

# What matters most

Report of the  
**Áras Attracta Swinford**  
Review Group

July 2016

Following the broadcast of the *Prime Time* programme 'Inside Bungalow 3' by RTE, the Áras Attracta Swinford Review Group was established by the Health Service Executive to undertake an independent review of the quality of care being provided in Áras Attracta. The findings of the Review Group are presented over a series of three reports.

***What matters most*** sets out the findings of the Review Group in relation to Áras Attracta itself. It includes recommendations relating to Áras Attracta management, actions for the HSE at a national level, and a 'road map' to guide all managers of congregated settings as they move towards decongregation.

***Time for action*** deals with the wider system of service provision for people with a disability, and proposes a range of actions including 55 priority actions that emerged from a national process of consultation with stakeholders involved in disability services and the wider public.

***Start listening to us*** is a documented record of the lived experiences of people with intellectual disability and how they perceive the support they receive.

# What matters most

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**Áras Attracta Swinford**  
Review Group

July 2016

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# Foreword

'Inside Bungalow 3', an RTE Investigations Unit programme shown on *Prime Time* on 9 December 2014 will leave a lasting and indelible impression on anyone who viewed it. The programme focused on a situation where some of the most vulnerable people in our society, seven women with intellectual and physical disabilities living in a congregated residential setting, Áras Attracta, run by the Health Service Executive (HSE), were subjected to abuse. The footage shown had been taken by an undercover reporter working for RTE who had posed as a student care worker, and who had placed a hidden camera in Bungalow 3 for a number of months.

Quite rightly public outcry ensued.

Everyone with an intellectual disability has the right to the same opportunities as anyone else to live a satisfying and valued life, and to be treated with dignity and respect. They should be able to live in a place they call home, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

As a society we are quite a long way from making that reality happen and for some years to come we may still be reliant on large institutional provision for care and support. Therefore, while making the simple vision outlined above a reality, we will need to ensure that all residents are treated with respect, dignity and compassion by staff who have the values, knowledge, skills and time to care for and support them.

One of the initiatives taken by the HSE following the showing of the programme was to establish this Review Group to undertake an independent review of the quality of care being provided in Áras Attracta.

Our approach to the task has been to put residents and their relatives at the centre of all of our activities. In this way we have brought a different perspective to assessing what matters most in respect of the quality of care and support that is being provided and what needs to be done to make things different and better for residents.

The report we have produced highlights the findings of the Review Group in relation to Áras Attracta itself. It identifies a number of key initiatives for the HSE to take in the wider intellectual disability sector in the coming twelve months. It also includes an action plan directed to managers of all congregated settings, identifying the steps needed to support a rights-based social model of service delivery, in compliance with national policy. These initiatives could enhance the lives of people with intellectual disabilities living in congregated settings in Ireland. They should also help to prevent situations such as those that took place in Áras Attracta occurring in the future.

The fallout from the screening of the RTE programme has been extensive for the people who live in Áras Attracta, their relatives, the staff and management, the HSE as nominated provider, and other agencies that have an involvement with the centre. Events have combined to create a situation of ongoing flux, change, fear and uncertainty for residents, their families, and staff alike.

This report is one of a series of reports produced by the Review Group. As part of our work we undertook a consultation exercise and have produced a report *Time for action* which sets out the responses to the questions and issues posed in the consultation. We also produced an 'easy read' version of the consultation paper and engaged Inclusion Ireland to organise and facilitate focus groups of self-advocates throughout the country. The outcome of these groups is contained in the report *Start listening to us*.

It is the hope of the Review Group that the impact of the events themselves, the work of the group and initiatives taken by the HSE will result in an improvement in the quality of life not only for the people living in Áras Attracta, but for others who live in congregated settings elsewhere.

There can be no doubt about the changes that are necessary.



Dr Kevin McCoy

## Aras Attracta Swinford Review Group Members

Dr Kevin McCoy, Child Care and Social Care Consultant, Chair

Deirdre Carroll, Independent Disability Policy Analyst

Ann Judge, Management and Organisation Development Consultant

Dr Bob McCormack, Service Quality Consultant

## Acknowledgements

The Review Group offers its sincere gratitude to those who participated in the review especially the residents and their relatives who contributed directly to this review and to them we are extremely grateful.

We would like to thank the management and staff of Áras Attracta who gave readily of their time to assist the work of the group members and its specialist consultants.

Thanks are also due to the general practitioners attached to the centre and the representatives of the following trade unions who met with the Review Group – IMPACT, SIPTU, PNA and TEEU.

We could not have completed our task without the assistance of the people listed below.

Specialist	Liz Chaloner *
Consultants	Bernard McDonald
	Paul White

Mr Stephen Biesty, HSE Senior Manager for the Review Group.

Ms Marian Cavanagh, HSE Support Officer for the Review Group.

Inclusion Ireland for organising the focus group, the output of which is included in Chapter 2.

The Team of POMS Assessors	Margaret Farrell, who coordinated the Survey
	Suzanne Bennett, Sunbeam House Services, Bray
	Nora Brosnan, Kerry Services, St. John of God Hospitaller Services
	John Farrelly, Dunshane Camphill Community
	Geraldyn Jackman, Cheshire Services, Tullow
	Michael Tiernan, Malta Services, Drogheda
	Sarah Walshe, Cheeverstown House Services, Dublin

The Advocates from the National Advocacy Services who undertook the 'Day in the Life Exercise'	Clare O'Neill, Senior Advocate
	Elaine Morris, Advocate
	Josephine Keaveney, Advocacy Service Manager, Western Region, National Advocacy Service for People with Disabilities.

Ms Ciara O'Halloran, MCO

Thanks are also due to Kaytlin Chaloner, Dr Lorna Day and Brigid O'Dea for their administrative assistance.

\* Liz Chaloner deserves special mention for her work in shaping up our approach to many important aspects of the review and for her skill and dedication in preparing our report for publication.

## NOTE

In carrying out this review in accordance with the Terms of Reference, the Review Group considered the operation of the bungalows and units at Áras Attracta at the latter end of 2015.

The Review Group wanted to learn directly from the residents, their relatives and staff at Áras Attracta about their experiences of living and working in Áras Attracta.

To do this, the Review Group undertook a number of internationally recognised exercises designed to ascertain the views of residents, relatives and staff about the quality of care being provided in Áras Attracta. These included meetings with groups of residents, relatives and staff which were followed up with questionnaires issued to relatives and staff (completed anonymously).

In addition, the Review Group commissioned advocates to look at 'A Day in the Life' of three residents. The Review Group also commissioned an examination of the Quality of Life of a sample of 21 residents drawn from the total cohort of residents.

This report reflects the comments and observations made by those residents, relatives and staff in relation to their own experiences and therefore such comments and observations do not and cannot apply to all staff.



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# A

## INTRODUCTORY

**Chapter 1: Background to the Áras Attracta review** sets the context for the work of the Review Group. It includes:

- ▶ A short overview of the context within which the Review Group was appointed and an outline of its key objectives.
- ▶ Some background on Áras Attracta and its residents – where they came from and a gender and age profile.
- ▶ Some details of the legislative and policy background.
- ▶ Details of some important local factors that influenced the work of the Review Group.
- ▶ A description of how the Review Group approached its task.



# 1

## Background to the Áras Attracta review

Following the broadcast of the RTÉ *Prime Time Investigates* programme 'Inside Bungalow 3' in December 2014, the HSE commissioned an independent review of the quality of care at Áras Attracta. The **Áras Attracta Swinford Review Group** was appointed within a month of the broadcast of 'Inside Bungalow 3', and its terms of reference were agreed on 7 January 2015 – see Appendix A1.

The Áras Attracta Swinford Review Group consists of specialists in the fields of intellectual disability, the protection of vulnerable people, and change management; and the group was supported by people with expertise in the areas of disability, ageing, and social research. The key objectives of the Review Group in carrying out our work were:

- ▶ To review the programme of work already under way at Áras Attracta on foot of reports from HIQA and the HSE, to establish the effectiveness of this work, to identify any gaps in service, and to make recommendations for further service improvements.
- ▶ To identify any issues of immediate concern in relation to the care and safety of the residents, and to bring these to the attention of the HSE.
- ▶ To identify any factors that might have caused or contributed to the events shown in the *Prime Time* programme.
- ▶ To recommend actions to reduce or eliminate the risk of events such as those shown in the *Prime Time* programme happening again.
- ▶ To recommend actions to ensure that the learning from the Review Group is reflected and promoted throughout the residential care sector.

### 1.1 About Áras Attracta

Áras Attracta is a HSE-run residential centre located in Swinford, a small rural town in Co. Mayo. At the beginning of this review there were 96 men and women with intellectual disabilities living in Áras Attracta. It is located on a 13 hectare site and comprises 29 buildings, including 16 bungalows ranging from 200 to 400 square metres in size, an administration block and a suite of offices, training rooms, a swimming pool and gym, a Snoezelen, a prayer room, a day centre, a canteen, and lots of open space. Over 300 people work at Áras Attracta, including nurses, health and social care assistants, social care workers, allied health professionals, administrative staff, service staff, and others. A number of contracts for service also exist – for example, cleaning, catering, transport, security, hairdressing and laundry (except personal laundry).

See chapter 8 for more detailed information about Áras Attracta.

## Where residents came from

Opened in 1988, Áras Attracta was a specially designed campus-style facility developed to look after adults with intellectual disabilities. Approximately a third of residents previously resided in their own homes, about a third were transferred from St Mary's Psychiatric Hospital in Castlebar, and roughly a third came from other institutions, residential centres or psychiatric hospitals.

**Table 1.1** Place of residence of current residents prior to transfer to Áras Attracta

Place of residence prior to transfer to Áras Attracta	Number of residents
Their own home	30
St Mary's Hospital Castlebar	31
St Mary's Drumcar	7
Brothers of Charity	6
Other	22

## When residents arrived

Roughly two thirds of the current Áras Attracta residents arrived before 1993. The largest intake was in 1992 following the closure of St Mary's Castlebar. Only one or two new residents have arrived in most years since 1992.

**Table 1.2** Year of arrival of residents at Áras Attracta

Year of arrival	Number of residents
1988–1992	34
1992	31
1993 to date	31

## Gender of residents

Men make up 62 per cent and women make up 38 per cent of residents.

## Age profile of residents

Many of the people living in Áras Attracta are now older people, with more than half being over 60.

**Table 1.3** Age range of residents in Áras Attracta

Age range	Number of residents
30–39	4
40–49	14
50–59	28
60–69	32
70–79	15
80–89	3

## 1.2 Legislative and policy context

The legislative framework, policy context and general thinking about the care and support of people with intellectual disabilities has changed since Áras Attracta was established in the late 1980s.<sup>1</sup> Even at that time, questions were beginning to be raised internationally as to whether ‘congregated settings’ were the best place for people with disabilities to live,<sup>2</sup> with increasing emphasis being placed on community inclusion for people with disabilities.<sup>3</sup>

A summary of key reports, legislation, strategies and policies relating to people with disabilities is outlined below, together with some recent changes relevant both to the lives of people with disabilities, and the work of the Review Group itself.

**Table 1.4** Summary of key reports, legislation, strategies and policies

<p><b>1996: important reports on disability services</b></p>	<p>The Commission on the Status of People with Disabilities published <i>A Strategy for Equality: Report of the Commission of the Status of People with Disabilities</i> which argued for legislative change and a recommendation to redesign all disability services to enable provision ‘in the mainstream’.</p> <p>Also in 1996 came the publication of <i>Towards an independent future</i>, the report of the Review Group on Health and Social Services for People with Physical and Sensory Disabilities. This had the stated aim ‘to enable people with physical and sensory disability to live as independently as possible in the community’.<sup>4</sup></p> <p>One of the outcomes of these reports was the establishment of the National Intellectual Disability Database (NIDD) and the National Physical and Sensory Disability Database (NPSDD), which were designed to collect data which could assist the planning of services.</p>
<p><b>Education Act 1998</b></p>	<p>The Education Act 1998 provides for the education of every person in the state including any person with a disability or special education need.</p>
<p><b>Health Act 2004</b></p>	<p>This Act established the Health Service Executive (HSE) as the body responsible for the provision of health care services in this state. The <i>Health Act 2004</i> requires the HSE to ‘use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public’.</p>

<sup>1</sup> For a fuller description of the historical perspective see McCormack, B., 2004. Trends in the development of Irish disability services. In Walsh, P.N. and Gash, H. eds., 2004. *Lives and times: practice, policy and people with disabilities*. Bray, Co. Wicklow: Rathdown Press.

