Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Overview of HIQA's monitoring activity in Áras Attracta 2015-2017

November 2017

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services –** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation –** Registering and inspecting designated centres.
- **Monitoring Children's Services –** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality –** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment –** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information –** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

About the regulation of centres for people with disabilities

The Health Information and Quality Authority (HIQA) regulate designated centres 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.

HIQA has, among its functions under the Health Act 2007 as amended, responsibility to regulate the quality of service provided in designated centres for children and adults with disabilities.

Regulation has two aspects:

1. 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.
2. 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 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 HIQA'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 wellbeing of residents.

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1. Executive summary

Áras Attracta is a large campus-based residential setting for people with intellectual disabilities, located near Swinford in County Mayo. The service is operated by the Health Service Executive (HSE). The campus comprises 29 buildings on a 10 acre site. The main building has residential units, a swimming pool, large canteen, and centralised services such as kitchen and laundry. The other buildings consist of 12 residential bungalows arranged in a street-like manner, offices and service areas.

The campus is divided into three designated centres. Centre 1 comprises two residential units in the main building and accommodated 36 residents at the time of the most recent inspection. Centre 2 comprises six residential bungalows and accommodated 17 residents on the most recent inspection. Centre 3 comprises six bungalows and accommodated 33 residents on the most recent inspection.

In December 2014, an undercover television programme was broadcast which depicted disturbing and abusive practices in the centre. Following the programme, the provider (the HSE) undertook a range of actions which were intended to improve the safety of residents and the quality of life for residents in the centre.

Inspectors from the Health Information and Quality Authority (HIQA) have been continually monitoring the implementation and effectiveness of these actions and found that the actions were not achieving an acceptable level of improvement for residents.

On 1 October 2015, HIQA's Chief Inspector of Social Services met with the registered provider of Áras Attracta to discuss these findings. The registered provider was represented by the National Director of Social Care and the Áras Attracta management team. The registered provider also invited a number of other organisations to participate in the meeting including an organisation which specialised in behaviour support, a national advocacy organisation and a local voluntary provider organisation.

During this meeting, the registered provider submitted a detailed, time-bound improvement plan to the Chief Inspector setting out the planned actions to be taken over the following three years to ensure the lives and experience of residents in all three centres on the campus would significantly improve. The plan outlined how the registered provider would create a community-based, person-centred model for the future and in the interim, would ensure the safety and quality of life for residents in the designated centres was improved. The provider also stated how the centres would be brought into compliance with the requirements of the regulations and National Standards.

The Chief Inspector informed the provider that HIQA would monitor the implementation of the programme, and should the actions not result in an improvement for residents, would take further regulatory action.

In response to the provider's three-year improvement plan, and to allow sufficient time for the provider to implement these service-wide improvements, the Chief Inspector developed a regulatory schedule to:

- monitor the implementation and effectiveness of the registered provider's improvement plan,
- speak and listen to residents and to assess whether the plan has resulted in improvements to the residents' quality of life,
- assess compliance with regulations and national standards,
- continually monitor the quality of service through notifications received from the provider and through responding to any solicited and unsolicited information,
- make a decision on the registration of Centre 1, Centre 2 and Centre 3 in Áras Attracta.

Throughout this process the provider was required to submit regular updates to the Chief Inspector on the progress being made across Centres 1, 2 and 3. In addition, a schedule of unannounced inspections, as detailed below, was completed. While inspectors undertook unannounced inspections and monitored all of the information received in relation to the centres, two major assessments of the provider's improvement plan were undertaken through two full, 18-outcome inspections in October 2016 and in May 2017.

Throughout this regulatory programme, the updates from the provider included confirmation by them that they were implementing a programme to improve the governance and management of the centre, and stating that their programme was improving the safety and quality of life of residents. Inspection activity confirmed that while the centres continued to require significant improvement, the registered provider was making slow progress in improving the quality of service for residents and were moving towards compliance with regulatory requirements.

In the first full 18-outcome unannounced inspections of October 2016, inspectors found that while there remained a significant number of areas for improvement, the provider had achieved improvements in the levels of regulatory compliance in Centre 1 and Centre 3. However, while some improvements were evidenced in Centre 2, these were not as comprehensive as evidenced in the other two centres. This is discussed in detail under the key outcome areas in this report.

In response, the provider submitted written assurances in their action plan to the October 2016 inspection that further progress towards compliance would be made in

the following months. Given that there had been improvements for some residents, and that the action plan submitted contained specific actions to extend those improvements further, the Chief Inspector invited the registered provider to apply to register all three centres.

Five months later, in May 2017, announced registration inspections in each centre were conducted. While the inspection team found some good practice, they also found a significant deterioration in the safety arrangements and quality of life experienced by most residents living in the centres since October 2016.

Despite giving the registered provider an opportunity to improve the lives of residents by implementing their own action plan, the Chief Inspector has found limited progress and improvement overall on the campus. Throughout this period, regulatory activity has seen evidence of a range of actions being initiated and significant additional resources being allocated across the three centres. However, while there have been some improvements for a minority of residents, there is insufficient evidence to show that these improvements have been maintained. HIQA has found that the provider failed to ensure that their actions were improving the safety and quality of life for all residents. In addition, the provider failed to sustain many of the improvements that had been made during the early part of their action plan.

Furthermore, the governance arrangements put in place by the registered provider have failed to effectively monitor the use of additional resources to ensure that the actions taken resulted in sufficient and sustainable improvements to the safety of residents and their quality of life.

Inspectors found ineffective implementation of and adherence to the HSE's own national safeguarding policy which was an essential part of their improvement plan. Inspectors identified a range of significant issues relating to the protection of residents from the risk of abuse, which is discussed in this report.

The provider has also failed to progress the plan to transition residents to more appropriate, community-based accommodation. When the provider submitted their plan in October 2015, there were 89 residents living in Áras Attracta. The plan included a goal to transition 27 residents to more appropriate, community-based accommodation by the end of 2016, with a further 26 due to transition by the end of 2017. However, at the time of the most recent inspection, 86 residents were still living on the campus.

As a result of these findings, and poor progress on improving the lives of residents, the Chief Inspector decided to take action in relation to the registration of the centres without waiting for the completion of the provider's three year plan. On 28 September 2017, the Office of Chief Inspector issued the registered provider with

notices of HIQA's proposed decision to cancel the registration of all three Áras Attracta centres.

As set out in the Health Act 2007, the registered provider then had 28 days to make written representations to the Chief Inspector before a final decision would be made. These representations were received on 31 October 2017. They set out the actions that are now being taken by the provider to ensure that the care and support to residents in the Áras Attracta is improved.

The Chief Inspector has given consideration to these proposed actions by the provider. The Chief Inspector will schedule an unannounced inspection of the centres to verify whether these latest actions have been effective in making life better for residents who live in Áras Attracta, and will use the findings from these inspections to inform a final decision on the registration of the centres by February 2018.

2. Introduction

This report provides an overview and findings of the regulatory programme completed between October 2015 and May 2017 in relation to the Áras Attracta campus. The report has been developed using a number of sources of information including; inspection reports, action plan updates, communications between the Health Information and Quality Authority (HIQA) and the Health Service Executive (HSE), and reports submitted by or on behalf of the HSE.

2.2 Overview of the Áras Attracta Campus

The Áras Attracta campus is located on the outskirts of Swinford, County Mayo and comprises a number of both residential, therapy and day services, and office buildings on a 10 acre site. The registered provider is the HSE. The provider has divided the campus into three designated centres, each with its own person in charge. At the time of the last inspection, in May 2017, there were 86 residents living in these centres.

Centre 1 Áras Attracta – OSV-0003321

The designated centre is a full-time residential facility for adults with intellectual disability and complex health needs. This centre is comprised of two residential units in the main campus building and at the most recent inspection the centre was home to 36 residents. The centre also provides respite (a short break) services on a planned basis throughout the year.

Centre 2 Áras Attracta – OSV-0004910

The designated centre is a full-time residential facility for adults with intellectual disability, complex health needs, mental health needs and behaviours that challenge. The centre is comprised of six bungalows and at the most recent inspection the designated centre was home to 17 residents. The centre also provides respite services on a planned basis throughout the year.

Centre 3 Áras Attracta – OSV-0004911

The designated centre is a full-time residential facility for adults with intellectual disability and complex needs. This centre is comprised of six bungalows and at the time of the most recent inspection the designated centre was home to 33 residents. The designated centre also provides respite services on a planned basis throughout the year.

Each centre is managed by a person in charge, with the overall campus overseen and managed by a director of services. The management structure for Áras Attracta within the HSE is described below in Figure 1.

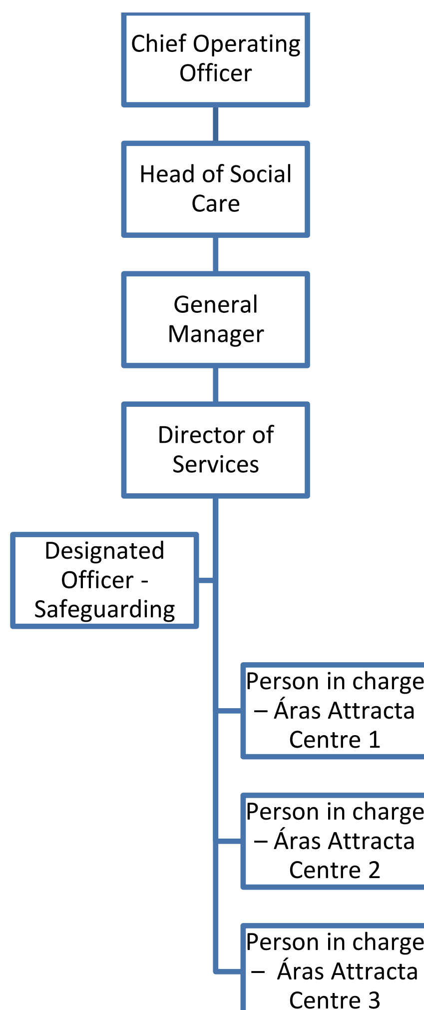


Figure 1: HSE Community Health Organisation (CHO) Area 2 Management Structure

2.3 HSE's Assessment of the Campus

As part of the regulatory monitoring of Áras Attracta, HIQA examined the provider's own assessment of the campus, their response to that assessment and how they were using the learning from this assessment to make real improvements in the safety arrangements and quality of life for residents.

