.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

While there was a governance structure in place, the findings in outcome 8 (Safeguarding) indicate that significant improvements are required in systems for oversight and monitoring of practice.

This relates both to the review of incidents which occurred, the monitoring of the care practices, and actions taken to address obvious detrimental outcomes. Staff were not developed or managed sufficiently to carry out their personal and professional responsibility in an appropriate manner.

The governance systems included the provider nominee, the person in charge who is suitably qualified and the team leader. As the person in charge is responsible for more than one centre the role of team leader is pivotal to ensuring effective governance and operational management. There were reporting systems evident both formal and informal and the person in charge was present in the centre for a number of days each week.

As a result of the findings from this inspection the provider nominee informed the inspector that he would resume his position as direct regional manager for this centre in order to more effectively support the person in charge.

This inspection found that two unannounced visits had taken place and the reports available were comprehensive with actions and timeframes identified. An annual report was also available for 2016 and the views of residents were sourced.

Although incidents such as medicines errors were reviewed individually there were no systems for auditing of analysis of such events to identify causal factors, trends or time frames and thereby improve practices. The provider nominee informed the inspector that systems for such analysis were currently being developed.

**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):**

No actions were required from the previous inspection.

**Findings:**

The staffing levels were found to be suitable in numbers and skill mix.

There were a total of 11 rehabilitative assistants employed with three staff on duty at all times during the day and a waking and sleepover staff at night. The ratio was increased to reflect the support needs of the residents and ensure they could participate in the rehabilitative and social programs. Residents were assessed as not requiring full or part time nursing care.

A review of the training matrix indicated that manual handling and patient transfer was completed for 10 staff and all staff were listed as having completed fire safety training. On line safeguarding training had been completed for 11 staff and practical safeguarding for 6 staff. The reminder was scheduled for full safeguarding training in the coming weeks. They had also attaining training specific to the residents `needs and the staff group had various academic training in social care or FETAC (Further Education and Training Awards Council) level five.

Focused induction and probationary systems were evident and new staff confirmed this to the inspector. A review of a sample of personnel files indicated good practice to recruitments with the required documentation including A Garda Siochana vetting being sourced.

**Judgment:**

Compliant

**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:***

Noelene Dowling  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Peter Bradley Foundation Limited
<b>Centre ID:</b>	OSV-0001517
<b>Date of Inspection:</b>	14 February 2017
<b>Date of response:</b>	13 March 2017

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Ensure that resident's views informed decisions taken in regard to them.

#### 1. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

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

- The service always endeavours to seek clarification with all our residents in how they would like to spend their money as part of their Individualised Rehabilitation Plan. Budgeting and choice are core issues. We will continue to ensure clients are supported to make informed decisions in order to work towards increasing their financial independence. Ultimately, it is the resident's choice how they wish to spend their money and we respect this choice.
- All financial decisions and planning will be documented clearly on the new one to one document which we introduced on the 2.3.17.

**Proposed Timescale:** 02/03/2017

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

Fire doors were wedged open which negated their value to contain the spread of fire.

**2. Action Required:**

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

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

Door guards to be fitted on all necessary doors throughout the house.

**Proposed Timescale:** 31/03/2017

**Theme:** Effective Services

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

Schedules for the servicing of fire management equipment were not satisfactory.

**3. 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:**

- The fire maintenance provider was contacted immediately and they carried out necessary servicing and issued us with the required documentation.
- Quarterly services to be completed and certified as per requirement.

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

**Theme:** Effective Services

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

Ensure that staff are familiar with the systems for the evacuation of residents.

**4. Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

- Training has been scheduled for those staff members who have not yet completed training using the evacuation aid (ski sheet).
- The emergency evacuation plan has been circulated to the team to ensure all staff members are familiar with the procedure to be followed in the event of an evacuation.
- By the 14th of April every staff member will have completed an evacuation drill to ensure they are familiar with the evacuation procedure.
- The PIC and PPIM will ensure evaluation sheets are completed by each staff member to address any areas for improvement.

**Proposed Timescale:** 14/04/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Behaviour support programmes were not implemented in a manner which demonstrated an understanding of the underlying conditions and in a way which ensured that residents were protected from abuse.