<sup>2</sup> A congregated setting is one where ‘ten or more people with disabilities live together or in close proximity’ (HSE, 2011, *Time to move on from congregated settings: a strategy for community inclusion*, p.25).

<sup>3</sup> HSE, 2011. *Time to move on from congregated settings: a strategy for community inclusion*, p10.

<sup>4</sup> Costello, L. and Cox, W., 2013. *Living in the community: services and supports for people with disabilities*. Dublin: Disability Federation of Ireland, p.18.

<b>National Disability Strategy, 2004</b>	<p>The <i>National Disability Strategy</i> was launched in 2004 to underpin the participation of people with disabilities within Irish society. The strategy built on existing policy and legislation, including the policy of mainstreaming public services for people with disabilities. It comprised three key elements:</p> <ul style="list-style-type: none"> <li>▶ The <i>Disability Act 2005</i> – Part 3 of which required six Government departments to prepare sectoral plans; and Part 5 provided for a statutory target for the recruitment and employment of people with disabilities in the public sector.</li> <li>▶ The <i>Education for Persons with Special Educational Needs Act 2004</i>.</li> <li>▶ The <i>Citizens Information Act 2007</i>.</li> </ul> <p>The strategy was endorsed in the subsequent partnership framework, <i>Towards 2016</i> (see below).</p>
<b>Equality Act 2004</b>	<p>The <i>Equality Act 2004</i> prohibits discrimination, harassment and victimisation on eleven grounds, including disability and age.</p>
<b>Education for Persons with Special Educational Needs Act 2004</b>	<p>The <i>Education for Persons with Special Educational Needs Act 2004</i> provides for the provision of education plans in an inclusive environment for students with special educational needs.</p>
<b>Disability Act 2005</b>	<p>The <i>Disability Act 2005</i> supports the provision of disability-specific services and improved access to mainstream public services through a range of measures.</p>
<b>Towards 2016 (published in 2006)</b>	<p><i>Towards 2016</i>, published in 2006, was a ten-year strategy agreed within the (former) Social Partnership Framework which envisioned that people with disabilities have, 'to the greatest extent possible, the opportunity to live a full life with their families and as part of their local community, free from discrimination'.<sup>5</sup> A 'life cycle' framework for health and social services was adopted and it was envisaged that every person with a disability would:</p> <ul style="list-style-type: none"> <li>▶ Have sufficient income to sustain an acceptable standard of living.</li> <li>▶ Have access to appropriate care, health, education, employment and training, and social services.</li> <li>▶ Have access to public spaces, buildings, transport, information, advocacy and other public services, and housing.</li> <li>▶ Be supported to enable them, as far as possible, to lead full and independent lives, to participate in work and in society, and to maximise their potential.</li> </ul> <p>It was also envisaged that carers of persons with a disability would be acknowledged and supported in their caring role.</p>
<b>Citizens Information Act 2007</b>	<p>The <i>Citizens Information Act 2007</i> established the Citizens Information Board and provided for the development of a personal advocacy service for people with disabilities, which became the National Advocacy Service in 2011.</p>

<sup>5</sup> Department of An Taoiseach, 2006. *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015*.



<p><b>United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), 2006</b></p>	<p>The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was adopted in December 2006 and has since been ratified by 156 countries. Ireland is a signatory to the UNCRPD, but has not yet ratified it because of legislative obstacles which are currently being addressed.</p> <p>States that ratify the Convention undertake to ensure and promote the human rights of people with disabilities without discrimination. The guiding principles underpinning the UNCRPD are:</p> <ul style="list-style-type: none"> <li><b>a.</b> Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of person.</li> <li><b>b.</b> Non-discrimination.</li> <li><b>c.</b> Full and effective participation and inclusion in society.</li> <li><b>d.</b> Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.</li> <li><b>e.</b> Equality of opportunity.</li> <li><b>f.</b> Accessibility.</li> <li><b>g.</b> Equality between men and women.</li> <li><b>h.</b> Respect for the evolving capacities of children with disabilities to preserve their identities.</li> </ul>
<p><b><i>Time to move on from congregated settings – a strategy for community inclusion</i> (HSE, 2011)</b></p>	<p>The UNCRPD addresses the issue of the equal right of all persons with disabilities to live independently in the community, with choices equal to others, and to be included in the community.</p> <p><i>‘States Parties to this Convention recognise the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community ...’ (Article 19 of UNCRPD).</i></p>
<p><b><i>National housing strategy for people with a disability 2011–2016</i> (Dept of the Environment, Community and Local Government, 2011)</b></p>	<p>The key principle of the HSE’s <i>Time to move on</i> report is that all housing arrangements for people moving from congregated settings should be in ordinary neighbourhoods in the community with individualised supports tailored to meet the residents’ particular needs and wishes.</p> <p>As part of the implementation of this strategy, €1 million euro was transferred to the Department of the Environment, Community and Local Government (DCELG) from the Department of Health in 2013–2014 to provide housing for up to 150 people leaving disability or mental health institutions. In 2015, a further €1 million was allocated to DCELG to continue this process.<sup>6</sup></p> <p>The vision outlined in the <i>National Housing Strategy for People with a Disability</i> is that people with disabilities will be facilitated to access ‘the appropriate range of housing and related support services, delivered in an integrated and sustainable manner, which promotes equality of opportunity, individual choice and independent living’ (p.7).</p> <p>The strategy cites international research which consistently points to the better quality of life that people with disabilities enjoy in community settings compared with those living in institutional care (p.125).</p>

<sup>6</sup> Houses of the Oireachtas, 16 July 2015, Written answer 537 to question 29994/15

<p><b><i>New directions – review of HSE day services and implementation plan 2012–2016 (HSE, 2012)</i></b></p>	<p><i>New directions</i> is the HSE's national guidance framework for day programmes of personal support services for adults with disabilities. It proposes the development of a person-centred individualised planning approach within a quality assurance framework. The focus is on the enhancement of the capacity of people and recognition of the diversity of their needs – with a view to delivering better outcomes and better value for money.</p>
<p><b><i>Transforming lives (Dept. of Health, 2012)</i></b></p>	<p><i>Transforming lives</i> is the programme to implement recommendations of the <i>Value for money and policy review of disability services in Ireland</i> (Department of Health, 2012). The key message from the review was the necessity to move from group-based service delivery towards a model of person-centred and individually chosen supports.</p> <p>As part of the evaluation, an Expert Reference Group on Disability Policy was established to conduct a policy review, and from this Group's public consultation on existing services what emerged was that people wanted 'flexible supports to suit individual needs, to use local services, do ordinary things in ordinary places, with more opportunities for families to play their part in supporting their family members'. On reviewing existing services the Expert Group found little evidence of individual service provision; instead they found that there was a lack of standardised needs assessment, and that provision was largely based in groups.</p>
<p><b><i>HIQA's enhanced role from November 2013</i></b></p>	<p>From November 2013 the Health Information and Quality Authority (HIQA) became responsible (under the Health Act 2007) for the regulation of all residential and residential respite services for children and adults with disabilities, including those provided by the HSE, by private organisations and by voluntary bodies.</p> <p>This was the first time that all such services were subject to independent scrutiny.</p>
<p><b><i>Safeguarding vulnerable persons at risk of abuse – national policy and procedures (HSE, 2014)</i></b></p>	<p><i>Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures</i> is a statement of the HSE's policy and is currently being rolled out throughout the country with a programme of training for staff involved in the support of vulnerable adults. It is at the early stages of its roll-out, and its full effect has yet to be realised. It was due for review at the end of 2015.</p>
<p><b><i>Appointment of Confidential Recipient</i></b></p>	<p>In December 2014, the HSE appointed a Confidential Recipient to whom anyone can in good faith address concerns and allegations of abuse, negligence, mistreatment or poor care practices in HSE or HSE-funded residential care facilities in good faith.<sup>7</sup> The Confidential Recipient's role is to advise and assist patients, service users, families, and other concerned individuals and staff members on the best course of action to take to raise matters of concern, to assist with the referral and examination of concerns, and to ensure that these matters are appropriately addressed by the HSE and its funded agencies.</p>

<p><b>HSE National Service Plan 2015</b></p>	<p>In its <i>National Service Plan 2015</i> (pp 51–5), the HSE sets out its intention to ensure service improvement and to place quality and patient safety at the heart of health service delivery. It underlines the critical importance of good governance and the need for continual enhancement of accountability arrangements. It outlines its plans for putting in place a new accountability framework in 2015 which makes explicit the responsibility of all managers to deliver on the targets set out in the <i>Service Plan</i> within the context of formal performance agreements.</p> <p>In relation to services for people with disabilities, it identifies both the implementation of the Department of Health’s <i>Value for Money and Policy Review</i>, and enabling people to move from congregated settings, as service priorities. It aims to work towards the transition of up to 150 people from congregated settings to homes in the community in line with the <i>Time to Move on from Congregated Settings</i> report (p53).</p> <p>It aims to support people with disabilities in line with the vision of the <i>Value for Money and Policy Review</i>. This includes the principles of a person-centred model of services and supports; involvement and participation of people with disabilities in service design and delivery; enabling people with disabilities to achieve their full potential, including living as independently as possible and achieving optimal independence and control of their lives; and enabling people with disabilities to pursue activities and living arrangements of their choice.</p>
<p><b>Building a high quality health service for a healthier Ireland – Health Service Executive corporate plan 2015-2017 (HSE, 2015)</b></p>	<p>In March 2015, the HSE launched its corporate plan for 2015–17, <i>Building a high quality health service for a healthier Ireland</i>, setting out how the HSE aims to improve the health service over the next three years. One of the plan’s goals is to deliver person-centred community-based services that support choice and independence for older people and people with disabilities. The success of this will be measured by ‘less people with a disability living in congregated group residential settings’ (p.7).<sup>8</sup></p>
<p><b>Assisted Decision-Making (Capacity) Act 2015</b></p>	<p>The <i>Assisted Decision-Making (Capacity) Act 2015</i> was signed into Irish law in December 2015, repealing the <i>Lunacy Regulation Act 1871</i> and the <i>Marriage of Lunatics Act 1811</i>. The new Act will result in significant changes in the lives of people with intellectual disabilities, as their ability to make decisions for themselves where possible, will be enshrined in law.</p> <p>Enactment of this law also removes a barrier to Ireland’s ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)</p>

### 1.3 The local context in 2015

In addition to the policy and legislative landscape described above, a number of other important local factors influenced the conduct of the work of the Review Group.

- ▶ At the time the Review Group embarked on its work, An Garda Síochána was still in the process of undertaking its investigations. For that reason and for fear of evidence contamination, the Review Group could not visit Áras Attracta until early February 2015.

<sup>8</sup> See <<http://hse.ie/eng/services/corporateplan20152017>>

- ▶ Changes in personnel at senior management level in Áras Attracta had resulted in an interim arrangement whereby the acting person in charge was on secondment from another service for a defined period which ended in May 2015. A new Person in Charge/Director of Services subsequently took up post in mid-July 2015.
- ▶ When the Review Group started its work, Áras Attracta was regarded as one single centre; however, during 2015 it was reorganised into three designated centres:
  - Centre 1 provides services to residents with intellectual disability with complex health needs and high physical dependency
  - Centre 2 supports residents with intellectual disability and behaviours that challenge
  - Centre 3 provides support to residents with intellectual disability and medium levels of dependency.
- ▶ Resulting from the reorganisation of the large centre into three smaller ones, three new nurse managers were recruited at Clinical Nurse Manager level 3 to manage the newly configured centres. These new members of staff took up their posts in autumn 2015.
- ▶ During the course of 2015, HIQA had carried out a further five inspections in Áras Attracta, some announced and some unannounced. One of these inspections led to a Notice of Proposal to Cancel Registration in August 2015 unless immediate changes were made.
- ▶ Changes have also taken place in the HSE at management level, with the introduction of the new Chief Officer post. This post covers the counties of Galway, Mayo and Roscommon, and carries responsibility for facilities such as Áras Attracta.
- ▶ During the course of 2015, a substantial staff training programme was initiated in Áras Attracta covering topics such as adult protection and managing behaviours that challenge.
- ▶ The American Association of Intellectual and Developmental Disabilities (AAIDD) was commissioned by the HSE to undertake an assessment of the support needs of all individuals in Áras Attracta; it carried out this work in November and December 2015.
- ▶ A Family Forum was developed in collaboration with Inclusion Ireland in September 2015. It is chaired by a family member and will play an important part in the advocacy support for families and residents..