Following the broadcast of the RTÉ *Prime Time Investigates* programme 'Inside Bungalow 3' in December 2014, the provider commissioned The Áras Attracta Review Group. '*What matters most: Report of the Áras Attracta Swinford Review Group'* was published in September 2016. In this report the review group proposed a number of recommendations, to ensure that learning from its work was reflected and promoted throughout the wider intellectual disability sector, including:

- Three overarching recommendations relating directly to service delivery in Áras Attracta.
- Thirteen actions for the HSE to improve the quality of lives for people with intellectual disabilities, and to ensure national policy is fully implemented.
- An action plan for the management of all congregated settings, as they move people to the community, in compliance with the '*Time to Move on from Congregated Settings*'.

(Áras Attracta Swinford Review Group, 2016, p167)

In relation to the Áras Attracta campus, the group recommended:

1. A move to a rights-based social model of service delivery
2. The voices of residents to be facilitated, listened to, and promoted
3. Strengthening and enhancing the leadership and management of the services being provided on the campus.

(Áras Attracta Swinford Review Group, 2016, p167)

It was identified by the review group that these actions would guide management at Áras Attracta to address the deficits found at Áras Attracta during the course of their work *(see Figure 2).*

Deficits in Áras Attracta	
Residents	‣ Absence of full life and meaningful relationships ‣ A culture of dependency and lack of empowerment ‣ Inadequate protection ‣ Insufficient opportunities to take risks ‣ Insufficient access to advocates
Relatives	‣ Ineffective engagement in person-centred planning ‣ Untimely and insensitive communication with relatives ‣ Lack of opportunities to be informed about changes ‣ Poor consultation around decisions ‣ Inadequate consultation
Staff	‣ Absence of a strong person-centred focus ‣ Low expectation of residents' potential and capacity for risk-taking ‣ Inflexible staffing arrangements and frequent staff movement ‣ Low staff morale
Management	‣ No clear vision for Áras Attracta ‣ Lack of strong leadership and direction ‣ Poor communications ‣ Ineffective use of staff resources ‣ Lack of support, supervision and performance management of staff ‣ Lack of implementation of national policy ‣ Weak accountability and governance systems
Environment	‣ Unexplored community housing options ‣ Poor engagement with the local community and community organisations, and underuse of transport facilities ‣ Dearth of employment and educational opportunities
Policy	‣ Lack of awareness training for the residents and their relatives in how to use complaints and protection policies effectively ‣ Lack of staff access to and familiarity with organisational policies ‣ Inadequate compliance with national disability policy

Figure 2: Deficits in Áras Attracta, The Áras Attracta Swinford Review Group, 2016, p169

In tandem with the publication of *'What Matters Most'*, the HSE published *'A roadmap setting out the vision for the future model of service at Áras Attracta'*. Over the course of the regulatory programme, inspectors found that the provider failed to make any meaningful progress on this 'roadmap'. This 'roadmap' states that residents at Áras Attracta would:

> '...move from an institutional model of care to a community based, person centred model, enabling and supporting meaningful lives as chosen by service users, within the resources available and in line with national policies'. (HSE,

> *A roadmap setting out the vision for the future model of service at Áras Attracta*, 2016, page 2)

The 'roadmap' clarifies that this means residents would transition from the Áras Attracta campus to live ordinary lives in ordinary places within a phased time frame of three years.

> Phase 1 – By end of 2016 - 27 residents would transition to community living.
> Phase 2 – By end of 2017 - 26 residents would transition to community living.
> Phase 3 – By end of 2018 - 37 residents would transition to community living.

At the beginning of the regulatory programme, inspectors found that there were 89 residents living on the campus. At the most recent inspection in May 2017, there were 86 residents living on the campus.

3. HIQA's regulatory plan

On 1 October 2015 the Chief Inspector of Social Services met with the registered provider who was represented by the HSE's National Director of Social Care and the Áras Attracta management team. The provider also asked other stakeholders to attend that meeting. These were organisations that the provider had engaged with to assist them in the implementation of their improvement plan and included representatives from an external consultancy and change management organisation, a national advocacy organisation and a local voluntary organisation that provided services to people with intellectual disabilities.

During this meeting the provider submitted a three-year improvement plan for Áras Attracta to the Chief Inspector. The plan outlined the progress the provider had made to date in improving services at Áras Attracta, and set out the provider's planned actions to improve the safety and wellbeing of residents and to ensure that support would be provided to all stakeholders participating in the improvement process.

The plan stated that the provider had implemented a range of actions in the centres including a significant training programme for staff at Áras Attracta. The provider also stated that safeguarding arrangements had been improved on the campus, including the introduction of analyses of incidents involving residents and staff practices. They stated that daily incident report review meetings, weekly safeguarding review meetings and monthly safeguarding review meetings were now being held with an external expert overseeing the process to ensure that residents were safe in the centre.

In addition, the provider told the Chief Inspector that they had made a significant number of additional staffing resources available. This was to support residents to live more independently with one-to-one or two-to-one staffing support, where deemed necessary.

The provider asserted that these actions, together with further planned changes to service delivery, would 'ensure that resident care, safety and outcomes are optimised [and] ensure an improved quality of life for all residents of Áras Attracta, creating a community based person centred model for the future'.

In response to the three-year improvement plan, and to allow sufficient time for the provider to implement these service wide improvements, the Chief Inspector developed a regulatory schedule to:

- monitor the implementation and effectiveness of the provider's implementation improvement plan,

- speak and listen to residents and to assess whether the plan had resulted in improvements to the residents' quality of life,
- assess compliance with regulations and national standards,
- continually monitor the quality of service through notifications received from the provider and the receipt of solicited and unsolicited information,
- make a decision on the registration of each centre in Áras Attracta.

The Chief Inspector also required the provider to undertake a series of audits of the centre. These audits were intended to support the provider in effectively identifying and responding to issues of concern for themselves. Following these audits the provider was required to submit a written report on the safety and quality of care and support in the centres to HIQA. They were also required to submit any plan that had been developed in response to issues identified through their own audits.

In addition to the ongoing monitoring of information and notifications received by HIQA, a schedule of unannounced inspections was arranged to monitor the implementation of the provider's improvement plan for Áras Attracta and their compliance with the regulations and standards.

Below is a summary of key events in HIQA's regulatory programme from July 2015 to July 2017. In total, 14 inspections were carried out over the period. All inspection reports can be found on www.hiqa.ie.

Six major inspections took place during this period in October 2016 and May 2017. These were full inspections where all 18 outcomes were inspected against. While improvements were found on the October 2016 inspections, inspectors found that there was slow progress on improving the quality of service provided to residents. The provider was issued with an action plan for each of the three centres; with 27 actions identified for Centre 1, 31 actions for Centre 2, and 21 actions for Centre 3.

Prior to the May 2017 inspection, the provider submitted an update to HIQA which stated that the majority of the actions had been completed. However, on the May 2017 inspection, inspectors found that

- In Centre 1: 20 of the 27 actions required had not been completed.
- In Centre 2: 27 of the 31 actions required had not been completed.
- In Centre 3: 18 of the 21 actions required had not been completed.

Type of engagement	**Date**	**Brief description**
Unannounced inspections of the three centres	12 July 2015	Unannounced, two-day inspection to monitor compliance with the regulations and standards at each of the three centres.
Unannounced inspection of Centre 2	18 Aug 2015	Unannounced, one-day inspection to monitor compliance with the regulations and standards at Centre 2.

Meeting between HIQA, the provider (HSE) and other stakeholders	1 October 2015	Provider submitted an improvement plan to improve safety and quality of life for residents in Áras Attracta.
Audit Report	23 October 2015	Provider completes initial audit reports for each of the three centres.
Audit Report	11 January 2016	Provider completes second audit reports for each of the three centres.
Unannounced inspections of the three centres	30 March 2016	Unannounced, two-day inspection to monitor compliance with the regulations and standards at each of the three centres.
Unannounced inspection	26 April 2016	Unannounced, two-day inspection to monitor compliance with the regulations and standards at Centre 2. Second day of inspection took place in July 2016.
Audit Report	4 July 2016	Provider completes third audit reports for each of the three centres.
Unannounced inspections of the three centres	12 October 2016	Unannounced, two-day inspection to monitor compliance with the regulations and standards at each of the three centres.
Meeting between HIQA and the provider	21 November 2016	Meeting held with the registered provider of Áras Attracta to discuss the findings of the recent inspection and given initial improvements achieved, to discuss potential registration pathway for each of the three centres.
Telephone conference between HIQA and the provider	20 January 2017	Provider confirmed that improvements from most recent inspection had been sustained and extended within campus. Discussed plan to inspect centres to inform a registration decision. Provider to be requested to submit registration applications and informed that announced registration inspections would be planned for the second quarter of 2017.
Notification of announced inspection	2 May 2017	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relative to fill in were sent to each centre.
Action plan update from previous inspection	8 May 2017	At the request of inspectors, the registered provider submitted an update on the actions from the previous inspection and stated that the majority of actions had been completed.
Announced inspections of the three centres	16 May 2017	Announced, three-day inspection to inform a registration decision for each of the three centres.

Meeting with the HSE’s Office of the National Director of Social Care	11 July 2017	Meeting held by Chief Inspector with representative of the provider to provide feedback on poor findings during registration inspections for Centres 1, 2 and 3.

3.1 Summary of findings during monitoring programme

During the initial phases of the regulatory programme the provider reported, through their audit reports, that a number of key milestones had been achieved in their plans to make improvements for residents. These included the development of a social care model of support within some of the bungalows on the campus. The provider reported that they had significantly improved the overall governance arrangements in the centre to ensure the achievement of key improvements including; full implementation of the national safeguarding policy, staff training, incident management, consistency of staffing and the overall care of residents.