**5. 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:**

- An Integrated Positive Behaviour Support Plan was implemented on the 22.2.17 for all staff to follow for one particular client. This plan has merged all previous plans into one cohesive document and has been reviewed and updated by the IDT (Intra Disciplinary Team): Senior Clinical Neuropsychologist, Clinical Neuropsychologist, PIC, PPIM and Provider Nominee.
- A copy of the Integrated Positive Behaviour Support Plan was submitted to the inspector on the 22.2.17.

- All staff will follow this plan consistently and document clearly. All fluid and food intake will be logged in the daily log including where food/fluids have been refused. All staff will use a positive and supportive approach/positive and supportive tone of voice when assisting the client and ensure their primary care needs are met at all times. The client's dignity and respect will continue to be the focus of our care and rehabilitation approach at all times. All staff will use appropriate professional & respectful language when communicating with or about the residents at all times. This will be monitored closely by the PIC and PPIM and an ongoing agenda item at the monthly staff meetings.
- The Integrated Positive Behavioural Support Plan will be reviewed every two weeks by PIC, PPIM and Clinical Neuropsychologist to discuss and monitor progress. Where changes are required, we will have an action plan following each meeting, and the necessary changes will be made to the plan. We will communicate this to the team via email with a "read receipt" to ensure all staff have read it, ensure consistency of approach through one to one supervision & direction, with the updated plan printed and filed in the resident's Individual Rehabilitation Plan (IRP) for easy access.
- All staff attended Safeguarding and Report writing training on the 22.2.17. All staff will attend a refresher in Challenging Behaviour Training, on the the 21st and the 28th of March 2017. All staff to attend self-care training on the 4th of April to deal with stress, this was outlined above.

Proposed Timescale: 22.2.17- this will be monitored closely on an ongoing basis.

**Proposed Timescale:** 22/02/2017

**Theme:** Safe Services

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

Staff did not have training in specific intervention techniques, which may on occasion and under clinical guidance, be required to safeguard residents from harm.

**6. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

- All staff to attend a refresher in Challenging behaviour training, the dates for this are the 21st and the 28th of March 2017.
- Staff, PIC and PPIM attended Safeguarding of Vulnerable Adults training on the 22.2.17.
- Remaining staff will be scheduled to attend Managing Aggression and Potential Aggression training (MAPA). The training dates for MAPA are the 24th and 25th of May 2017 and the 13th and 14th of September 2017.
- The Statement of Purpose will be amended to specify that we will not admit residents who require restrictive practices of a hands-on physical nature as a part of a

behavioural intervention.

**Proposed Timescale:** 14/09/2017

**Theme:** Safe Services

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

There was a failure to protect residents by virtue of the implementation of programmes which were occasionally resulted in:

- Failure to provide support at times of illness or accidents
- The use of unkind and disrespectful language in written and spoken word.

There was a failure to identify such actions as detrimental.

**7. 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:**

- An Integrated Positive Behaviour Support Plan was implemented on the 22.2.17 for all staff to follow for one particular client. This plan has merged all previous plans into one cohesive document and has been reviewed and updated by the IDT: Senior Clinical Neuropsychologist, Clinical Neuropsychologist, PIC, PPIM and Provider Nominee.
- A copy of the Integrated Positive Behaviour Support Plan was submitted to the inspector on the 22.2.17.
- All staff will follow this plan consistently and document clearly. All fluid and food intake will be logged in the daily log including where food/fluids have been refused.
- All staff will use a positive and supportive approach/ positive and supportive tone of voice when assisting the client and ensure their primary care needs are met at all times.
- The client's dignity and respect will continue to be the focus of our care and rehabilitation approach at all times.
- All staff will use appropriate respectful language when communicating with or about the clients at all times. This will be monitored closely by the PIC and PPIM and an ongoing agenda item at the monthly staff meetings.
- A specific updated Fall Protocol has been put in place in the event that a client has a fall. We received input from our Manual and Client Handling Training Co-ordinator on this protocol. This has been circulated to the team via their email, put up on our office notice board and discussed with the team at our Team meeting on the 22.2.17. A copy of this protocol was sent to the inspector on the 22.2.17
- Training Manager will review the effectiveness of the Report Writing Training given ON 22/2/17.