All of the events and changes outlined above have combined to create a situation of on-going flux, change, and a degree of uncertainty for residents, relatives, and staff alike. In addition they impacted on the work of the Review Group, as the context for our work was constantly changing. “ Overall, much of the change taking place has created a good foundation for developments for all involved in Áras Attracta.

The Review Group acknowledges that our work impacted on this changing environment and placed some extra demands on residents, their relatives, and staff.

## 1.4 The Review Group's approach

As a Review Group, we had a clear vision in conducting our work. We took a person-centred approach that looked at the service from the perspective of the people who live there. This principle guided how we consulted with residents, explained their day-to-day lives and measured their quality of life. It also guided how we reviewed the practices and procedures in all bungalows and units.

Throughout the report we have used the term 'resident' to refer to the people living in Áras Attracta, though we do not see this term applying as people move into community settings.

The approach of the Review Group was underpinned by the following further principles:

- ▶ The right of the residents, families, staff, and managers to be treated with respect and courtesy.
- ▶ The right of residents to privacy and confidentiality (unless a person's safety is in jeopardy).
- ▶ The right of each resident to be appreciated as a unique and valued person.
- ▶ The right of every person to due process, and natural and constitutional justice.

We took a range of approaches to ensure that we could meet our key objectives. These are summarised here and are more fully detailed in later chapters.

### Reviewing work already under way

At the time the Review Group began its work, Áras Attracta had already been the subject of a substantial number of audits and reviews, of internal and external inspections, and also of a number of HIQA inspections. All of these had resulted in many recommendations.

We decided to analyse all of these recommendations up to the cut-off point of January 2015, and issued a management review questionnaire to both the senior management of the centre (as it was at that time), and the nurse manager of each bungalow and unit.

This management review questionnaire was reissued some six months later to afford senior management and staff the opportunity to indicate any changes or improvements that had taken place in the intervening period. However, in light of staff changes the two sets of management review questionnaires were not truly comparable. See chapter 9 for a summary of the findings of the two management review questionnaires issued to senior management and local managers.

### Identifying issues of immediate concern

The Review Group maintained communication with the HSE throughout the period of the review and areas of concern were brought to the HSE's attention as appropriate. For example, it emerged in the course of the review that no person-centred assessments had been carried out for

residents for quite a long time,<sup>8</sup> and that there was a need to develop a rights-based/social model for the support of all residents. The Review Group is aware that individual assessments of all residents in Áras Attracta were completed in December 2015 and inform the individual care plans for all residents.

In addition to recommending the assessment of each resident, the Review Group recommended that the governance of the service should be strengthened by two short-term appointments to facilitate the transfer of residents to community settings. These were to form a new Innovative Community Settings Transfer Unit. The Review Group is aware that transition coordinators are now in place, engaging with all stakeholders in order to progress transition to community living.

A staff member raised a number of historical concerns which were referred to senior management in Áras Attracta to ensure that the issues causing concern were not evident in the current services. The Review Group was assured that monitoring arrangements have been put in place in relation to this.

We also recommended the establishment of a Strategic Advisory Group for Áras Attracta whose role would be to:

- ▶ Take a long-term view of the support needs of all residents and put appropriate plans in place.
- ▶ Provide strategic vision and a guiding framework for the development of services in the community.
- ▶ Provide advisory support to the management team.
- ▶ Ensure integration with national policies and funding opportunities.

The proposed composition of the Group was:

1. An independent industry/commerce representative with change management experience (Chair).
2. The Head of Social Care, CHO Area.
3. A HSE Representative.
4. Non-HSE Task Force members (two). The HSE accepted this recommendation and a Strategic Advisory Group consisting of a small senior group of experts has been established to support the implementation of the change programme.

## Identifying causal and contributory factors

In seeking to identify what were the key factors that might have caused or contributed to the events shown in the *Prime Time* programme we took a number of approaches, including:

- ▶ Consultations with residents – see chapter 2.
- ▶ A study of ‘a day in the life’ of three residents – see chapter 3.
- ▶ A survey of the quality of life of a representative sample of residents – see chapter 4.

<sup>8</sup> The HSE has since ensured the comprehensive assessment for every resident using the Supports Intensity Scale (SIS-A™), an assessment tool that evaluates the practical requirements of a person with an intellectual disability.

- ▶ Group consultations and some private interviews with relatives, followed by an anonymous questionnaire – see chapter 5.
- ▶ Group consultations with a number of staff members, followed by an anonymous questionnaire – see chapter 6.
- ▶ A management review questionnaire for senior management and local managers – see chapter 7.
- ▶ A person-focused assurance framework that we used to present a profile of Áras Attracta and to explore its organisational and management supports and practices across three broad thematic areas – see chapters 8 and 9.

## Testing our results

Having completed the tasks and activities outlined above, the Review Group invited residents, relatives, staff and management to meetings to receive feedback on the outcome of our work. This feedback was provided in Áras Attracta over a two-day period at which reports from the activities undertaken were presented by members of the Group and by the specialist consultants. On completion of the presentations there was time set aside for discussion. The purpose of this was to seek to eliminate any errors or omissions in our assessment and findings regarding the quality of care and support being provided to residents. Another reason for adopting this approach was to give all participants an early indication of the contents of the report which was to be produced.

## Actions to reduce or eliminate risk

In the course of our work, we identified a range of deficits in Áras Attracta, and these are highlighted in chapter 10 – this sets out the actions required to reduce the risk of abuse occurring.

## Identification of key initiatives

The Áras Attracta Swinford Review Group has identified thirteen key initiatives that it recommends the HSE take in the coming twelve months to improve the quality of lives of people living in congregated settings in Ireland. We have also developed an action plan for all congregated settings to help ensure that individuals live in appropriate settings in the community. These are outlined in chapter 10.





# B

## PERSPECTIVES: RESIDENTS

As a Review Group, we listened to and sought the views of the people who know most about life in Áras Attracta: the residents.

**Chapter 2: What Áras Attracta residents told us** describes the outcomes of meetings we had with some Áras Attracta residents. These included:

- ▶ Meetings held at Áras Attracta
- ▶ A meeting facilitated by Inclusion Ireland

**Chapter 3: A day in the life of three residents of Áras Attracta** describes the daily routine of three residents. Our main purpose here was to try to come to an understanding of the day-to-day realities of life at the centre.

**Chapter 4: Measuring the quality of life in Áras Attracta** presents the findings of an independent survey that sought to measure the quality of life of residents in a systematic way. In arriving at its assessment, the study takes into account 23 separate personal outcome measures.



# 2

## What Áras Attracta residents told us

The Review Group met with or heard from a wide range of stakeholders including staff, relatives and advocates during the course of our work. However, from the start we wanted to hear from those who lived in Áras Attracta – about their lives, about their day-to-day living experience, and about what they thought would make their lives in Áras Attracta better.

People with intellectual disabilities are seldom asked for their views or given opportunities to make basic life choices that the rest of the population take for granted.

*Where do I want to live?*

*Who do I want to live with?*

*What do I like to do with my day?*

*What are my hopes and dreams for the future?*

It is frequently assumed that other people know best – staff, families, professionals; or that the person does not have the capacity to make such choices or to communicate these for themselves.

It was therefore central to the approach of the Review Group to listen to the views of the residents about what they thought about their circumstances, and what changes they would like to see.

We listened to the views of residents in two different ways in two different forums. The first sessions were undertaken early on in the course of our work and were conducted by members of the Review Group in a venue in Áras Attracta itself. Some six months later, a second discussion forum of residents from Áras Attracta was facilitated by Inclusion Ireland at an external location, as part of the wider consultation process commissioned by the Review Group.

The two sets of consultations are outlined below.

### 2.1 Meetings held in Áras Attracta

All residents were invited to meet with members of the Review Group. Three meetings were held in March 2015 in training rooms located in the administration block of Áras Attracta. Staff were informed and encouraged to facilitate residents to attend. An 'easy read' poster with pictures was put up in all bungalows and in communal places advertising the meetings and their purpose.

Nineteen residents and six day service users attended the meetings and one resident spoke to a Review Group member privately. For some residents, it was their first time in these training rooms. Some attended more than one meeting, most of those at the meetings spoke, but some just listened. Staff did not attend the meetings, apart from one healthcare assistant who was present to assist with the needs of a resident.

The meetings were informal and relaxed and the discussion covered the following topics:

- ▶ What do you like about Áras Attracta?
- ▶ What do you not like about Áras Attracta?
- ▶ Do you feel safe?
- ▶ What contact do you have with family/relatives?
- ▶ What activities are you involved in?
- ▶ What changes would you like?

## About living in Áras Attracta

Some of the residents were aware of the public outcry following the revelations on the RTE *Prime Time* programme and were sad about it, but the general view was that they were happy living in Áras Attracta, and for many it was their home for years. They liked the staff and saw them as kind, helpful and ready to sort out problems for them. The comments of residents about living in Áras Attracta were mainly positive, although two residents who came to the meetings had hopes of moving out.

*Bungalow X is nice and quiet. There are only six people. There are enough people in the house. Some people need lots of help in my bungalow.*

*I like it here; we went to town today; we were at a meeting today; the advocacy group meets every six weeks; four or five of us go.*

*It's very quiet; I like the peace and quiet; there are seven or eight in a bungalow.*

*I like it here in Bungalow X ... the place was hard to get used to but after nine years I'm used to it now. I like the people and the staff. Seven or eight live in the bungalow; I think there's enough in it now.*

*I'd like to go and live in (named place) with my family.*

There was quite a variation in the number of residents sharing their homes:

*There are ten people living in some bungalows.*

*There are six in my bungalow.*

*There are four in other houses.*

*I get on great with them.*

*People in most houses are good.*

*I have been around different bungalows; why did they close the bungalows? The heating broke down but it is fixed now.*

One person said she did not like one of the other residents living in her house

*He shouts an odd time.*

## About the staff

Comments about the staff were almost all positive, and residents felt supported by them.

*I like all staff in the bungalow.*

*Staff are very nice.*

*They sort out problems for you.*

*They're good to me. They help me to count money so that I can move out (to a house in the community). They help me with cooking. They're trying their best.*

One resident commented that her bed is made for her every day, but stated that she could make her own bed.

## Most residents feel safe

Despite the recent attention and focus on abuse, the residents said they felt safe and that they would tell a staff member if anything bad happened to them.

*I feel safe living here.*

*I tell staff if someone pushed me.*

One resident reported being bullied and being hit by another person, but informed us this was sorted out by staff. Another resident reported she did not like all the moving from bungalow to bungalow. And another did not like the noise in the bungalow.

*I live in Bungalow X. I didn't like all the change and moving around bungalows.*

*I don't want any more change.*

## Contact with families

Those residents who had families valued and looked forward to their contact. Residents had varying contact with their families. Some went home at weekends or on monthly visits, and some saw their families less often. One never went home. Family members also visited some residents in Áras Attracta.

*I don't go home.*

Two residents said that they had boyfriends, and were both very happy about this. One says she goes for a walk around the block and they 'have a nice chat'. The other said she meets her boyfriend at the 'workshop'.

## How residents spend their time

The topic that most interested the residents and day attendees and generated most discussion was their activities and how they spent their time. They liked going out of the centre for shopping, and going on trips.

Meetings with the Roscommon Advocacy Group were mentioned along with the Special Olympics. Horse riding, pottery and trips to the cinema were mentioned in so far as they used to be on offer, but are no longer available.

*A (member of staff) used to bring us to the cinema, but not any more.*

Swimming, bowling and football were all popular activities. Residents wanted a lot more of these.

*Nobody went out yesterday.*

*I would like to do more visiting with my family.*

*Staff could take us on more trips out especially shopping.*

Residents had little to say about what changes they would like to see, apart from going out more often, having more money, and seeing more of their family. Only two spoke of leaving Áras Attracta – one to live with family, another to live in the community. There was no mention of education, work or learning new skills.