While there were some improvements noted in inspections in March and April 2016, inspectors undertook a full review of the safety and quality of service for residents through an 18-outcome inspection in each centre in October 2016. Inspectors found that while there continued to be a significant number of non-compliances, overall there had been progress in improving the quality of the service in Centre 1 and Centre 3. However, while improvements were noted in some areas in Centre 2, this was not as substantial as in the other centres. Following this inspection, the provider told inspectors that they were taking actions to extend the improvements to the whole campus, including Centre 2.

The provider gave written assurances that further progress towards compliance would be made in the months following the October 2016 inspections. On this basis, HIQA advised the provider that they would be requested to apply to register the centres and that further inspections to inform a registration decision would take place in the second quarter of 2017. They were reminded of these planned inspections again in January 2017 and received formal notification of the inspections on 2 May 2017.

3.2 Summary of findings from registration inspections May 2017

Prior to the registration inspections in May 2017, the provider informed the Chief Inspector that they had implemented a range of measures to improve the quality and safety of services in Áras Attracta. However, during the May 2017 inspections inspectors found that the governance arrangements which had been put in place had failed to ensure that the improvements identified during the October 2016 inspections had been sustained. In some cases, these improvements had deteriorated. Inspectors found that many issues which were impacting on the safety and wellbeing of residents would have been identified by the provider if appropriate review and oversight arrangements had been in place. As a consequence, these issues had not been identified and were left unaddressed.

In addition, in May 2017 inspectors found that the experience of residents living in these centres varied. While some residents had moved into individual living arrangements in Centre 2 and others had experienced positive outcomes from changes to a social model of care in their homes in three of the six bungalows in Centre 3, the majority of residents had not experienced these improvements. Most residents continued to experience an institutional model of care, with centralised practices and limited or no opportunities for personal development and growth.

Governance and leadership arrangements, which were introduced in 2015, had failed to deliver the planned improvements in the overall quality of the service. Inspectors found evidence of poor oversight and management of safeguarding, infection control, fire safety measures, health and safety, risk management, maintenance of the centre and the management of resources; including staffing levels. In addition, inspectors found that the provider had failed to effectively implement actions required following previous inspections and from their own internal reviews of the service.

Over the course of inspections referred to in this report, inspectors found evidence of the provider's failure to ensure that the systems and processes developed to safeguard residents from harm and abuse were being effectively implemented and overseen. In particular, the provider had failed to respond to a significant number of occurrences and reports of alleged abuse between residents. In some cases, inspectors found that the provider was not ensuring that safeguarding concerns were being responded to in line with their own policies and procedures. In other examples, where safeguarding plans had been developed, inspectors found evidence that the provider was failing to implement these plans appropriately.

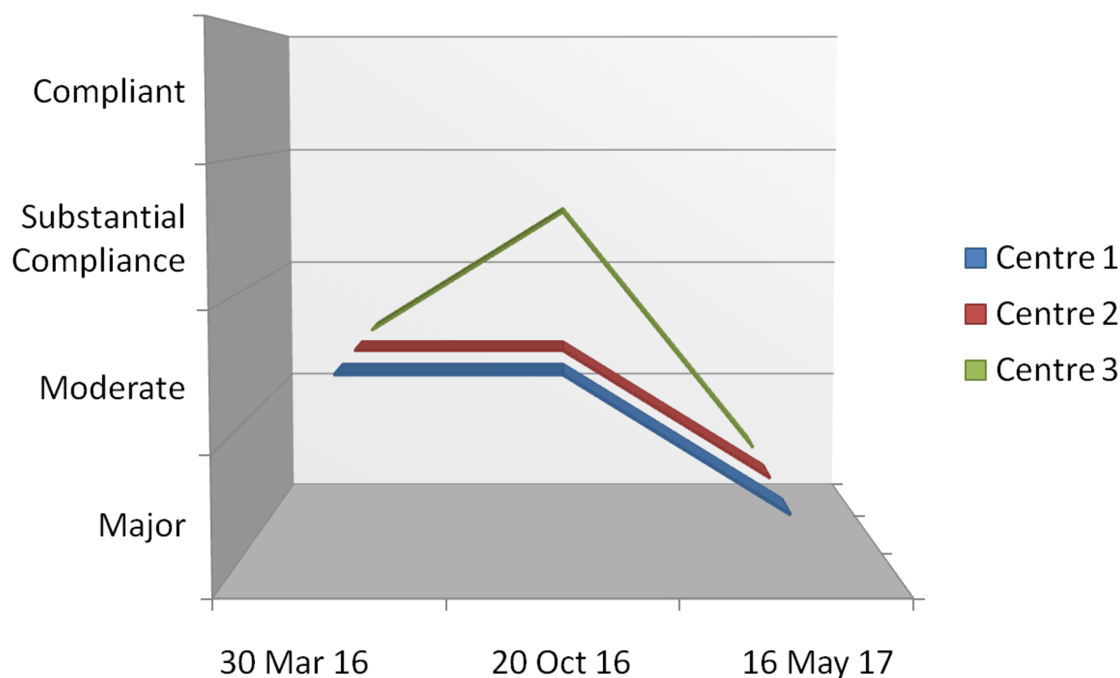
The staff who were providing day-to-day care and support to residents were found to be caring and respectful towards residents during the inspections. However, there continued to be a significant over-reliance on temporary or relief workers. This meant that residents were not always receiving continuity of care. On a number of

occasions, inspectors found that the number of staff available in the centres was insufficient to meet residents' needs. This resulted in some residents being unable to participate in community activities of their choice, or at the time they had planned to participate in these. For example, in some bungalows, the majority of staff time available was allocated to residents with higher personal support needs, meaning some residents with lower personal support needs often spent a significant amount of their day in their home without any meaningful activities or engagement with staff or the wider community.

The next sections of this report set out the overall findings from the regulatory programme in the following specific, critical areas of service provision:

- Outcome 14: Governance and management
- Outcome 8: Safeguarding and safety
- Outcome 7: Health and safety and risk management
- Outcome 5: Social care needs
- Outcome 11: Healthcare needs
- Outcome 1: Residents' rights, dignity and consultation
- Outcome 6: Safe and suitable premises

3.3 Outcome 14: Governance and management



Overall judgment

Inspectors found the provider had failed to ensure that their own governance and management arrangements were effective in delivering and sustaining the required improvements in Áras Attracta.

Inspectors had fundamental concerns with the leadership and governance arrangements on the campus, which were having a direct and negative impact on the overall quality of life, experience and safety of residents living at Áras Attracta.

In addition, inspectors found that the audits that had been undertaken by the provider were inadequate. They failed to identify issues of concern in key areas such as safeguarding and risk management. These audits were not being used to drive improvements in the quality of services.

Inspectors found that the provider had failed to act in a timely manner when issues of concern were brought to their attention and had failed to identify failures in their own governance and oversight arrangements.

Provider's action plan

In their October 2015 improvement plan, the provider detailed a range of improvements they had made to the overall governance and oversight arrangements on the Áras Attracta campus. These included:

- A dedicated full-time director of services, who was appointed in July 2015, to act as the representative of the HSE from the 1 October 2015. The priorities of the director of services were identified as:
  - resident safety and safeguarding
  - improvement of resident outcomes and quality of life
  - maintenance of adequate staffing levels to meet the needs of the residents
  - effective risk management and implementation of risk management control measures
  - implement specific commitments made to the authority to date
  - meet the requirements under the Act, the 2013 regulations and the standards.
- From December 2015 the director of services would be supported in their role by a full-time assistant director of nursing.
- A full-time person in charge (clinical nurse manager [CNM] grade 3) would be appointed to Centre 2 with responsibility for:
  - resident safety and safeguarding
  - improvement of resident outcomes and quality of life
  - maintenance of adequate staffing levels to meet the needs of the residents
  - effective risk management and implementation of risk management control measures
  - implement specific commitments made to the authority to date
  - meet the requirements under the Act, the 2013 regulations and the standards
  - the observation of care, audit of practice and support and supervision of staff on the ground.
- A clinical nurse manager [CNM] grade 2 would work in each centre on a supernumerary basis to support the person in charge.
- In addition to the above, the provider set out a schedule of planned and unplanned visits by the director of services to the centres and a range of meetings where discussions and analysis of issues such as safeguarding, service change projects, staff matters and resident consultation would occur for the purpose of driving improvements in the centre.

Unannounced, full 18-outcome inspections October 2016

Inspectors found that the provider had appointed the director of service, who was supported by a person in charge in each of the three centres on the campus.

Inspectors found that management resources were deployed within the service in line with the provider's action plan.

While improvements were noted across the campus during these inspections, supported by an improved governance arrangement, inspectors found a number of ongoing areas of non-compliance, particularly in relation to fire safety, risk management, behaviour support, use of restrictive practices, the use of resources and suitable levels of staffing. No areas of immediate risk were identified during these inspections and there was evidence that while improvements towards achieving compliance in these areas was slow, progress was ongoing.

The provider was issued with an action plan for each of these centres following this inspection with 27 actions identified for Centre 1, 31 actions for Centre 2, and 21 actions for Centre 3. Subsequently, the provider submitted a comprehensive response to each of the actions identified with time frames for their achievement outlined.

Announced, registration inspections May 2017

In preparation for the registration inspections, inspectors requested an update on the action plans arising from the previous inspections. While the provider reported that they had completed many of the actions within the relevant timelines, inspectors noted that the dates for completion on some of the actions had been changed without any discussion with HIQA. In some instances, the HSE had significantly increased the length of time for when required actions would be completed.

During the May 2017 inspections, inspectors reviewed the actions reported as completed by the provider in their update and found that the majority of these actions had not been completed. Inspectors also found that little progress was being made in achieving actions within the agreed dates. Overall, inspectors found:

- In Centre 1: 20 of the 27 actions required had not been completed.
- In Centre 2: 27 of the 31 actions required had not been completed.
- In Centre 3: 18 of the 21 actions required had not been completed.