**Proposed Timescale:** 22/02/2017

**Theme:** Safe Services

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

Staff and managers did not have satisfactory training in systems for the management of any allegations of abuse regarding the protection of vulnerable adults.

Responsibilities and designated functions were not clear or adhered to.

**8. 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:**

- Staff, PIC and PPIM attended Safeguarding of Vulnerable Adults training on the 22.2.17.
- The PIC has been linked with a trained Designated Officer for support until the Designated Officer training recommences and they have completed the training.
- The organisations policy on Safeguarding of Vulnerable Adults is currently being reviewed and will be updated.
- The PIC will be scheduled to attend Designated Officer training as soon as training recommences.

Proposed Timescale: 31.3.17 (Points 1 – 3) 31.6.17 (Point 4)

**Proposed Timescale:** 31/03/2017

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

Systems for oversight and monitoring practice were not sufficient to ensure the safety and well-being of residents.

**9. 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:**

- Increased and scheduled one to one support and supervision for all staff with their Line Manager, which will be documented clearly.
- Ongoing monitoring and evaluation of all daily records. Training needs analysis will be completed for all staff with needs and any gaps forwarded to Training Manager for review.
- If staff have any issues, queries or suggestions, through an Open Door policy, they

can discuss those with the PIC/PPIM at any time. This is noted in the Positive Behaviour Plan and will be reinforced at the monthly Team meetings.

- The PIC and PPIM will provide ongoing oversight to ensure that all clients are treated with respect and dignity at all times
- All staff will be supported to be positive in their approach on a daily basis in order to achieve positive outcomes
- The PIC/PPIM will oversee the overall approach on a daily basis to ensure all plans are being followed consistently and are reviewed as required
- Provider Nominee is now Line Manager for the PIC

Proposed Timescale: 22.2.17- this will be monitored closely on an ongoing basis.

**Proposed Timescale:** 22/02/2017

**Theme:** Leadership, Governance and Management

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

There was a need to ensure that staff practices were monitored to ensure that duties were carried out in a professional manner according to required standards and in a safe and suitable manner for residents.

**10. Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- The PIC had one to one supervision meetings with all staff members to address the issue of recording the provision of basic primary care. All staff must focus on positive relationships and positive reinforcement with all clients. The PIC highlighted all concerns raised by our recent HIQA inspection. Report writing was addressed with each staff member and the daily log writing needs to capture all refusals and positive appraisal throughout the day. The Training Manager will be reviewing the impact of the Report Writing Training held on 22/2/17 on the residents records and will forward on any recommendations to the Provider Nominee & PIC
- Increased scheduled supervision and monitoring of all staff and report writing in the future.
- Staff attended Report Writing training on the 22.2.17
- The PIC, PPIM and the Provider Nominee have increasing the level of supervision and oversight in all aspects of the service.
- The PIC & PPIM are monitoring daily log reports closely and meet with staff on a regular basis.
- All Incident Reports will be reviewed in a timely fashion with regard to content and approach.
- Action plans will continue to be put in place to reduce the level of risk.
- Accident and incident reports at all our team meetings. We will continue to

discuss/analyse on an ongoing basis.

- The PIC and PPIM will ensure that the staff approach is positive at all times and staff will be respectful in terms of content and tone of communication, both written and verbal
- There is guidance for staff through the Integrated Positive Behaviour Support Plan and in acknowledging the stressful nature of the service on staff, we are scheduling self-care training for staff on the 4th of April 2017 which will aim to improve skills in managing stress in the workplace and containing the stress of others in order to promote a positive working environment and interactions with other staff and residents.
- At an organisational level, the daily logs are being expanded to ensure basic care needs are documented and will include breakfast, lunch and dinner. The daily logs will also include one to one work with the clients and a breakdown of work completed and goals they are working towards.
- The quarterly Goals and Progress Reports and the Clinical Review Meetings will be merged to ensure clinical input for all SMART goals. This will ensure Clinical input when reviewing of all progress and issues that may arise, we will also have clinical input on risks outlined and the assessment process.

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