Residents had few hopes or aspirations for the future. Their horizons were limited to what they knew, although two residents said they would like to go on holidays to Spain.

## 2.2 Meeting of residents facilitated by Inclusion Ireland

The second consultation meeting was held at the end of October 2015 at a location away from Áras Attracta. It was conducted as part of the wider consultation process initiated by the Review Group, and was one in a series of meetings facilitated by Inclusion Ireland that focused on key questions in relation to practice, policy, legislation and reform. An 'easy read' version of the consultation document was made available to the participants. Some of the questions were quite general in nature. Most comments made by residents, however, were based on their direct experience of living in Áras Attracta.

Eleven residents from Áras Attracta attended most of the session, and two support staff were present in order to provide assistance. It was explained that the meeting was about the residents, their likes and dislikes about where they live, and other issues. The facilitator encouraged them to speak without fear, and assured them that comments would not be recorded under individuals' names.

## Changes in organisational structures

The first topic of conversation focused on the *Time to move on from congregated settings* report (HSE, 2011). About half of the group had heard of this report, and were aware that it was concerned with where people live, how many people live together, and how many larger residential units were to be closed down. They also knew that from 2018 more people with intellectual disabilities would be living in smaller units in the community, close to shops, churches, services, and other people with intellectual disabilities. Some of the comments made about this were:

*It's better to live in smaller houses – near other homes – it's my choice, about what I want.*

*It's a big disadvantage to be living with lots of people – you cannot choose who you live next to.*

The second topic was in relation to the *New directions* report (HSE, 2012) and the *Value for Money* report (Dept of Health, 2012), and again about half the participants were aware of these reports. Some welcomed the changes that had been implemented in relation to an increase in activities both outside and in Áras Attracta.

*I didn't do anything; I don't do anything during the day.*

One person had been to a day seminar on managing money with Inclusion Ireland, and would welcome more events of this type.

Another participant was worried about 2018 and whether and when Áras Attracta would be closing down, but by the same token she expressed a wish to move 'home' to her village where her family are from.

## About HIQA

In relation to implementing policy, HIQA was discussed, and the general feeling was that it was a good idea to have an organisation overseeing the process of ensuring that things were done properly. Residents expressed mixed feelings about HIQA's visits to the houses.

*I have met people from HIQA. They called to my house.*

*I didn't mind people coming to my house. If I wanted to move I would tell the people from HIQA that. If I wasn't happy, I would have to say something, if people weren't mixing well or something.*

Another resident had been asked by HIQA 'if I was happy there, do I like it living there, how long I'm living there'.

*It's a bit weird having strangers calling to your house and asking questions, but they were nice.*

*The staff in Áras Attracta talk about them coming to see us.*

## About dignity and respect

One of the questions posed was in relation to actions that could be taken by service providers to ensure residents are treated with dignity and respect.

*You need something like HIQA as things can go astray.*

*You need to make sure all is in order and going right, it's very important.*

*I don't like people coming to my house.*

*I don't like where I'm living, the people in the house with me are too old. I want to live with young people like myself.* (This person was due to move to a new bungalow shortly and was going to be with younger residents. He felt that this meant that he was being treated respectfully, according to his wishes and needs.)

## About privacy

The issue of privacy was discussed and some of the residents confirmed that they have their own rooms, some had a key, and some had not. Some were not keen to have people come into their rooms – they believed that this is their choice, and were not afraid to say no to someone coming into their room.

*I don't ask anyone in, it's my room, they should mind their own business.* (This resident did not have his own key at the time; however one of the carers present agreed to arrange one for him once they got back to Áras Attracta).

*My own space, my own room, it's very important to me – all my things are in my room.*

*I would not like a person coming into my room; if they did I would tell the nurse – she would help me.*

Others who did not have keys were happy with this – 'fine the way I am' was the general consensus.

## Other matters raised

On the question of making complaints, very few residents knew about the Confidential Recipient. (Her contact details were distributed to the group subsequently.)

An important issue was raised by one resident who was struggling to deal with the recent death of another resident. He made the point that he would welcome training about how to manage feelings about death and grief.

In relation to the question about what steps should be taken to improve the management of residential services for people with intellectual disabilities, residents felt that having more choices would improve things for them.

Concerning money management, some residents said that they have an arrangement whereby 'Reception' gave them money as and when they needed it. They had a small amount of money in their purse/wallet, but for larger ticket items they asked for money from Áras Attracta.

*I have never bought anything for anybody in my life.*



Despite the fact that money management was discussed, only one of the participants would be happy to look after their own money.

## What matters most to residents

The issues that emerged as mattering most to residents were:

- ▶ Being supported to be safe.
- ▶ Being with people they choose to live with.
- ▶ Being able to make choices about what television programmes they watched.
- ▶ Being able to meet and have friends over.
- ▶ Being respected.
- ▶ Having privacy.

A number of female residents attended an advocacy group once a week, and they believed that it was important to have an independent advocate in place to assist residents with any issues or needs that arise.

## 2.3 Concluding comment

The two sets of consultations were quite different in nature, and yielded different insights.

The key conclusions of the first consultations in March were that residents were positive about staff, but wanted to go out more, have more activities, have more money, and have increased contact with their relatives. A small number expressed the wish to move out. Moving out was not under general discussion at the time within Áras Attracta, and therefore most of the residents would not have considered moving as an option.

The key conclusions of the second consultation centred more on training for increased independence such as money management, relationships and friendships, making choices, respect and dignity, privacy, and safety.

Strengthening the voice of people with intellectual disabilities is something that takes time. People with intellectual disabilities need support and training to learn how to voice their opinions, and how to challenge decisions made by others for them.

Those that work with people with intellectual disabilities also need training in how to listen effectively, and how to facilitate and encourage the voices of the people they work with.

The effort to do this is in its infancy in Áras Attracta.



# 3

## A day in the life of three residents of Áras Attracta

This section presents a 'day in the life' narrative for three residents in Áras Attracta. The purpose of this exercise was to help us 'step into the shoes' of residents and see daily life in Áras Attracta through their eyes and their experiences.

The observation work of collecting the narrative took place in September 2015, and was carried out on behalf of the Review Group by the National Advocacy Service for People with Disabilities (NAS), an independent confidential representative advocacy service that works exclusively for the person.

### 3.1 The approach we followed

The Review Group had detailed consultation with NAS on what data we needed and on how to collect it, and we developed a template to help structure the observations and data collection. We briefed Áras Attracta management on the exercise, as did the NAS observers who outlined the approach they were to take. Three residents were chosen in a controlled random process to ensure that the 'day in the life' narratives would cover a reasonable spread of life experiences (gender, age, and place of residence).<sup>11</sup>

Initially, observers met with the three residents individually in their bungalow or unit<sup>12</sup> to introduce themselves and get to know each person. Relevant staff were also involved as appropriate and suitable dates and times were agreed. The observers explained to each resident what they were going to do and that they would need to spend time with them in order to write a piece on a 'day in your life'. For the residents who communicate non-verbally, the observer also spoke with family members to explain the task.

Observers introduced themselves to residents at the beginning of each session and checked their comfort level with the process at frequent intervals. Verbal consent was obtained from one resident who cannot write and at no stage in the process did the resident indicate or refuse the observer's presence. Hand contact was used with another non-verbal resident to confirm their comfort in continuing with the process. On an occasion when one of the residents appeared unsure of the observer's presence, the observer moved away and returned at a later stage. The resident's ease with the observer (in the absence of written and verbal communication) was deemed as permission to undertake and continue the 'day in the life' process.

In order to get a comprehensive view of each person's day while at the same time being sensitive to their tolerance, the narratives were collected over a four-day period. A combined total of just under forty hours was spent with the three residents: Joan, Michael and Jack (names and other details have been changed to preserve anonymity).

<sup>11</sup> Residents already selected for the Personal Outcome Measures (POMs) study (see chapter 4) were specifically excluded.

<sup>12</sup> Called 'house' or 'home' in this chapter of the report.

## 3.2 A day in Joan's Life

Originally from a rural background, Joan has lived in the care of services from a young age. Now aged in her fifties, Joan lives in one of the houses in Áras Attracta with a number of other residents. She is very independent, enjoys company, has a sociable personality and communicates non-verbally using gestures and facial expressions. Joan enjoys regular contact with her family siblings.

<b>9am</b> <i>morning routine</i>	At <b>9am</b> Joan gets up independently in her bedroom and arrives in the dining room in the house. She is asked by a staff member if she wants a shower or a bath and indicates her choice. She requires minimal support in her morning routine and once showered/bathed Joan returns to her room, chooses her own clothes and dresses with some support from staff (who ask permission to enter the bedroom).
<i>breakfast</i>	Joan makes her own bed and a staff member asks her to take a seat in the dining room to have her hair blow-dried. After this is complete she then goes to have breakfast at the table and is offered a choice of cereal. Joan selects the cereal, pours the milk herself and eats the cereal independently. A new staff member asks if she takes milk in her tea and another resident responds to the question. Having finished breakfast, Joan sits for 15 minutes in her chair with her head resting in her hands. The staff member comes and sits with her for a few minutes.
<b>10am</b> <i>medication</i>	At <b>10am</b> , the staff nurse calls Joan for her medication. The nurse is wearing a red plastic apron with the words 'Drugs round in progress, do not disturb' written on it. On taking the medications with a choice of drink, Joan immediately leaves the house and walks independently to the Day Centre, by a particular route.
<i>craft activity</i>	On arrival at the Day Centre, Joan is greeted by staff and asked if she wants to choose from her large box of crafts/interests. She selects a particular craft activity and is shown how to use it. She is prompted to do the task by a staff member. Once the staff member leaves to work with someone else, Joan does not engage independently with the activity.  A staff member comes over to Joan again and she sits upright. On prompting, Joan engages with the task but when the staff member leaves she stops.
<i>coffee</i>	Coffee is mentioned by staff and Joan gets up and goes to the kitchen. Staff make the coffee for her and once her cup is empty she points to it indicating a wish for more. She is reminded that the kettle must boil and after a few minutes has a second cup, then leaves the kitchen and returns to the table in the main room.
<i>spin in a car</i>	On a separate morning, Joan is in the Day Centre and prior to the observer's arrival was offered a spin in the car for later that morning. Joan indicates she would like this by clapping her hands and smiling broadly. In the meantime she sits at a table with other people and is supported to take out a different craft activity from the box of interests. She is prompted by staff about what to do with the craft and praised and encouraged. Joan does not engage with the activity without prompting.

After a while a staff member calls to the Day Centre to collect Joan and another person to go for a spin in the car. The staff member opens the car door for her and assists her with the seat belt. No particular destination is offered or sought but it was communicated that a bowling trip that day had been cancelled because of staff shortages. The staff member drives by the airport and into Kilkelly village. Joan sits quietly throughout the journey and does not get out of the car. The car returns to Áras Attracta after 30 minutes.

*craft activity*

Joan returns to the Day Centre and continues with the same craft activity she was doing before the spin in the car. Once again she is prompted by staff, praised, encouraged and guided in the use of the craft. She is offered a soft drink and then another drink. After this she is offered relaxation time in the Snoezelen room for later in the day.

Another person/service user in the Day Centre comes close to Joan – this has occurred on a number of occasions during the morning. (This person is later described by staff as having an off day). Appearing uncomfortable with the situation, Joan gets up from the table and joins others in the TV room where a video is playing on a portable TV.

**2pm**  
*lunch in the canteen*

At **2pm**, Joan is prompted by staff to go to the canteen for lunch. She walks to the nearby canteen, picks up a tray and cutlery and then joins a queue for lunch. A choice of two main meals is offered. Joan makes her choice and takes her meal to a canteen table. She eats her meal, then gets up and places the tray with used dishes in a trolley. After this she chooses a dessert from the canteen display area and staff engage with her to offer tea/coffee. After drinking a number of cups of tea, Joan leaves the canteen and walks back to the Day Centre by herself.

**3pm**  
*Snoezelen room*

On a separate day, at **3pm** Joan is in the Snoezelen room sitting on a beanbag. She appears relaxed and is offered assistance to get up from the beanbag. She then walks back to the Day Centre with the others in the group and sits at a table with crayons on it. She takes off her jacket and a staff member mentions tea, at which point she gets up immediately and walks towards the kitchen. Joan presses the buttons on the door keypad but it does not open. A staff member enters the code and opens the door. Joan enters the kitchen and seeks tea by an open expression with her hands towards the tea caddy. Staff make her tea and Joan requests a bun. She then sits quietly with others at the table and seeks another person's tea but is reminded by staff that she has her own. She asks for more tea and staff make it for her.