A series of meetings were held with the provider's representative during the course of these inspections. During these meetings, the provider was asked to demonstrate the governance arrangements to ensure that action plans were being effectively managed and implemented, how the risks towards achieving these had been assessed and what control measures the provider had put in place to ensure that actions would be achieved within the agreed timescales. The provider could not demonstrate the governance arrangements that had been put in place to monitor the implementation of their action plans. There was no evidence to demonstrate that

the level of risk had been assessed or the impact of failing to deliver these actions would have on the quality of life of the residents. In addition, audits that had been completed by the provider had failed to identify that these actions were neither being effectively implemented or proactively monitored.

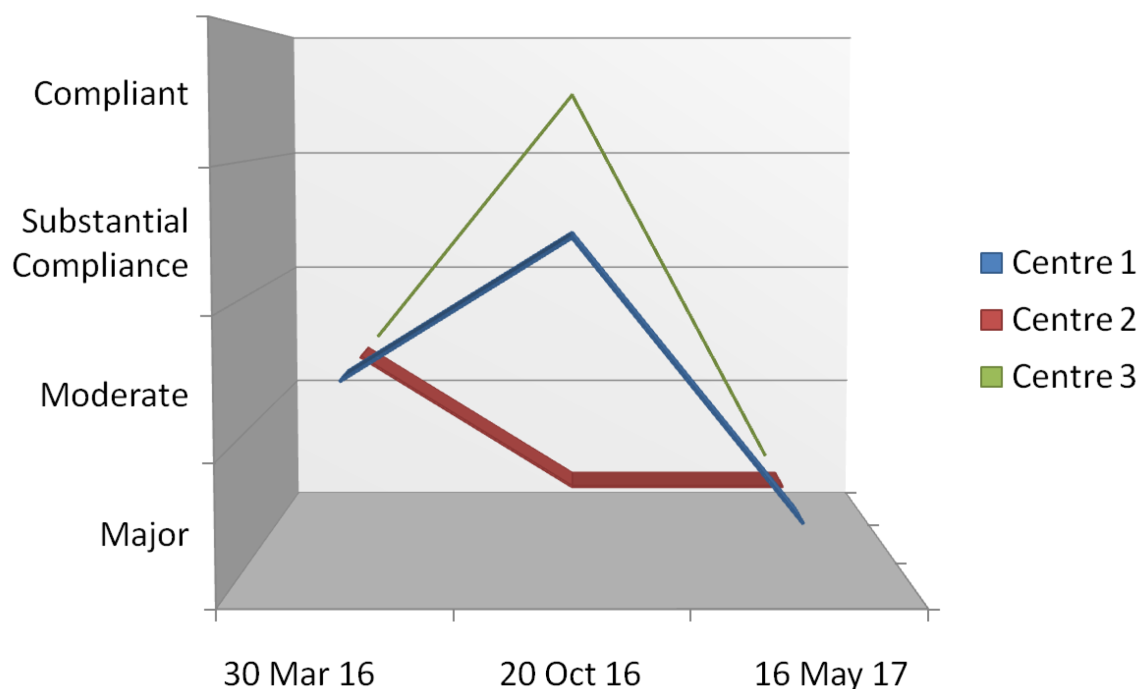
Inspectors reviewed the governance arrangements for the management of risk, safeguarding, and health and safety and found significant weaknesses in the provider's campus-wide arrangements. For example, staff who were identified as responsible for implementing residents' safeguarding plans were unclear on the number of safeguarding plans in place in each centre. There was no evidence of thematic analysis of safeguarding incidents within the centres to inform reciprocal actions that would improve the safety of residents. Inspectors found examples of unexplained bruising that were not being reported or investigated in line with the provider's policy. The implementation of these safeguarding measures had been previously identified as an action to be taken by the provider in their own October 2015 improvement plan.

Inspectors found that the maintenance arrangements across the campus were reactive as opposed to proactive - the provider had failed to ensure that a log of the required repairs was being maintained and risk assessed. Staff did not know when urgent repairs would be made and the provider's representative did not have a summary of or any evidence of oversight of this process.

Inspectors reviewed the provider's plan for the transition of residents to community living. The plan, at the time of the inspection, was not consistent with the improvement plan that had been submitted to the Chief Inspector by the provider in October 2015. The provider told inspectors about plans for residents to move to new houses within the coming weeks and months but the provider had not yet submitted applications to register any new centres in the community to HIQA. In addition, inspectors found that residents, their family members and representatives were not being adequately informed about and involved in the transition plans.

Inspectors found that the HSE had failed to ensure that governance arrangements, as set out in their October 2015 improvement plan, were robust enough to be sustained. This resulted in a poor level of oversight of the service and a failure to achieve the fundamental requirements of the national regulations and mandated standards. The failure to appropriately recognise, manage, oversee and address a number of key areas of risk in a timely manner directly contributed to a significant deterioration in compliance across a number of outcomes and as a consequence negatively impacted on the overall quality of life for many residents living in these centres.

3.4 Outcome 8: Safeguarding and safety



Overall judgment

Inspectors found that the oversight and management of safeguarding arrangements for residents continued to be an area of significant concern. While the provider had put new safeguarding arrangements in place following the submission of the October 2015 improvement plan, inspectors found these had failed to ensure improved safety for residents. Furthermore, the revised governance arrangements had failed to identify significant deficits in the effective implementation of their safeguarding arrangements.

Inspectors found evidence of institutional abuse, where the provider had failed to recognise and respond to situations where residents were regularly harmed and injured through altercations with their peers. In addition, the provider had not responded to allegations of abuse appropriately and in compliance with their own policies.

Provider's action plan

At the meeting with the Chief Inspector in October 2015, the provider set out a number of priority actions in relation to safeguarding arrangements in Áras Attracta, which included:

- The new management team would prioritise the safeguarding of residents.

- The introduction of more robust governance of safeguarding arrangements which included the identification of trends in relation to safeguarding issues and using this to inform actions for improvement.
- Safeguarding training for all staff to improve their understanding and knowledge of how to respond to incidents or suspicions of safeguarding issues.
- Moving specific residents to safer living environments.
- Appointing a senior social worker as a designated safeguarding officer whose role was to ensure the full implementation of the *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (National Safeguarding Policy).
- Arrangements for all incidents of concern and all incidents of unexplained bruising to be reviewed and the information used to inform priority actions.

A provider's audit, conducted in January 2016, stated that all safeguarding issues were being reviewed in line with the National Safeguarding Policy and that training for all staff would be completed by July 2016. In addition, the audit stated that the new designated officer had been appointed and that newly appointed managers were supernumerary and would be ensuring the continuing oversight of safeguarding and other arrangements.

The follow-up audit, conducted by the provider in July 2016, outlined the actions that had been undertaken to ensure effective safeguarding arrangements. These included assessing the need for all restrictive measures to ensure the least restrictive practice is used for the shortest duration, a management review of all safeguarding incidents within 48 hours, weekly review of all safeguarding incidents with agreed actions and monthly safeguarding oversight meetings to identify actions to be taken. In addition, it set out the actions that had been taken to ensure the safe and appropriate administration of medication.

Unannounced, full 18-outcome inspections October 2016

On these inspections, inspectors found that while the provider had implemented a number of safeguarding actions, they had not put adequate governance and management arrangements in place to ensure that the actions were effectively making the service safer for residents.

A new management team had been appointed, as well as a senior social worker, to oversee the implementation of the National Safeguarding Policy. A small number of residents had moved from multi-occupancy accommodation to single occupancy

bungalows on the campus. In addition, staff had been provided with safeguarding training.

Inspectors found that while it had not yet been fully implemented, the provider had made progress in implementing the HSE's National Safeguarding Policy, identifying safeguarding issues and developing safeguarding plans in response to them.

However, there continued to be safeguarding issues that were impacting on the safety and the quality of life of most residents in the centre. Inspectors saw examples where the behaviour of some residents continued to result in harm or injury to other residents. Some residents told inspectors that they felt afraid in their homes and inspectors could see that they were intimidated by their peers.

Inspectors found that while behaviour support plans had been developed for residents who needed them, many of the plans did not provide adequate guidance to staff on interventions to be used with residents and many plans were not being implemented in practice. In addition, some staff members were not familiar with the support plans.

Improvements were also required in relation to the management of medicines. Inspectors were informed that medicines were being used to assist with the management of behaviour issues. Inspectors found that these practices were not being adequately assessed and managed. This had been identified as an area requiring improvement in the provider's own audit, but an action plan had not been developed to address these issues.

Inspectors recognised that since October 2015 there had been progress in improving the safeguarding arrangements across the campus, but further progress was required to ensure the sufficient management of safeguarding risks. The provider set out how they intended to extend and build on those improvements so that safeguarding was improved for all residents. The provider was informed that there would be a further inspection to verify whether the improvements had been sustained and extended to all residents.

Announced, registration inspections May 2017

In May 2017, inspectors found that the provider had not sustained the improvements that had been identified during the October 2016 inspections. The safeguarding arrangements in the centres had deteriorated which resulted in increased risk for residents. Inspectors found that the provider was not monitoring safeguarding arrangements and many of the issues which posed a risk to residents could have been addressed had they been identified and responded to by management.

Inspectors found that there had been little progress on extending the safeguarding arrangements on the campus to all residents, as set out by the provider following the previous inspections. The National Safeguarding Policy was not being fully implemented and this had not been identified as a concern by the provider.

An essential component of the National Safeguarding Policy is to develop safeguarding plans, which are an important part of responding to identified safeguarding risks for residents. Inspectors found a high level of inconsistency in the development, implementation and review of safeguarding plans. The designated officer identified the safeguarding plans that were active in each of the centres. However, inspectors found that the persons in charge of each centre and staff working in the centres were not aware of a significant number of these plans. This issue had been identified in the provider's own audit but no action had been taken to address this risk.

In addition, inspectors found that where safeguarding plans were in place, staff were failing to implement some of these. Inspectors saw examples of specific support requirements for residents to manage safeguarding risks, such as modified staffing arrangements or arrangements for undertaking specific activities with residents. However, these arrangements were not being implemented. Inspectors also saw examples of safeguarding plans that had not been reviewed even though the circumstances for the resident had changed, and in some situations, inspectors found that staff clearly identified safeguarding issues which did not have any safeguarding plan.

Inspectors found that staff were not implementing safeguarding procedures in relation to reporting of unexplained bruising. While these incidents were being recorded, they were not being referred to the designated safeguarding officer as required by the provider's own procedures. This meant that injuries sustained by residents were not being reviewed appropriately to inform safeguarding actions.

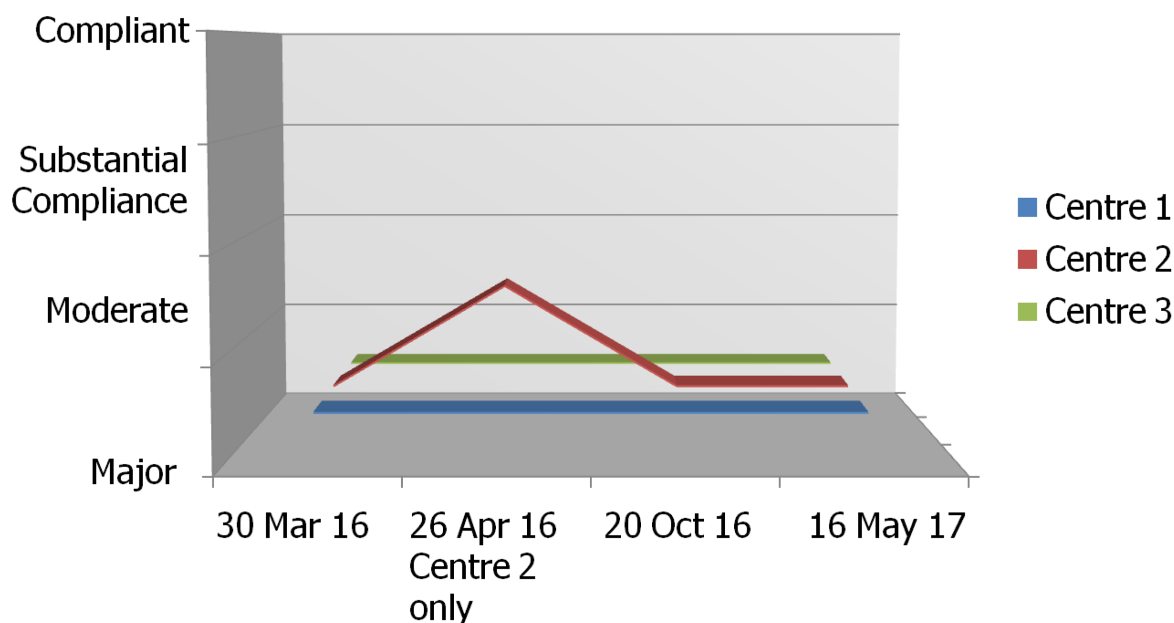
While inspectors saw allegations of abuse were being responded to in some parts of the campus, inspectors also saw that the National Safeguarding Policy was not being implemented in other parts of the campus. For example, staff described a situation where residents made frequent allegations of abuse. However, while these were being recorded, they were not being reviewed or investigated in line with national policy.

Inspectors found that there was poor oversight of the use of medicines which, staff told inspectors, were being used as a response to residents' behaviours. Inspectors found examples where the administration of medicines was not in accordance with the doctor's instructions. For example, in one situation the instructions were for staff to implement the proactive and reactive behaviour support plan prior to the administration of 'as required' medicine. Staff were administering the medicine but

the proactive and reactive plans had not been developed and staff were not aware of any such plans. In another example, staff were instructed to request the review of an 'as required' medicine if it had to be administered more than three times. This review had not been sought.

Inspectors also saw that restrictive practices were not being implemented in accordance with the provider's procedures and as set out in an action plan from the provider's audit. Inspectors saw examples where restrictive practices were being implemented in some parts of the campus, such as use of bedrails, locked doors and restricted access to certain common areas and toilet areas. An appropriate assessment had not been completed for the use of these practices and the provider had not given consideration to the impact of these practices on other residents in those parts of the campus.

3.5 Outcome 7: Health and safety and risk management



Overall judgment

There was evidence of early improvements in risk management processes in October 2016; however, these improvements were not systematically applied in identifying and mitigating risk. By the inspection in May 2017, inspectors found that the improvements were not being sustained, and there was deterioration in some aspects of risk management on the campus.

Provider's action plan

The action plan submitted by the provider in October 2015 in relation to the identification and management of risk in the centre included the following measures:

- Risk management and implementation of risk controls were identified as a priority area of work for the newly appointed management team.
- The provider set out the enhanced programme of oversight, supervision and communication arrangements by the new management team in monitoring risk and ensuring that risk management actions were being implemented.
- The plan stated that all risk assessment documents had been reviewed using an audit tool.

Unannounced, full 18-outcome inspections October 2016

In October 2016, while inspectors found that there were some improvements to arrangements for fire precautions and risk management in the centres, management had failed to ensure that these measures were being implemented in a consistent manner across the whole campus, and inspectors also found continued, major non-compliances in this area.

Inspectors found that there had been improvements in fire precautions, but that there continued to be a requirement for further, significant improvement. Inspectors required the provider to take immediate actions to address areas of risk in relation to fire, including:

- A review of residents' personal emergency evacuation plans (PEEPs). While the provider had made progress in developing these plans for all residents, many of them did not include arrangements for specific issues relating to residents' conditions that were readily identifiable to inspectors and that would impact on the implementation of the PEEP.
- Improvements to the arrangements for staff attendance to assist with emergency evacuations.
- Implementation of learning arising from fire drills.

While each of these issues was addressed by the end of the inspection, inspectors were very concerned that the provider was not monitoring fire arrangements and identifying these critical actions for themselves.

Inspectors reviewed the emergency plan for responding to emergencies, should they arise. The plan included an alert system to ensure that staff from other parts of the campus provided assistance in the event of an emergency. However, inspectors found that the alert system had been broken for a number of months; while this had been reported to the provider, it had not been identified as a risk and the provider had not responded to it.

The provider had retained the services of a fire consultant who detailed a range of improvements that were required in the centre. While the provider had completed the works identified as requiring immediate attention by the consultant, they had not progressed with the remaining work such as the provision of further emergency lighting, the installation of additional fire doors and improvements in compartmentalising the buildings.

Inspectors did note some improvements in fire precautions. There were improvements in the provision of fire safety training to staff, there were regular checks of fire equipment and most staff were able to tell inspectors about the fire precautions.

In relation to risk management, inspectors found that while there had been some improvements, further improvements were required. The provider had recently established a health and safety committee which had started to review risk arrangements on the campus. Inspectors found an improvement in risk assessments, particularly in relation to the physical environment, and these were being reviewed and adjusted on a regular basis.

Inspectors reviewed the management of accidents and incidents and found that there had been improvements in reporting accidents and incidents. There was also evidence that management were reviewing accidents and incidents at regular management meetings. However, inspectors found that these reviews were not adequately identifying trends and informing actions to reduce the risk to residents. For example, the risk of falls for residents was being reviewed and assessed effectively in one centre but in another centre this was not occurring and no actions were being taken to reduce the risk of injury from falls.

Inspectors also found that some risks were not being managed appropriately. For example, the provider was not safely storing oxygen cylinders.

Inspectors also found poor infection control practices. Inspectors saw dirty personal and healthcare equipment which posed an infection risk. There was no protocol to ensure the regular checking and cleaning of this equipment. Inspectors also saw some areas of the centres were very unclean and which posed an infection control risk, including dirty floors and stains on walls.

Announced, registration inspections May 2017

Generally, inspectors found that there was deterioration in the risk management arrangements since the previous inspections. Following the previous inspections, the provider had submitted an action plan to the Chief Inspector setting out their plan to address the areas of concern. On these announced inspections, inspectors found that the provider had failed to implement the action plan and had failed to ensure that actions that had been taken were effective in reducing the risk to residents. Most of the action plans had not been implemented, and inspectors found that there continued to be major non-compliance with managing risk in the three centres.

During the inspection, inspectors required the provider to take immediate action in relation to risks that the provider should have identified themselves. These included:

- An emergency exit was blocked by the inappropriate storage of healthcare equipment.
- Emergency lighting in one centre was broken and had not been repaired.
- A pager system, which was a critical aspect of the campus emergency plan for alerting staff should an emergency arise, was not being used in practice.
- Infection control risks.

The provider addressed the areas of immediate concern by the end of the inspection, but it was of significant concern to inspectors that the provider had again failed to identify these risks for themselves or to put risk controls in place to ensure the safety of residents.

In response to the identification of faulty emergency lighting in one centre, the provider put a temporary arrangement in place while awaiting a technician to repair the lighting. However, when an inspector reviewed this temporary arrangement later on this inspection, she had to request a risk assessment of the arrangement as it had resulted in obstructing a fire exit and there were trailing wires which presented a trip hazard to residents. The provider was required to take further action to make the arrangement safe.

The provider's emergency plan identified the requirement for 10 staff to assist with the evacuation of residents in one centre on the campus, in the case of an emergency. To achieve this, the provider had introduced a pager system to ensure that staff from elsewhere on the campus would come to the assistance of residents in the event of an emergency.

However, inspectors found that the provider was failing to monitor the implementation of this measure. Inspectors spoke with staff who were supposed to respond to the pager, but staff were unclear about their responsibilities and some did not have the pager with them. Some staff explained that even if they were called by pager, they would be unable to respond given the care and support needs of the residents that they were working with. In addition, some staff told inspectors that they had been off site on a trip with residents earlier that day and would not have been able to respond to the pager if there had been an emergency. This meant that if there had been an emergency, there was a significant risk that residents would not be evacuated in a timely manner to ensure their safety.

Inspectors reviewed fire drill records and found that regular fire drills were occurring and being recorded. However, the provider was failing to implement learning from the outcomes of fire drills. For example, in a recent fire drill, there was an insufficient number of functioning wheelchairs to enable staff to evacuate all residents. This had been identified on the fire drill record but no action had been taken to address it. This was brought to the attention of the provider by inspectors and resolved on the day of inspection.