On finishing her tea, staff invite her to sit at a table which has plastic flowers and an oasis placed on it. Three other people and one staff member are at the table. Staff prompt her to put the flowers into the oasis. Joan does not respond, the other people leave the table, and she is prompted once again to add flowers to the bunch held by the staff member. Joan picks up the flowers on prompting.

**4.10pm**

At **4.10pm**, she leaves the Day Centre and returns to her house via the same route as the morning. Once there she appears excited about having a drink and makes instant coffee. She does not boil the kettle. She gets the milk from the fridge and seeks assistance to open the carton.

	<p>A staff member returns to the house and states that the GP is expected in relation to an injury Joan received the previous day from another person at the Day Centre. The staff member engages with Joan, asks if she is in pain and checks if she has any marks.</p>
<i>TV in the sitting room</i>	<p>The television is on in the sitting room and Joan sits in her chair. A staff member offers her the remote control, shows her how to use it but then changes the channel while engaging with her.</p>
<i>Facebook</i>	<p>Using a private mobile phone, a staff member shows Joan her sibling's Facebook page and composes a message on her behalf '... from drizzly Swinford'. Joan is excited at seeing her sibling's Facebook page and continues to sit in the sitting room in the company of two other residents. A few minutes later, the staff member reads out a reply from Joan's sibling and Joan smiles broadly on hearing it.</p>
<i>folding towels</i>	<p>A staff member then asks the residents for help with folding towels. Joan goes with two other residents and independently folds the towels. On being asked to leave some items of laundry into some other residents' rooms, she does so promptly.</p> <p>She returns to her chair in the sitting room and two other residents are there. A staff member from the Day Centre is also seated doing paperwork.</p>
<b>5.15pm</b>	<p>At <b>5.15pm</b> Joan walks independently to the canteen via the same route as earlier. She joins a queue and is given tea by the catering staff as requested.</p>
<i>GP visit</i>	<p>A staff member from the house comes to her and asks that she return to the house because the GP has arrived. She leaves her tea and returns as requested, meets with the GP briefly and returns to the canteen within ten minutes. She selects her meal and chooses to sit at a table alone.</p> <p>A staff member greets all the residents in the canteen, chats about the weekend and asks all if they are okay. A staff member asks Joan if she would like tea or coffee. She indicates her choice and pours her own milk, returns her dishes to the canteen kitchen and is thanked by the staff.</p>
<b>5.50pm</b> <i>back to her house</i>	<p>At <b>5.50pm</b> Joan returns to her house, by the same route. On entering it, a staff member prompts and supervises her as she puts on the kettle, gets a cup and a teabag, pours the hot water, asks for assistance to open the milk carton and then sits down in the sitting room.</p> <p>The Angelus bell sounds on the television at <b>6pm</b>. A staff member engages with Joan, blesses herself and starts to say the prayer. Joan blesses herself too and looks intently at the staff member and blesses herself again on finishing the prayer.</p> <p>Senior management arrive in the house without ringing the bell. They engage with some of the residents but do not engage with Joan – she is resting in her chair.</p>
<b>6.45pm</b>	<p>At <b>6.45pm</b> Joan assists with making tea and coffee for everybody in the house. With prompting and minimal guidance she washes, dries and puts away her mug. She is given her medications and asked if she is in any pain. She indicates she is not.</p>
<i>Connect4 and Ring Throws</i>	<p>At <b>7pm</b> a staff member asks if anyone wishes to play a game. Residents, including Joan, play Connect4 and Ring Throws.</p>

A staff member asks Joan if she wants a hand massage. She accepts and the staff member sings two songs to which Joan sings along in tune. The staff member states that Joan is very musical and also attends art therapy during the week.

At **7.30pm** one of the residents is getting ready to go out to the pub. A staff member asks if Joan would like to go too as another staff member has arrived to drive the car there. She indicates yes and immediately gets up and puts on her coat. Staff organise money for drinks and Joan departs with two other residents, a staff member and a volunteer.

**7.45pm**  
*in the pub*

**7.45pm – 8.45pm.** At the pub, she sits with her coat on, in the company of others in the group. Staff member asks her what she would like to drink. Staff then order and pay for the drinks. Joan has one soft drink and then seeks another. She is asked if she wants another of the same. She indicates yes. Another soft drink is ordered for her. After this Joan seeks another drink and staff order tea for her. Shortly afterwards she is prompted to go to the bathroom, reminded to close the door and wash her hands afterwards. Soon after this the group leaves the pub.

**8.00pm**

On a separate evening at **8pm**, Joan is watching television in her house with a number of other residents in the dining/sitting room. A staff member asks would she set the table for supper and make a cup of coffee for the observer. She does exactly as prompted – sets out plates and mugs on each table; gets a mug out for the observer, pours the water and the milk. She sits back down in the sitting room. A night staff member comes in and engages with the residents, and gets a mug out for the observer.

**9.15pm**  
*supper*

At **9.15pm**, at the mention of tea, Joan appears excited and looks towards the kitchen. Residents move over to the dining tables for supper and with the assistance of a staff member Joan gets the bowls from the press and pours milk into jugs. She is offered a choice of cereal and hot or cold milk and is supported by staff to put milk in the microwave. She is offered a selection of drinks and indicates her choice. The drink is prepared and brought over to her. She drinks it quickly. A pot of tea is brought to the table and she pours her own tea but appears bothered when tea spills onto the plate. Staff replace the plate, she has more tea and goes over to her chair to watch television.

**10pm**

At **10pm** the nurse starts dispensing drugs from the trolley in the dining area. She wears a red plastic apron as per the morning routine. Joan goes over to the nurse when requested, she sits down and while waiting, stands up again. The staff member asks her to sit down again and she takes her tablets with a choice of juice.

Joan then goes to the bathroom, and with minimal support from a staff member, she retires for the night to her bedroom. Staff state that she will get up during the night to use the bathroom or seek a drink. Otherwise, she normally sleeps well.

## Observations on Joan's day

Nurses wear a red plastic apron when administering medication in her house, with the words 'Drugs round in progress, do not disturb' written on it.

Joan shows a capacity for independent living skills. This is not reflected in her planning goals which are to go on a trip down town for coffee and shopping, to go horse riding, and to go on holidays.

She demonstrates a capacity for fine motor skills at the Day Centre but the particular tasks she is engaged in do not appear to interest her.

The occupation of placing plastic flowers into an oasis with no particular purpose does not seem to be a meaningful activity or a good use of her time.

The spin in the car was just that, with no choice of destination or duration.

There is no internet access in her home. Because of that she is reliant on a staff member's private phone to make contact via social media with family.

A large built-in desk and file storage area for staff use occupies much of the residents' sun lounge.

Joan showed active engagement with domestic activities, and she demonstrates home-making skills in her bungalow. This contrasts noticeably with her lack of engagement in the activities at the Day Centre.

She visits the canteen seven days a week for dinner and tea, despite the kitchen in her house being fully equipped for meal preparation and cooking.

### 3.3 A day in Michael's life

Michael is in his forties and has lived in Áras Attracta for many years. He is a wheelchair user, very dependent on care and support for daily living, has a sensory impairment and communicates non-verbally using facial expressions and body movements. Michael has an engaging smile, enjoys the company of others and maintains a close relationship with his family.

<p><b>9am</b> <i>morning routine</i></p>	<p>At <b>9am</b>, Michael is up and dressed in a tracksuit bottoms and jumper. He is seated in his chair and the hoist sling remains around him. There is a discussion between two staff members about how this is best left in place. Michael is going to the swimming pool this morning. A staff member pushes his chair from his bedroom to the table in the dining/sitting room. Two other residents are also in the room and relaxing music is playing on the stereo.</p>
<p><b>9.50am</b> <i>breakfast</i></p>	<p>From <b>9.10am</b> to <b>9.40am</b> Michael places his fingers in his mouth at three different times. At <b>9.50am</b> a staff member supports him with having breakfast. After ten minutes this staff member leaves to join the activation team and another staff member sits with him. A discussion takes place with another member of staff on how best to support Michael with taking his meal. A cushion is placed behind his head and he takes some breakfast but also indicates he does not want his meal. Three different drinks are suggested and offered to him.</p>
<p><b>10.40am</b> <i>medication</i></p>	<p>At <b>10.40am</b> a nurse attempts to give him his medication without success. At <b>10.50am</b>, breakfast is put away and he is moved away from the table to relax. The nurse tries again to give him his medications and is successful this time round. Staff agree he may wish to eat after his swim.</p>



<p><b>11am</b> <i>swimming</i></p>	<p>At <b>11am</b>, a physiotherapist arrives to escort Michael to the swimming pool. Once there he is hoisted to enter the pool safely with the support of three staff members. He is supported by the physiotherapist and an activation staff member throughout the period in the water. Michael vocalises loudly and kicks his legs while in the warm pool. Staff engage with him verbally and physically by moving his limbs to exercise. He smiles and appears to enjoy the activity and interaction for approximately 30 minutes and then exits the pool as per his entry.</p>
<p><b>11.40am</b> <i>television</i></p>	<p>On a separate morning, at <b>11.40am</b>, Michael is seated in the dining/sitting room facing the television. The movie <i>Happy Feet</i> is playing. At <b>11.46am</b>, a staff member offers him 7Up. He drinks it all from a spoon with the support of staff. At <b>12pm</b>, he is finished and vocalises in a low tone. Another staff member greets him.</p>
<p><b>12.20pm</b> <i>soft play area</i></p>	<p>At <b>12.20pm</b> he is moved by hoist with the support of two staff, to lie on soft mats in the corner of the room (referred to by staff as the soft play area). Another resident is also sitting in the same area nearby. This area consists of coloured soft mats and cushions; three small plastic mobiles hang from the roof and one wall has a mirror on it.</p> <p>From <b>12.20pm</b> to <b>1.50pm</b> at five different times, Michael repeatedly puts two of his fingers into and out of his mouth and appears to rub them along his gums. At one stage he does this constantly for five minutes.</p> <p>During this period, one staff member engages with him twice and moves the mobiles. A staff member addresses a query from the observer and sits beside Michael to examine his fingers. She notes his relaxed demeanour.</p> <p>At <b>1.30pm</b> and <b>1.35pm</b> he vocalises in a low tone. Then at <b>1.50pm</b> he is hoisted with the support of staff, back to his chair for dinner. He is spoken to and engaged with by staff.</p>
<p><b>2.03pm</b> <i>dinner</i></p>	<p>At <b>2.03pm</b>, dinner arrives from the industrial-style kitchen located on the corridor. Michael appears to be asleep. He is supported by a staff member a few minutes later to have his dinner. He appears sleepy and staff continue to support him with eating his dinner in a patient and respectful manner.</p> <p>On a separate day at <b>2pm</b>, Michael is seated in the dining/sitting room having his dinner with the support of a staff member. Beatles music is playing on the stereo. At <b>2.40pm</b> he finishes his meal, leaves the room for personal care and returns at <b>3pm</b>.</p>
<p><b>3.10pm</b> <i>in the gym</i></p>	<p>At <b>3.10pm</b>, a member of the activation staff team arrives and brings him to the gym via the internal corridor route. He joins a Fit for Life class with other residents and staff. He is asleep for much of the class. He wakes up during an activity and staff are concerned by his reaction and he returns to his house. At <b>3.55pm</b> he is hoisted by two staff members onto the soft mats in the sitting/dining room. He remains there until <b>4.30pm</b>.</p>
<p><b>5.55pm</b> <i>tea</i></p>	<p>On a separate day at <b>5.30pm</b>, Michael is awaiting his evening tea and is seated in his chair in the dining/sitting room area. Staff are commenting that three agency staff should be working this evening but only two have arrived.</p> <p>At <b>5.55pm</b>, a staff member supports him taking his tea. He takes two spoonfuls and a different sweet drink is sought for him but he does not take it.</p>

<p><b>7.25pm</b> <i>supper</i></p>	<p>At <b>6.25pm</b> another staff member touches his hand. At <b>6.32pm</b> a staff member comes to rub saliva from his mouth. Until <b>7.05pm</b> Michael remains seated without interaction from others. Then, the staff member who touched his hand earlier touches foreheads with him and they smile at each other. There is noted concern by staff that he is not smiling today.</p>
<p><b>8.00pm</b> <i>night time routine</i></p>	<p>At <b>7.25pm</b> another staff member sits with him and gives him supper, which he eats. Staff comment about his changing needs over recent months.</p> <p>At <b>7.45pm</b>, he is brought to his bedroom with the support of two staff. A strong odour is evident in the area and staff spray air freshener in the bedroom, in the bathroom next door and in the corridor. Staff prepare items for personal care and night time routine. A staff nurse greets him and explains that she needs to check his blood pressure and temperature and proceeds to do this.</p> <p>Michael is hoisted with the support of two staff onto his bed and is supported by them in his night-time routine. At <b>8pm</b>, a staff member places a DVD into the player/projector beside his bed. <i>The Country Bears</i> movie plays and he looks at the screen for short periods until approximately <b>8.30pm</b>. He appears sleepy, staff check in on him during the night and inform the observer that he generally sleeps well.</p>

## Observations on Michael's day

Staff put considerable effort into supporting Michael with his meals by offering choice, a change of location, a change in sitting position, a change in staff involved.