Inspectors did note improvements in some areas. A sample of personal emergency evacuation plans (PEEPs) for residents were reviewed and found to be reflective of each resident's individual evacuation requirements. A new fire alarm system had been installed in some parts of the campus. However, not all staff had received training in using the fire alarm system. Inspectors also found that generally, staff had a good knowledge of the fire safety arrangements in the centre.

However, there had been minimal improvement in the management of other risks in the centre. While there was a risk register in place, inspectors found that there was poor monitoring and reporting of risks, and in some situations, risks were identified but no control measures had been put in place to reduce the risk. For example, inspectors saw designated emergency exits from residential units which had no pathways and uneven, sunken ground. Some gates on exit routes were either locked or were very difficult to open.

The management of resident falls continued to be an issue in the centre. This had also been identified on the previous inspection. There were no assessments for some residents who were experiencing falls. Inspectors saw other residents who had been assessed as being at risk of falls, but no action had been taken to manage that risk. Inspectors saw records for two residents who had 14 falls in recent months and three who had up to 20 falls. While these were being recorded, there was no overall review and no plan to reduce the risk to residents.

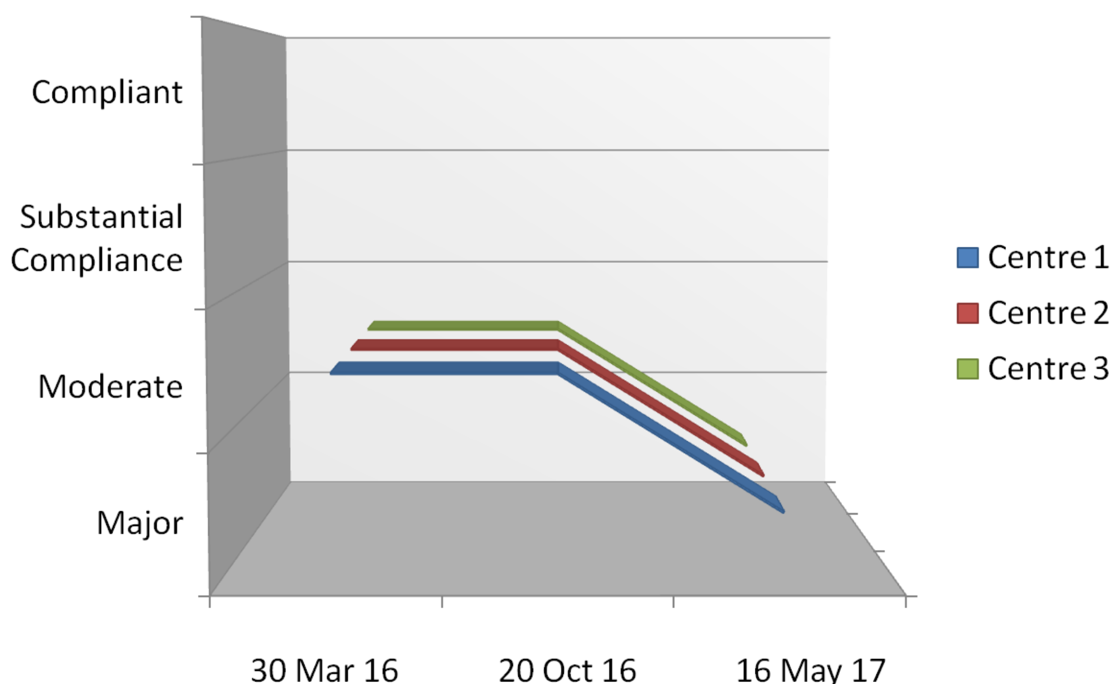
While there continued to be improvements in the recording of accidents and incidents, and there was evidence of management reviewing these records, these reviews were not being used to reduce the risk to residents and inform improvement actions. For example, there had been a review of incidents where residents were at risk of choking. The review found that staff had responded in a timely manner and were very attentive to the residents. The review also made recommendations to reduce the risk to residents but these recommendations had not been implemented.

Inspectors found that there continued to be poor infection control arrangements in the centre. This had been identified as an issue on the previous inspection. Inspectors read that there was MRSA present in one of the residential units. While care staff were aware of its presence, cleaning staff were not, and cleaning practices increased the infection risk. Inspectors spoke with cleaning staff and they were not aware of the presence of the infection control precautions. The same cleaning equipment was being used throughout the residential unit, thereby increasing the risk of infection for others.

In addition, a room used for therapeutic purposes for residents was very dirty, with mould in parts of it. Inspectors again found unclean personal and healthcare equipment, and healthcare equipment was stored in a manner that increased the risk of infection.

Inspectors also observed a number of other risks which had not been identified by the provider and were not being monitored adequately. While the storage arrangements for oxygen cylinders had improved in one centre, in another, they continued to be stored inappropriately and not in line with the supplier's guidelines. In another residential unit, inspectors saw that equipment which posed a risk to residents, such as needles and syringes, were being stored in a secure cupboard, but the lock on the cupboard was broken and the materials could be easily accessed. This had not been identified as a risk and had not been reported to the maintenance department for repair.

3.6 Outcome 5: Social care needs



Overall judgment

Inspectors found that while social care for some residents in the centre had improved in the early part of the regulatory programme, very little progress had been made since the April 2016 inspection on improving the quality of life for other residents.

Inspectors found that while staff were respectful and caring towards residents during the inspection, staff reported that they did not have sufficient time to ensure that all residents' social care needs were being met in line with their assessed needs and wishes as set out in their personal plans. As a result, many residents were spending significant amounts of time in their homes with little or no social engagement either on the campus or in the wider community. Inspectors found a number of occasions where residents had plans for activities in the local community, but these were cancelled at short notice due to the lack of available staff to accompany them.

Inspectors found a continued over reliance on institutional routines across many areas of the campus. In addition, many residents who had social care plans were consistently unable to participate in the social activities of their choice due to the poor allocation of resources in the centres, including the availability of suitably trained staff in sufficient numbers and access to suitable transport.

Provider's action plan

In their 'Roadmap' for Áras Attracta published in September 2016, the provider stated that they 'will continue to improve services at Áras Attracta, while working towards the transition to community living....[and] in the interim [the HSE] remain committed to continuously improving the care delivered at Áras Attracta and promoting the autonomy and independence of each individual resident...'.

In order to achieve this, the provider informed the Chief Inspector that an additional €3 million in revenue funding had been provided to Áras Attracta over the course of the two years to support the development of a social care model of service and to improve existing services in the centre.

The provider had also stated that by December 2015 all residents would have an individual assessment of their needs completed which 'clearly outlines the range and level of supports require for each individual to live a successful life in an appropriate community setting and this has informed the individual plan for each person'.

Unannounced, full 18-outcome inspections October 2016

In October 2016, inspectors found a mixed approach to the delivery of social care across the campus. Some residents were now benefitting from a new model of care, while the remaining residents continued to be in receipt of care that was task focused and reliant on centralised practices including activities support, meal preparation and laundry.

During the inspections, inspectors noted that not all residents had a comprehensive assessment of their personal and social care needs completed, despite the provider stating this had been done by December 2015. The assessments in place in one centre focused on residents' healthcare rather than social care, and continued to be nurse-led. Where residents had identified social goals that they wanted to achieve, these were for one-off activities rather than identifying plans to improve the overall quality of life for residents. In addition, as required by the regulations, the provider was not ensuring that records were being maintained of whether these goals were being achieved or how they were contributing to the overall improvement in quality of life for residents.

In some areas of the campus, inspectors noted a significant improvement had been made by the provider. Some residents were now benefitting from an increase in their social care support having moved from living in houses with many residents, into individualised social care-led accommodation on the campus. Inspectors noted that residents who still lived in multi-occupancy units continued to have less access to social care support.

In an action plan response to this issue, the provider stated that all of the remaining residential units in one of the centres would have the new model of social care by April 2017. The provider also planned to open a further unit on the campus to enable a further reduction in the number of residents living in some of the bungalows which had a lot of residents.

Announced, registration inspections May 2017

In Centre 3, inspectors noted that the provider had ensured that each resident now had a comprehensive assessment and a personal plan in place. These plans set out the goals and aspirations of each resident. However, inspectors noted that although plans were in place, there were many occasions where residents could not achieve their goals due to the shortage of available staff to support them or the shortage of available, suitable transport.

While each resident in Centre 3 had a comprehensive assessment of their social care needs completed, inspectors found that some residents had not had an annual review of their care and support needs, particularly where there had been a change in their needs.

While the provider had established a team of staff members to support residents in achieving their personal goals, due to staff absences in the centre, staff from this team were frequently deployed into other duties. This meant that residents' planned social care activities were being frequently cancelled. Inspectors noted that this had negatively impacted on residents who were spending extended periods of time in the centres with little or no alternative activities or engagement.

Some residents were assessed as requiring constant support and supervision. However, over the course of the May inspections these residents were being left alone on a number of occasions. For example, inspectors observed a resident who required constant support attempting to move around the centre and placing themselves at risk. This was immediately brought to the attention of the staff on duty.

Some residents lived alongside residents with high support needs. The staff in these houses did not have sufficient time available to them to meet the needs of all the residents.

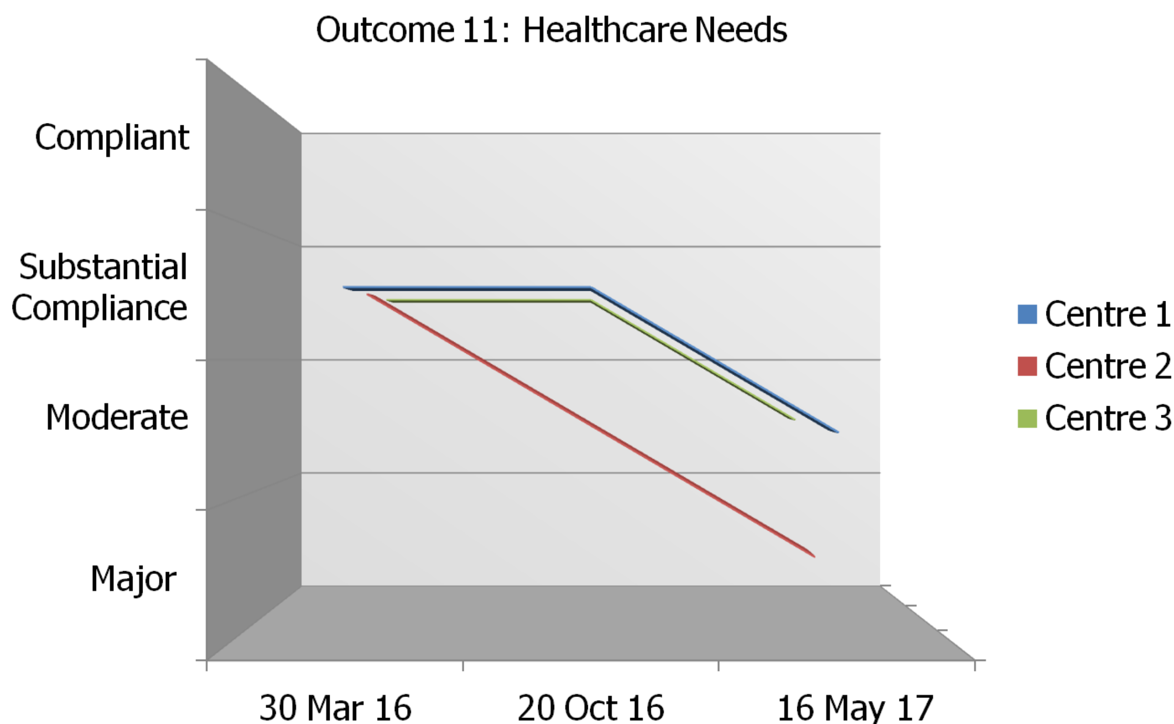
In the remaining two centres, inspectors found that the consistency of care to residents was being affected by the availability of suitably qualified staff. As a result, some residents were unable to take part in planned activities. Reviews of residents' social care goals had not been completed every year as required by the regulations, with some not having had a review since 2015. Where reviews had occurred, these

did not always include the input of the resident or their representative and did not include a review the effectiveness of the resident's current personal plan.

The quality of annual reviews was also identified by inspectors as an issue. Many of these did not include either the resident's or their representative's views. In addition, reviews did not include observations made by the multidisciplinary team or evaluate the effectiveness of the current personal plan. Transition plans for residents moving into the community were not being clearly articulated to residents or their relatives, and plans lacked detail on when and where the resident would be moving.

Inspectors found that no progress had been made on introducing a social care model to the remaining houses in the campus, as set out in the provider's action plan response to the previous inspection. As a result, residents living in those houses continued to experience institutional care, with centralised services provided in a task-oriented way. Access to social activities and the community remained limited.

3.7 Outcome 11: Healthcare needs



Overall judgment

While the inspectors found that in general, residents' healthcare needs on the campus were being met, there were occasions where the provider's failure to follow their own policies and procedures had led to poor outcomes for some residents, particularly in Centre 2.

Unannounced, full 18-outcome inspections October 2016

Overall, residents' healthcare needs were being met. There was evidence of good healthcare planning. However, some improvement was required to the implementation of some healthcare plans.

Residents had timely access to certain specialist services such as a speech and language therapist, psychologist, and occupational therapist. Inspectors found that where residents required specialist medical support, including with urgent care needs, this was provided in a timely manner.

While the majority of healthcare needs were being well managed, inspectors found examples where residents' needs were not being regularly reviewed following a change in their condition. For example, a resident had been admitted to hospital following a serious epileptic seizure but had not had their healthcare needs reviewed on return to the centre. Inspectors found that improvements were also required to the protocols used to guide therapeutic interventions, including the use of

nebulisers, oxygen and catheter care to ensure that temporary staff were given adequate guidance on the specific care needs of each resident.

The management of residents' nutritional needs in some parts of the campus was observed to be very good, with residents choosing and helping to prepare wholesome, home cooked meals. In other parts of the campus, residents were not provided with opportunities to be involved in the preparation of their meals and their meals were provided from a central kitchen. Inspectors noted that while these meals appeared nutritious, there was little access to snacks and alternative food choices if residents did not like the meal on offer. In addition, inspectors found that improvements were required to the availability of dietitian services for the campus.

Announced registration inspections May 2017

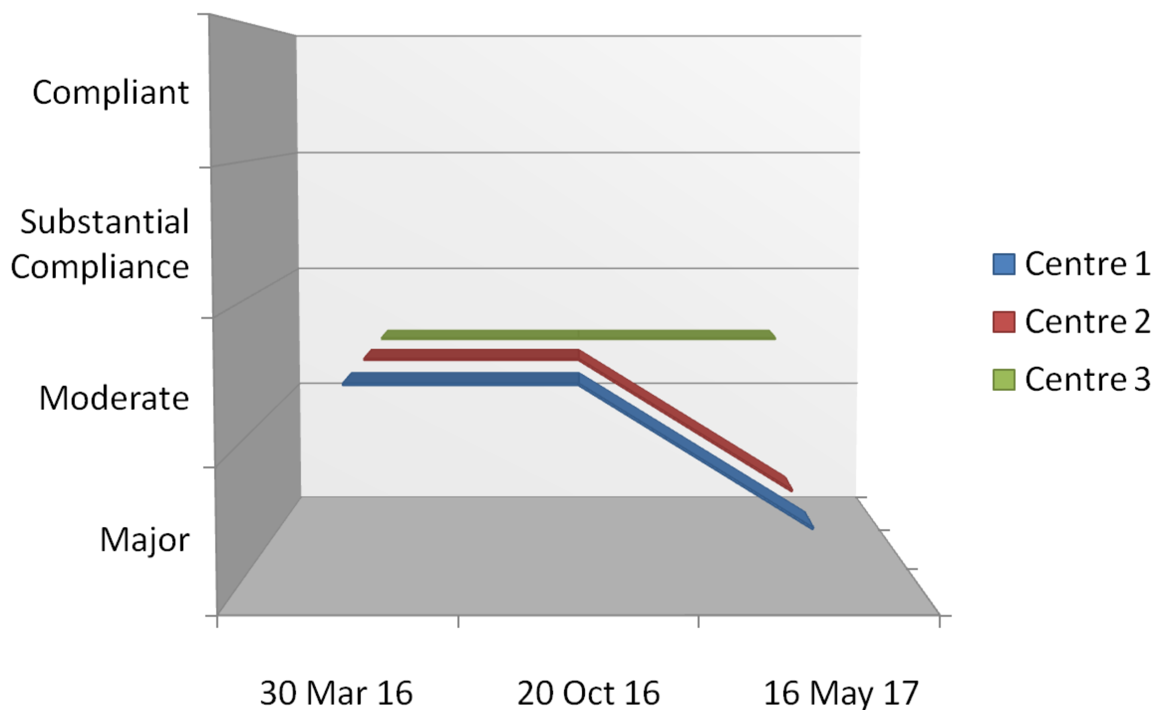
Inspectors found that there had been deterioration in the quality of healthcare provided to residents across the campus since the previous inspections. The provider had failed to ensure that access to a general practitioner (GP) was consistently available across the campus. For example, inspectors found that there was no GP cover every fourth week. During this week, residents who had healthcare needs could only access out-of-hours GP support or emergency treatment via the local hospital.

Inspectors found that care plans developed for residents with healthcare needs did not provide sufficient guidance to staff on how to support residents. This was particularly concerning given the reliance on temporary staff within the service. For example, inspectors identified a situation where staff in Áras Attracta had failed to develop a care plan for a resident with a serious healthcare need.

In addition, the provider had failed to ensure that the healthcare systems in place to support residents were effective. This led to a resident's planned surgical procedure being cancelled as the resident had not been given the prescribed care and medication required prior to attending hospital.

Across the campus, inspectors found that end-of-life care needed improvement to ensure that the spiritual needs and rights of residents was central to planning for a resident's end of life. One resident spoke with inspectors about their distress and anxiety about their end of life, as their spiritual needs and wishes were not being adequately addressed in the centre.

3.8 Outcome 1: Residents' rights, dignity and consultation



Overall judgment

Inspectors found that the provider had failed to ensure that the rights and dignity of residents were paramount in decisions made relevant to the quality of care and experience for people living within the centre.

HIQA found that the provider made decisions impacting on residents' personal finances on behalf of residents without consulting with them. In addition, where concerns about the experience of living in the centre had been raised by residents and their representatives, inspectors found no evidence to show the provider had appropriately investigated and responded to these cases.

Provider's action plan

In their submission to HIQA in October 2015, the provider set out their plans for improving the governance and management of the service. As part of that, the provider identified improved outcomes and quality of life for residents as a priority for the newly appointed management team. The actions that the provider identified to achieve this and to be completed by the end of 2016 included:

- Development of day service opportunities for residents.
- Improved access to advocacy services.
- Completion of individualised assessments of need.

- Provision of person-centred, individualised services.
- Improved complaints process to ensure that residents and their representatives were facilitated to make complaints and that all complaints were appropriately managed.

Unannounced inspections March and April 2016

Prior to these inspections, the provider had submitted findings from their own audit which included an action plan to improve the rights of residents and consultation arrangements. Inspectors undertook follow-up inspections in March and April 2016 to verify whether the provider's actions arising from these reviews were effective. On those inspections, inspectors found the actions being taken by the provider had improved the arrangements for a small proportion of residents to support their rights and to consult with them, and there were plans to extend those improvements to the rest of the residents on the campus.

Inspectors found that some residents had been moved from multi-occupancy accommodation to newly opened bungalows on the campus. In these and a small number of other units on the campus, inspectors found evidence of improved consultation and involvement of residents in the running of the centre. Residents had regular meetings, and they told inspectors that they were pleased with the new arrangements. These residents said they could make more decisions around their day-to-day living such as mealtimes, personal laundry and activities during the day.

However, there continued to be an institutionalised approach to care for most residents on the campus. These residents were not provided with opportunities for consultation or involvement in their daily routines, and inspectors found that their daily routines were being determined by staffing arrangements.