When staff engage with him they do so in a respectful and pleasant manner.

His Person Centred Plan (PCP) states that he shares his home with two females and four males. It also states that he shares his bedroom with two particular residents – this information is out of date.

There appears to be little provision for Michael's sensory impairment in terms of how some staff interact with him. His communication passport is incomplete and his file states that 'although I am deaf, speak to me as if I can hear with facial expression...'

His timetable states that he has three pool sessions per week. Six swimming sessions were recorded from June to September 2015. His stated PCP goal is to have one swim session per week.

The wheelchair he uses since late last year is described as unsuitable for outdoors and uneven surfaces. One outside walk is recorded between April and September 2015.

A new outdoor chair is on order for many months.

Relaxation time is noted throughout his timetable and appears to consist of him lying on the soft mats in the dining/sitting area in his home. This is separate to visits to the Snoezelen room. One of his stated PCP goals is a more stimulating sensory area to relax in.

Michael appears to have no interaction with other residents in his home.

Of the 12 hours observation, he spent all of his time in the dining/sitting room of his home, except for 1.5 hours in the gym/pool and 1.5 hours in his bedroom.

### 3.4 A day in Jack's life

Jack is in his sixties and has lived in the care of services for many years. He now lives in one of the houses in Áras Attracta with a number of other residents. Jack has several medical conditions and a visual impairment, and he uses a walking frame to get around his home independently. He is a sociable man who enjoys company, going out on trips and listening to music. Jack has good contact with his family siblings who visit regularly and take him out for lunch and to visit family.

**9am**  
*morning routine*

At **9am** the observer arrives at Jack's house as agreed and he is in bed sleeping. He had been awakened at **8am** for medication which was administered to him in bed. Soon after **9am** staff call him to get up and then support him with his personal hygiene. His preference is to have a bath and he is supported by staff to choose his own clothes and get dressed.

Jack uses his walking frame to make his way independently from his bedroom to the breakfast table in the living area. He positions his frame near the table in a corner of the living area and sits at the table on the chair he always sits in. A staff member greets him and asks how he is. He queries if he should put on his 'bib'.

*breakfast*

Jack asks for porridge and appears tired. A staff member offers him a choice between tea and juice. He selects juice and is reminded to drink slowly and prompted to leave the cup down between drinks. He is given porridge in a bowl and is again reminded to eat slowly. He asks for more porridge and gets a second portion. He asks for more tea and is given a second cup of tea. He then removes his bib, reaches for his walking frame which is still where he had placed it earlier and goes to the bathroom unassisted.

He returns and sits in his chair which is in the back corner of the living area. He has his head in his hands and appears to be snoozing. At times he makes low humming noises. He wakes a few minutes later, a staff member asks him if he is tired and he replies he is. The nurse dispenses medication from the drug trolley beside his seat. He snoozes for a while and wakes again asking if he can go to visit his friend in the canteen. A staff member explains he can go later when it stops raining. He continues to snooze making a low noise. After a while a staff member asks him if he would like music turned on. He says he would and is asked who he would like to listen to. He chooses the Clancy brothers.

**10.30am**  
*medication*

At **10.30am** he is given his medication with a drink and reminded to drink slowly. In response he asks 'What would happen if I drink too fast'. The nurse reminds him about a choking incident in the past.

A staff member chats to Jack and enquires about his tiredness. He replies saying that he was up late watching the television. He asks once again about going to see his friend and staff suggest he can but it will be after dinner. A staff member has a piece of paper and asks him if he wants to write. He explains that he cannot write.

A few minutes later he begins to talk in detail to the staff present about the day he spent with a family member two days previously.

Then Jack sleeps in his chair. The Clancy brothers' music is playing in the background. There are three other residents in the living area. The nebuliser is turned on for another resident. Staff check with Jack if he can still hear the music; he replies that he can. He asks staff again what time is he going to see his friend in the canteen.

Among themselves, staff discuss the availability of a bus to facilitate a bus trip.

**11.15am**  
*crying episode*

At **11.15am** Jack is sitting in his chair and begins to cry. Staff reassure him and he asks for tea, then stops crying. He asks staff 'what happens if I keep crying?' Staff explain he would have a sore head and sore eyes and continue to reassure him. Staff then resume attempts to organise a bus for the bus trip.

Staff ask Jack if he would like to go out on the bus and remind him that he cannot go for a walk because it's raining. He says 'yes', is given tea and a bun and prompted to eat slowly. Intermittently for the next 15 minutes he begins to engage in repetitive skin picking. Staff advise that Jack demonstrates this self-injurious behaviour at times.

Jack is supported to get on the bus with the other residents. Staff ask the residents where they would like to go. Jack suggests Knock but staff explain there is not enough time because they have to return for **12.30pm** to cover staff breaks. Staff promise to bring him to Knock another day. At **11.40am** the bus leaves the campus, drives to a local church and returns to Áras Attracta at **12.35pm**.

**11.40am**  
*bus trip to local church*

At **11am** on a separate morning Jack is sitting in a chair in the corner of the living area. A staff member asks him if he would like to go out in the bus or visit his friend in the canteen. He asks to go out in the bus and is told that the bus is waiting outside. He is prompted to go to the toilet, supported by staff to get on the bus and asked where he would like to go. He suggests Castlebar and a member of staff sits beside him and chats with him during the journey. He mentions Castlebar hospital, asks the staff member about returning to the hospital and is reassured that he would not be returning there. Jack repeats his question about Castlebar hospital and the staff member continues to reassure him. The bus travels into Castlebar town and then goes through the grounds of Castlebar hospital, on to Pontoon and returns to Swinford. No one alights from the bus at any stage and the bus gets back to Jack's house at **12.45pm**, not much more than an hour from the time of departure.

*bus trip to Castlebar and Pontoon*

On entering his house he is asked if he would like tea and if he wants to listen to music or to turn on the radio. Music is turned on and he is given a cup of tea and a bun. Staff ask about the bus trip and Jack tells them he went to Castlebar. He asks for and is given more tea and another bun. He requests a visit to his friend in the canteen, a staff member agrees to bring him later.

Jack shares with a staff member that he has a pain in his ankle. This information is communicated to the nurse who asks if she can examine it. After doing this, the nurse asks if he wants a painkiller, to which he agrees.

*lunch*

Jack repeats his request to visit his friend in the canteen and a staff member explains that they will bring him later in the afternoon. He sits on his chair holding stress balls and listening to music. Then the canteen staff arrive with lunch. He gets up, places his walker in the corner and sits at the table. He asks staff if there is soup, staff reply that there is and remind him to drink it slowly.

**2pm**

On another occasion the observer arrives at Jack's house just before **2pm**. The nurse explains that the residents have had a quiet morning as there was 'one less staff and they were a little behind'. Residents had no activities in the morning as a result. Another member of staff had not worked in this particular house for almost a year and yet another staff member was from the agency. It was her first day working in Áras Attracta and she had not yet received an induction or familiarisation.

Jack is sitting at the table in the same seat he always sits in. He is waiting for his dinner and while doing so is supported by staff to wear his bib. He is then served his dinner and a familiar staff member returns and places plate guards on his plate. On requesting more dinner he is asked what he would like. He replies that he does not want beef and is given shepherd's pie, which he appears to enjoy. He is offered a choice of drink with his dinner. He selects and is given a blackcurrant drink. He is offered a choice of desserts and chooses custard and cake puree. Staff ask him if he would like anything else, he requests and is given more dessert and orange to drink. Once finished he is prompted to go to the toilet, so he gets up from the table, reaches for his walking frame but it is not in its usual place – it had been moved slightly. Jack's facial expression changes, and he becomes anxious because the walking frame is not where he had positioned it. Because of his reduced vision he searches the area with his hands and then locates the walking frame. Staff not familiar with the house and his routine had moved it.

Following dinner the nurse reminds other staff members about his request to visit his friend in the canteen. As the nurse needs to assist a resident to attend a medical appointment, the other staff member explains that they are unable to facilitate this request. A telephone call is made to the activation team to see if there is another member of staff available, but there is no answer. The staff member notices the nurse manager walking past the house and runs out to discuss the staffing issue with her.

**3.00pm***mindfulness*

Jack is snoozing on his chair in the living area. At **3pm** he requests a cup of tea and staff ask if he wants to watch television or listen to the radio. He selects the radio. A member of the Studio 3 team enters the house to bring Jack to mindfulness. The Studio 3 team had previously been working with him regarding his social story<sup>13</sup> but he had experienced anxiety following his engagement with them. Following a letter from his key worker<sup>14</sup> he no longer engages with the social story technique and is now undertaking mindfulness. Neither Jack nor the staff on duty were aware that he was scheduled for mindfulness. Studio 3 staff agree to return in ten minutes to allow him time to drink his tea. During this time Jack asks 'He won't keep me over there too long?' Following his tea Jack is brought to the Studio 3 bungalow in a wheelchair and participates in mindfulness for a ten-minute introductory session. Jack is scheduled to undertake mindfulness daily for the next two weeks, after which his participation in it will be reviewed.

<sup>13</sup> This refers to a piece of work undertaken by Studio 3 with Jack as part of his behaviour support plan. The purpose of the social story was to confirm with Jack that Áras Attracta was his home and the particular actions he could take to alleviate any stress he might feel around this fact. Studio 3 is an independent organisation that provides training and clinical consultancy services to intellectual disability services, including staff training to deal with behaviours that challenges.

<sup>14</sup> The key worker is the member of the staff in the residential centre who carries particular responsibility for the person with a disability, liaises directly with him/ her, coordinates health and social services, and acts as a resource person (HIQA 2013, p110).