Inspectors found that there had been some improvements in arrangements to promote residents' privacy, particularly in shared bedrooms, but these continued to be insufficient. The provider had introduced screening curtains around beds in an effort to protect the privacy of residents. However, inspectors found that while these screens somewhat reduced the exposure of residents, they did not provide adequate privacy or cover for residents when they were receiving intimate care in shared bedrooms where other residents were present, and in some instances, where visitors were present.

The management of complaints was an area that the provider had identified for improvement in their October 2015 plan. On these inspections, inspectors found that there had been progress in improving the recording of complaints and there was evidence of complaints being discussed at staff meetings to inform learning.

Unannounced, full 18-outcome inspections October 2016

In October 2016, inspectors completed further inspections of each centre on the campus and found that the improvements previously noted in March and April 2016 had been sustained. However, little progress had been made in relation to extending these improvements to other residents on the campus.

In addition, inspectors found that while the complaints process was being implemented this needed to be improved to ensure that all complaints were being effectively resolved and responded to, in line with the provider's policy.

During the inspection, inspectors also noted that privacy screens in residents' bedrooms continued to offer limited privacy and this continued to negatively impact on the privacy and dignity of residents.

Announced, registration inspections May 2017

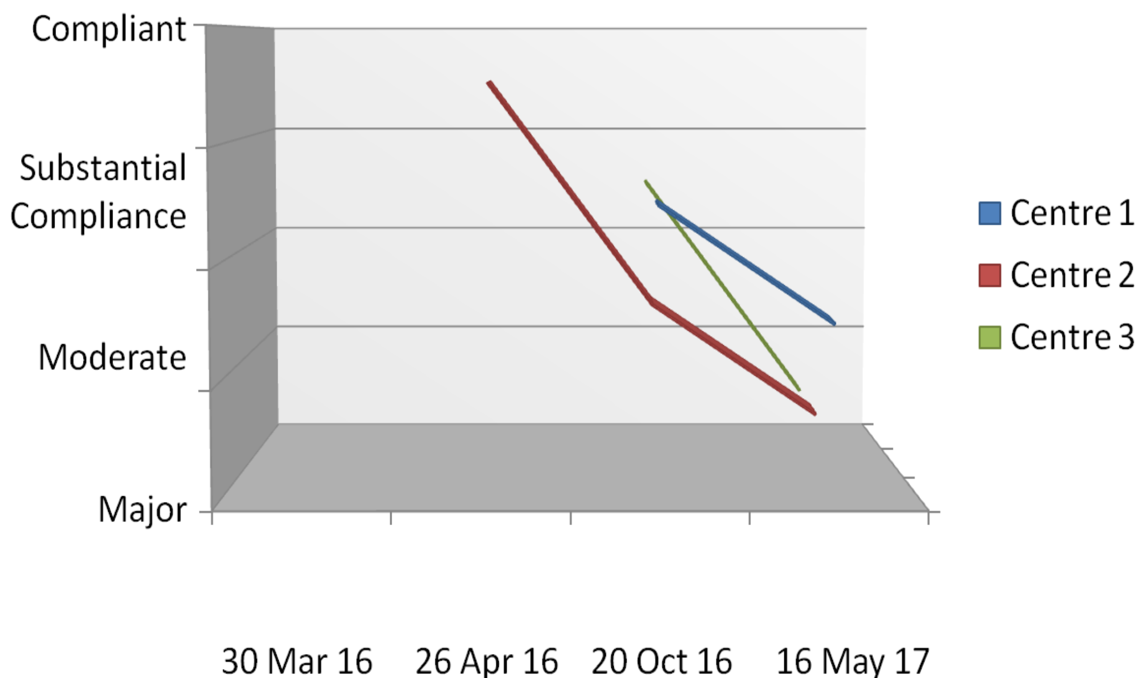
During these inspections, there was evidence that compliance against this outcome and the associated regulations had deteriorated in two of the three centres. Inspectors also found that the provider had failed to implement the actions required from the previous inspections which were continuing to have a negative impact on residents in all of the centres.

Inspectors found that the provider failed to effectively consult with residents, which was a fundamental breach of the regulations. For example, on a previous inspection the provider needed to complete assessments with some residents for the use of assistive technology. During this inspection, inspectors found that the provider was still failing to effectively complete these assessments, but had used approximately €9,000 of residents' personal money to purchase tablet computers. Inspectors found that each of these tablet computers had cost €433. Due to an absence of appropriate assessments, it could not be demonstrated that this type of assistive technology would benefit any of the residents or assist them to communicate. In addition, it was noted that the expenditure of residents' money to purchase these tablet computers had not been discussed appropriately with either the residents or their representatives.

Inspectors found that the management of complaints within the campus had deteriorated with many instances of verbal complaints not being responded to in line with the provider's policy and procedures. Further examples were found where the provider had failed to properly investigate and respond to written complaints made by residents' family members. In addition, where complaints had been responded to, inspectors found a continued failure by the provider to ensure that the outcomes of these complaints, any actions arising from these investigations and the satisfaction of the person who made the complaint were being appropriately recorded as required by the regulations.

The rights of some residents to exercise choice and control in their own lives was found to have been significantly impacted upon by the continued reliance on centralised and communal service provision in the campus. These residents were not consistently offered or supported to make individual choices about their living arrangements, laundry or the personalisation of their own bedrooms.

3.9 Outcome 6: Safe and suitable premises



Overall judgment

Inspectors found that the provider had failed to maintain the whole campus to a good state of repair. Inspectors found a significant number of areas requiring maintenance. During the most recent inspections in May 2017, staff reported that issues with the living environment were no longer being addressed through a routine and planned maintenance schedule.

In addition, where concerns about the quality of the environment had been identified by staff, there was no formal arrangement to record these, to risk assess their impact and to ensure that areas which had a significant risk impact were prioritised for resolution. As a result, the overall quality of the environment had deteriorated over the course of the two-year regulatory programme.

Unannounced, full 18-outcome inspections October 2016

While inspectors found that the environment was generally clean and suitably equipped to meet the needs of residents in October 2016, some minor improvement works were required across the campus. For example, in one unit the tiling in the kitchen had remained unfinished for a number of months. In another unit, inspectors

found that there was insufficient communal space for the number of residents living in the house.

Announced registration inspections May 2017

In May 2017, inspectors found that the lack of a routine programme of maintenance had contributed to deterioration in the overall quality of environment on the campus. Inspectors found a number of areas of dilapidation which had yet to be repaired. Staff told inspectors that while these had been reported they did not know when these repairs would be completed. This work included water damage to the ceiling tiles, missing doors in the kitchens and damage to worktops in kitchens. Externally, access areas were not being maintained clear from debris including moss, and gutters were blocked or leaking over emergency exits.

The provider told inspectors that all routine and planned maintenance schedules had been stopped and that they were now responding to repair work when requested. However, there was no mechanism in place which recorded all the maintenance requests in order to risk rate and prioritise them. In addition, there was no evidence that the provider was tracking the completion of these tasks or the time frames for completion.

Inspectors found that the provider had failed to implement the actions arising from the previous inspection and that the quality of the upkeep of the premises and gardens differed significantly across the campus. Some areas of the campus still had an institutional feel, with window panes in bedroom doors and kitchen areas enclosed in glass, and in some cases secured with lockable doors.

Inspectors noted that there was evidence of water damage to ceiling tiles in many areas of the campus, which had not been replaced. Inspectors found that the communal and private spaces in one centre were inadequate, with some residents sharing bedrooms which had been divided by portable screens. Inspectors also noted a significant number of broken wheelchairs were being stored in this centre. In some instances, inspectors found that residents had not been suitably assessed for assistive equipment. In other examples, where equipment had been provided, inspectors found that this was not being used as prescribed.

4. Conclusion

In October 2015, the Health Service Executive (HSE), the provider of Áras Attracta, submitted a three-year plan to the Chief Inspector of Social Services within HIQA identifying the planned changes and improvements they would make to service delivery to 'ensure that resident care, safety and outcomes are optimised [and] ensure an improved quality of life for all residents of Áras Attracta, creating a community based person centred model for the future'.

Over the course of the Chief Inspector's regulatory programme from 2015 to 2017, the provider of Áras Attracta had implemented a range of actions with the expressed objective of achieving improvements for residents. In doing so, the provider had invested significant additional resources in the context of governance, culture change, staffing levels, skill-mix, staff training and maintenance in the centres across the Áras Attracta campus.

Throughout this period, inspectors found that these actions had made improvements to the lives of some residents. However, the provider has failed to ensure that these actions were effectively improving the overall safety and quality of life for all residents living in Áras Attracta.

Across 14 inspections from July 2015 to May 2017, inspectors found consistent failure in the revised governance arrangements which should have, if effective, identified and appropriately addressed the institutional model of care, centralised care practices, safeguarding issues and lack of opportunities for residents' personal development and growth.

By May 2017, the provider had failed to progress their plan to transition residents to more appropriate, personalised, community-based accommodation. According to the HSE's improvement plan submitted to the Chief Inspector in October 2015, by the end of 2016, 27 residents should have been provided with community-based housing, with a further 26 being provided with community-based housing by the end of 2017. At the start of this regulatory programme in 2015 there were 89 residents living on the campus. By May 2017, there were still 86 residents living in Áras Attracta.

As a result of these significant regulatory non-compliances and the associated negative impact these were having on the quality and safety for residents living in Áras Attracta, on the 28 September 2017, the Chief Inspector issued the provider with notices of proposal to cancel the registration of each of the three designated centres in Áras Attracta. The provider was given 28 days to make written representations to the Office of Chief Inspector to inform a final decision about the registration of the centres.

On 31 October 2017, the provider submitted representation in response to the notices of proposal to cancel the registration of the centres, which set out the actions they had taken since the May 2017 inspection to achieve the delivery of a safer, better quality service for residents.

While the Chief Inspector has considered this representation and has sought further clarifications, unannounced inspections are being scheduled to verify whether the most recent actions are effectively improving life for all residents living on the campus and to inform the making of a final registration decision on the centres by February 2018.

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