<i>visit to a friend</i>	<p>On returning to his house the nurse asks if someone would support Jack's visit to his friend in another part of Áras Attracta. A staff member agrees to bring him and when he gets there he has tea and two buns with his friend. He returns to his house 45 minutes later and sits on his chair in the corner. Staff ask if he would like music on. He is offered a choice between two types of music and chooses rebel songs.</p>
<p><b>5.30pm</b> <i>medication and tea</i></p>	<p>At <b>5.30pm</b> he asks staff about tea. He is given medication and sits at the table for his tea. He is supported by staff to wear his bib and offered a choice between salad or eggs and beans. He selects salad and is given a second portion of salad and another cup of tea as requested.</p>
<i>tea with a friend</i>	<p>Jack finishes his tea and goes unassisted to the bathroom. He returns to his chair and holds his stress ball. The television is on in the background. Staff ask him what he feels like doing and he asks to visit his friend. He is supported to put on his hi-vis jacket and cap. He is greeted by several staff en route. Jack and his friend shake hands on meeting and make their way to the conservatory for tea and buns. He speaks in detail about a recent day out with a family member, talks about his earlier residential stays and also about staying in his friend's home (which he never wants to live in again) when recuperating from a fracture. He is unable to answer a question that is asked about his family and reverts to his friend who, knowing him and his family, answers the question for him. Jack requests and is given another bun. Staff ask him what he would like to do and he seeks to 'wait a while'. A short while later, the staff member asks him if he wishes to go for a small walk. He agrees and walks around the campus before returning to his house.</p>
<p><b>9.20pm</b> <i>supper</i></p>	<p>At <b>7.30pm</b> Jack is supported to take off his jacket and hat and is asked by a staff member if he would like tea. He says 'yes' and requests a bun with his tea. The nurse reminds him that he had two buns earlier and has in the past experienced cramps in his stomach from eating too many buns. He is also informed that it will be supper time soon. Jack remains in his chair, making low moans.</p> <p>At <b>9.20pm</b> Jack asks about supper and he is reminded supper time is after the news in a few minutes. At <b>9.30pm</b> staff ask him what he would like to eat, he replies 'cornflakes'. He is asked if he would like the milk heated, and he says no. He is supported to put on his bib, given the bowl of cornflakes and prompted to eat slower. He is offered another portion, which he takes along with more tea. A resident at the table becomes upset and an incident follows. The resident is supported to leave the table and supper continues. Jack is asked if he wants anything else, he requests and is given a bun.</p>
<p><b>10.35pm</b> <i>bedtime</i></p>	<p>Jack returns to his chair in the living area and a few minutes later the nurse asks him if he would like custard or mousse with his medication. He responds and is given custard.</p> <p>At 10:35pm Jack is still sitting on his chair and asks 'Is it bedtime nurse?' The nurse asks if he would like to go to bed, he replies 'yes'. The nurse prompts him to go to the bathroom first. It is suggested that he uses a different bathroom as another resident is using the bathroom nearest his bedroom. He uses the bathroom independently and then makes his way to his bedroom. A male staff member knocks on his door and asks if he requires any help. He is then supported to get ready for bed.</p>

Staff inform the observer that Jack wakes nightly after midnight to go to the toilet and does so independently of staff. They also explain that he normally sleeps well but occasionally may wake up and once reassured by staff, he returns to sleep.

## Observations on Jack's day

Jack's house is extremely busy with different staff and external agencies coming and going. It does not have a homely feeling.

It is also loud at times because of the mix of residents, and particularly so when the respite bed is occupied (according to staff). During a mealtime there was an incident when one resident threw his tea and shouted loudly for a period. Quieter residents, including Jack, were upset.

Jack did not speak or engage with any other residents in his house during the time he was being observed.

He maintains a close and caring relationship with a resident of a similar age with whom he lived previously. This resident lives in another part of Áras Attracta now.

On a morning when he asked for support to visit his friend, staff believed it was too wet. A bus trip was being arranged and he had the choice to go on this or remain in the house. He went on the bus trip and enjoyed it. The visit to his friend was facilitated in the afternoon.

The self-injurious behaviour Jack engages in (repetitive skin picking) was only observed while he sat on his chair in the house.

Jack does not have consistent familiar staff who can afford him meaningful one-to-one engagement.

According to his key worker and his file, Jack did not attend his annual review in December 2014. His understanding of his key worker's role is 'he opens and closes doors'. Jack's key worker works in another house and has not worked with him for some time. His key worker continues to act in this role.

A goal identified in his annual review is 'to return to the workshop' but this has not happened because it would require a personal assistant or volunteer.

Activities listed in Jack's social activities timetable are not reflective of what happens in reality – for example, he was timetabled to spend relaxation time in the Snoezelen on Friday morning but went on a bus trip instead. He was not afforded choice in relation to this.

The observer undertook two bus trips with Jack. No one alighted from the bus on either occasion. On one occasion the bus returned promptly after leaving Áras Attracta in order to facilitate staff breaks. While choice of destination was offered to the residents, this was restricted, owing to the requirement to return to cover staff breaks. On another journey Jack became anxious on the approach to Castlebar. He had negative memories of his experience in Castlebar Hospital, but the bus drove through the hospital grounds.

When his brother brings him out, Jack does not use the walking frame or wheelchair. This contrasts with his use of the walking frame at all times within the house and the use of his wheelchair going outside with staff.

### 3.5 In conclusion

The 'a day in the life' narratives present a picture of life in Áras Attracta that is characterised by inactivity, lack of stimulation, and dependency on the support of staff for many of the things that most people take for granted.

Residents' personal preferences or affinities are not supported as much as they could be. Some of the outings did not seem to have much purpose, and were frequently cut short to facilitate staff breaks.

The narratives leave no doubt that the residents of Áras Attacta have little opportunity to realise their potential to live the rich and satisfying lives that they have a right to aspire to.



# 4

## Measuring the quality of life at Áras Attracta

As well as listening to residents themselves and looking at their daily lives in Áras Attracta, we felt that as a Review Group we needed to arrive at a stronger understanding of their *quality of life*. We needed to know ‘did they feel safe?’, ‘did they have friends?’, ‘could they make personal choices?’, and so on. We needed answers to such questions so that we could more readily identify any gaps in service and any causes of immediate concern, and also to help inform recommendations for further action.

In determining how to carry out a quality of life survey, we felt it was important to focus on the lived experience of the residents, but to do so in a systematic way that could give some objective measure of residents’ quality of life. For all of these reasons, the instrument we chose was Personal Outcome Measures (POMs), an assessment tool widely used in disability services in Ireland and internationally.<sup>15</sup> POMs had previously been used in a national survey of disability services that provided an Irish baseline for our survey.<sup>16</sup>

### 4.1 Overview of the Personal Outcomes Measures tool

In carrying out a POMs assessment, trained people gather information relating to 23 individual personal outcome measures across four broad categories covering different aspects of the lives of those in the target population.

**Table 4.1** Personal outcome measures

Fundamental safeguards	Personal choices	Participation in the community	Personal relationships
I am connected to my family	I choose my personal goals	I live in an integrated environment	I have friends
I am free from abuse and neglect	I choose where and with whom I live	I participate in the life of the community	I have intimate relationships
I am safe	I choose where I work	I interact with other members of the community	
I exercise my rights	I realise my personal goals	I perform different social roles	
I am treated fairly	I choose my daily routine	I choose services	
I have privacy	I use my environment		
I choose when to share personal information			
I am respected			
I have best possible health			
I experience continuity and security			

<sup>15</sup> Schalock, R, Gardner, J. and Bradley, V., 2007. *Quality of life for people with intellectual and other developmental disabilities: applications across individuals, organizations, communities, and systems*. Washington, DC: American Association on Intellectual and Developmental Disabilities.

<sup>16</sup> McCormack, B. and Farrell, M., 2010. Using POMs to get a better quality of life: The Outcomes Network of Ireland Survey. *Frontline*, 78, 24–26.

The information gathering usually takes POMs assessors about half a day; they carry out this work in the following ways:

- ▶ In direct conversation (or other communication) with the person concerned.
- ▶ In conversation with those who know the person best.
- ▶ From their observations of the person and their environment.
- ▶ From the person's records (with consent) and any other relevant documentation.

The information that has been gathered is then reviewed with the POMs trainer/coordinator and the outcomes are scored to indicate the person's current quality of life.

The second dimension of the assessment confirms the presence or absence of effective organisational supports that make the achievement of each outcome likely in the short-term (in the next 6–12 months). While a service provider cannot guarantee an outcome such as 'I have friends' for a resident, it should attempt to facilitate it and make the outcome more likely. To inform a better service response, the POMs information gatherer identifies which of the personal outcomes that are determined to be *not fully present* are most important to the person. In other words, which missing outcomes does the person want addressed urgently. The person's priorities usually become clear through the conversations with the person and with those who know them best.

## Determining whether or not a personal outcome is fully present: three examples

Personal outcomes are primarily defined by the person themselves – through their words, or their alternative communication system, or through their actions or reactions, now or in the past. If the person has no obvious means of communicating, whoever knows them best may have some insight.

### Example 1: I have friends

Each personal outcome is explored through a sequence of key questions – for example the personal outcome *I have friends* is explored in stages:

Do you have any friends? ...

Do you have enough friends? ...

Do you see enough of your friends?...

For scoring purposes, the outcome is determined to be *fully present* if the answer to all of these questions is 'yes'.

## Example 2: I am free from abuse and neglect

The personal outcome *I am free from abuse and neglect*, is broad-reaching and includes mistreatment and exploitation, from anyone, including peers. The determining questions for assessors include:

Have there been any allegations of abuse or neglect by or on behalf of the person?

Is there any evidence that the person has been abused, neglected or exploited?

Is the person experiencing personal distress from a previous occurrence of abuse?

If the person is still experiencing distress from a past occurrence, even if the organisation has addressed the abuse, this would cause the outcome to be scored as *not fully present*.

For an effective organisational support to be scored as *fully present* for this outcome, the organisation must have provided the person and family with information and education about abuse and neglect, and have provided supports if there have been concerns expressed or occurrences of abuse, neglect, mistreatment or exploitation.

## Example 3: I have the best possible health

The personal outcome *I have the best possible health* acknowledges that many people with disability experience poor health and live with significant health conditions. The outcome explores the person's health concerns, information about their health status, and the provision of effective healthcare, reviews and supports to enable the person to self-manage their own healthcare. The questions for the person (or the person who knows them best) include:

Do you feel healthy? What do you do to stay healthy?

Do you receive regular examinations? If so, what kind?

Do you take any medication? If so, what is it and how does it help?

If you think the medications, treatments or interventions are not working, what is being done?

For an effective organisational support to be scored as *fully present*, staff must be aware of the person's health status and concerns, including the impact of medication and other treatments, and supports must be provided for the person to maintain their best possible health.

## The Áras Attracta sample

Given the time-consuming nature of the information gathering, it was decided to draw a controlled random sample of 20 people living in Áras Attracta to include residents from across the three designated centres, with different levels of ability, both men and women, and younger and older. A number of standbys were also selected to replace anyone who declined to participate. In the event, one person declined to participate and was replaced, but she later decided she did want to be part of the survey and was included, raising the number to 21.

The project manager for the 2007 National Survey was appointed as coordinator for the Áras Attracta survey.<sup>17</sup>

**Table 4.2** Profile of the Sample

	Number of residents	
<b>Centres</b>	Centre 1	8
	Centre 2	6
	Centre 3	7
<b>Level of disability</b>	Mild	6
	Moderate	7
	Severe	8
<b>Age group</b>	Under 60	10
	Over 60	11
<b>Gender</b>	Men	11
	Women	10

## Practical matters

In advance of the survey taking place, the coordinator and one member of the team, along with the Chair of the Review Group, met with Áras Attracta management, to give an overview of POMs, discuss the consent process, and to address queries and finalise practical arrangements for meetings with the selected residents and key others. An information sheet on POMs and details of how information would be gathered was made available to staff, to the residents and to their families. The residents selected for the sample were informed about POMs and the survey, and they were formally invited to participate.

The survey coordinator also arranged that staff who knew the survey participants well would be available for a follow-up conversation after the meeting with the resident, along with a family member where possible. This was to supplement the information gathered from the resident themselves. Information on each participating resident's personal plan, their photo albums and other communication supports were requested to be available, with the resident's permission.

The survey was undertaken during the week of 24 August 2015.

## The POMs assessment team

The POMs assessment team consisted of the coordinator and six other trained POMs assessors drawn from six different disability services. The team members were experienced in the use of the POMs tool with people with a range of disabilities, including those with severe/profound disability who were complex, non-verbal communicators. The coordinator had responsibility for the reliability of all scoring in the survey.

<sup>17</sup> McCormack, B. and Farrell, M., 2007. The Quality of Life of People with Disabilities in Ireland in 2007: Results of a National Survey. Dublin: Outcomes Network of Ireland and Delivering Outcomes to People Project.

## Gathering the information

Following an introductory tour of the campus with a member of Áras Attracta management, the POMs assessment team began with the first six interviews. The meetings with the rest of the sample continued over the next three days, some late into the evenings as convenient for the resident, their family and staff. The resident was met with in their preferred settings, which were all on-site in locations such as the canteen, sitting areas, a ward or bedroom, a meeting room, or conservatory.

At the outset, consent was again addressed with each person, and all but one agreed to proceed – at this stage residents could freely choose not to proceed if they so wished.

Some residents had a staff member present – where that was their preference or where staff suggested that this was required. This was particularly the case where the resident had very limited communication and interaction, and required someone to ‘speak for’ them, or where the resident had healthcare needs that required staff presence. Most participants met with the interviewer without staff present.

The information-gathering followed the standard POMs approach, with the interviewer spending between one-and-a-half to three hours with each resident, in different settings where feasible. Where possible, this was followed by time with family members, and then by one to two hours with staff who knew the resident well. The residents’ records were also reviewed, where necessary and with prior consent.

In all cases, the interviewer met with a staff member. In four cases, the interviewer spoke with more than one staff member. In three cases the interviewer also gathered information about one resident from another resident. In thirteen cases, the interviewers had contact with family members, while one person had no family to contact.

The information gathering required a considerable amount of organisation and cooperation from the staff in Áras Attracta, and some visits took place over different days to facilitate follow-up.

The individuals in the sample were generally very keen to participate, and appeared to enjoy spending time with the POMs interviewer. Family members were also keen to participate.

## 4.2 Findings of the survey

The findings of the survey are presented below. For each personal outcome, there is a short narrative that indicates how the presence or absence of a personal outcome and the presence or absence of organisational support for that outcome were determined. In some cases there is a combined narrative for two or more personal outcomes. At the end of each narrative the scores are shown for:

- ▶ The number of residents for whom the personal outcome was determined to be *fully present*
- ▶ The number of residents for whom effective organisational support for the outcome was determined to be *fully present*.

## Fundamental safeguards

The *fundamental safeguards* category gathers together the personal outcome measures that are the foundations for a decent quality of life.

### I am connected to my family

Several residents had regular contact (at least monthly) with their immediate family, with family visiting the centre, taking them out for Sunday afternoon, or the resident going to their family home for a night.

Some residents would like more contact with some family members; while others had lost contact with some family members, cousins, old neighbours or family friends.

The organisational support for this personal outcome was *not fully present* for 13 of the 21 residents surveyed, as relevant staff had little information about the person's views on their contact with their family, whether they had too much or too little contact with family members. Staff also had not explored lost family contact or sought to re-establish contact to any satisfactory extent. There was an untested assumption that the person always wanted visits.

For several residents, there was ineffective engagement with the family to support their involvement in the person's life. While family members visited, they were not actively involved in the planning process for their family member and expressed their interest in being more involved in:

- ▶ Attending planning meetings.
- ▶ Information on what their family member likes to do.
- ▶ Being more involved in the service through family forums.

For one person with high support needs, a parent said they trusted staff fully but did not know about the person's current situation, nor did they know how to ask for more information or how to have more direct interaction with their family member's support staff.

For another resident, the family member said that the service does not communicate effectively with his family, or include his family in his life, or in developing his plans. His mother did not know what was written in his plan and was not included in assessments. She said she had never been shown his plan, his assessments, his activity log, or any other relevant information.

Another family had not been informed about key changes in their family member's programme – for example, that he would no longer receive a day service once he lived in the centre. The family only found this out accidentally after several months.

Families also expressed their wish to have more information on the external reviews currently taking place in the service.

Overall there was room for a deeper engagement of families with the lives of their family members at Áras Attracta.

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#### Summary: I am connected to my family

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Personal outcome *fully present* for: **9** out of 21 residents

Effective organisational support *fully present* for: **8** out of 21 residents

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## I am free from abuse, neglect, mistreatment and exploitation

Two residents referred to abusive verbal behaviour that had occurred in the past, one by staff to a resident, the other by residents to other residents. The former involved staff shouting at a resident, and telling the resident to go to their room.

One resident reported that they were now sharing a room with another resident they had previously reported that they were afraid of.

One person commented: ‘things not as bad, people not as afraid’.

A parent did not know how her daughter with high support needs was kept safe in a communal environment. She also said she did not know who to ask, even though she visited regularly.

There was limited evidence that residents surveyed knew what constituted abuse, or that they had been supported to learn about abuse and mistreatment issues in a meaningful way. In other words, they were not supported to keep themselves safe.

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### Summary: I am free from abuse, neglect, mistreatment and exploitation

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Personal outcome <i>fully present</i> for:	5 out of 21 residents
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Effective organisational support <i>fully present</i> for:	2 out of 21 residents
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## I am safe

Many residents never leave the Áras Attracta campus other than with staff, and usually on service transport. These residents are safe on campus and not exposed to any safety risks outside the campus.

Some residents were exposed to physical or verbal behaviours that challenge from peers and such incidents were not always identified as behaviour incidents or safeguarding incidents by the relevant staff team. One resident, for example, spoke about their fear of some other peers, which they felt relevant staff or their family did not recognise as an issue.

People, especially many who were more able, were not supported to learn about keeping themselves safe in different environments. With some supports, some residents had successfully managed on their own before coming to live in Áras Attracta, and they had frequented places with some risk attached. In the present setting, risk was completely managed by staff, and often resulted in over-protection, which prevented people who wanted to be more independent, and had capacity to be so, from learning to keep themselves safe with appropriate safeguards.

The areas of safeguarding and risk are closely linked – staff supporting them should be aware of the residents’ human rights and what constitutes abuse or mistreatment, and they should be conscious of treating people as individuals. There was over-protection for some residents, while others needed more support. Many individuals and their staff can manage safely and productively in situations containing some risk, and can learn about keeping themselves safe, while having a wide range of human life experiences. For many of the residents interviewed, however, there was over-protection, amounting to control.

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**Summary: I am safe**

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Personal outcome <i>fully present</i> for:	<b>6</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>1</b> out of 21 residents

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**I exercise my rights and I am treated fairly**

There was virtually no evidence of these two personal outcomes being addressed.

There appeared to be a lack of awareness among some staff of the basic human rights of individuals with disabilities, or that they have the same rights as everyone else in their community. Residents needed to be supported to learn about human rights, and what their rights were – for example, the rights to: personal property, freedom of movement, freedom of speech, their good name, the same living and working environments as others, due process (a fair, independent hearing), and fair treatment in relation to restrictions on any of these rights.

There are restrictions on the rights of some residents – for example, in the use of psychotropic medication in the management of behaviour. There was limited knowledge among some staff as to why such medication might be prescribed – the staff member responsible for one resident was unable to confirm whether or not the resident had a psychiatric diagnosis, whether or not the medication was effective, or what the possible side effects might be.

Residents’ money was held centrally in the office, and there was evidence of residents not having control of their resources, regardless of their capacity to do so.

For many residents, their personal possessions were not safe, or were kept safe only by staff intervention and for that reason were not available to the residents.

One resident was deemed to need two staff present at all times, to protect staff and others from allegations being made by the person. This is a restrictive practice, and there was no evidence of this restriction being given a due process consideration, independently reviewed or time-limited.

At elections, residents were assisted to vote – and the ballot was brought into the campus. This, however, is another example of residents being deprived of an opportunity to be in an ordinary place.

There were some locked areas, with centres being accessible only by a code, known only to staff.

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**Summary: I exercise my rights**

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Personal outcome <i>fully present</i> for:	<b>0</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>0</b> out of 21 residents

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**Summary: I am treated fairly**

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Personal outcome <i>fully present</i> for:	<b>0</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>1</b> out of 21 residents

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## **I have time, space and opportunity for privacy *and* I choose when to share personal information**

Opportunities for privacy are limited – this is due to the use of shared bedrooms and ward-type accommodation, and large groups congregating in some areas.

Personal information relating to residents was discussed in communal areas. Most accommodation had a nurses' station located in the main living area.

In the bungalows and the high-support units, many residents interviewed had no day service, so they spent most of every day in the same small common area, for all activities, including meal times.

Many of those interviewed were seated together with others in a day room, often in confined, crowded and noisy areas with no private space available – just a few steps away from their ward or bedroom, and within view of the nurses' station/office. Ten residents were counted in one room even though one woman was known to dislike noise and people close to her. Noisy cleaning took place for extended periods during the visit.

In the bungalows, residents tended to be congregated in one sitting area. One woman spent a lot of time in a sunroom with a good view of the campus, while others who could not move, were confined to the sitting room.

While some residents had individual bedrooms, others shared bedrooms with up to three other residents in an open ward setting – with a 'privacy curtain' as the only screen, and in a bleak, exposed and impersonal aspect. For many residents interviewed, there was little evidence of personal effects, other than a few family photos over their bed, and these were sometimes out of their view.

People tended to congregate in the one area, while other areas inside and outside the building were spacious but empty, quiet and calm much of the time – these included corridors, the hall, the hairdressing room, and outside spaces.

Those who had a private room said that they could go to their rooms if they wished. One person said she was sent to her room by a staff member.

One man was observed having a visitor in the common room. He had no privacy and other residents were vying for the visitor's attention.

One woman who had a room to herself had it taken away to accommodate reconfiguration, but this was restored recently following family intervention.

Another resident was moved into a room-share situation with a person he had complained to a staff member about being afraid of.

Two men shared a very small bedroom, where one man's walking aid had to be left on the corridor, because of lack of space. He could not move around without staff support.

People's privacy was compromised across the centre, throughout the day.

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**Summary: I have time, space and opportunity for privacy**

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Personal outcome *fully present* for: 1 out of 21 residents

Effective organisational support *fully present* for: 0 out of 21 residents

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**Summary: I decide when to share personal information**

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Personal outcome *fully present* for: 0 out of 21 residents

Effective organisational support *fully present* for: 2 out of 21 residents

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**I am respected**

From the previous section, it can be noted that there was evidence of disrespect towards residents within the service.

While there were many examples of staff showing kindness and a caring attitude towards individuals across the service, the men and women living in Áras Attracta were generally treated as if they were eternal children. Residents in the survey were not shown respect in terms of how their day, and indeed their life, was spent, or how their interests were supported. Many residents spent their entire day in the same building.

Personal property was not always kept safe, unless the person was able to do this for themselves, and had a private room.

One woman’s personal belongings were kept in one of four drawers in a chest, in an open bedside locker and in a shared wardrobe, but they were not clearly identified as hers. Some residents and some staff reported that personal property was taken by others, including by a ‘friend’ who was more mobile. Personal property was sometimes held by staff at the nurses’ station for safe keeping.

*‘Staff gave me a t-shirt; mine got lost.’*

One resident said that a staff member spoke ‘nasty’ to her, and she was told ‘Get down to your room’.

The idea of having personal space or being able to keep personal property safely and within reach was more or less non-existent for many of the residents.

One woman told the interviewer she did not know what would happen now that the bus was not available for their outing. She said ‘we will just sit’; this was noted after a wait of at least 45 minutes.

In a number of instances, residents had made their preferences known to some staff, but there was widespread disregard for their preferences. Personal opinions and preferences were not valued or respected in any real sense.

Services, supports, interactions and activities did not enhance the resident’s self-image or promote a positive image of the person, as an adult, as having capacity, interests or potential.

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**Summary: I am respected**

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Personal outcome *fully present* for: 0 out of 21 residents

Effective organisational support *fully present* for: 0 out of 21 residents

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## I have the best possible health

There was very significant support going into healthcare provision in the service, but these supports were not always effective in ensuring that residents had the best possible health. Residents had minimal control over their own healthcare, regardless of their capacity or interest in doing so. All areas of the service were directed and managed by nursing staff, and the service provision is structured within a medical model. Residents had very little choice around what health care providers they could use – for example, they could not go out to a GP practice, as the service was provided on-site.

Residents’ healthcare assessments were not complete or signed off appropriately in some instances. In one instance, issues were attributed to behaviour without full exploration of possible health needs that might have contributed to them.

Some of the file notes relating to residents’ health were illegible.

In one case, a diagnosis a resident had received prior to admission to the centre was discounted by a staff member, and the staff’s knowledge of the person’s previous health issues seemed at variance with the information provided by the family.

In one case the family of a resident who was of slight stature and needed help with eating observed that he was losing weight, and they brought this to the attention of relevant staff. The resident was put on a feeding plan and had regained weight. The resident’s mother said she was very happy with his current key worker.

Some people who were relatively independent could have had more support to manage their own healthcare, but this was done by relevant nursing staff exclusively.

Some aspects of healthcare documentation had not been completed – for example, one resident’s hearing test was not completed, even though this was a priority for that resident.

In some instances, contributory factors such as anxiety, depression, poor environmental circumstances or boredom needed to be considered. One person said: ‘Coming in here was the biggest mistake I made in my life.’

There was also evidence that some residents’ health issues were unclear or not adequately investigated – for example whether a resident had an intellectual disability or a mental health issue.

One family member said she really only had good things to say about the staff in the bungalow, but felt that some of them were not really trained enough to deal with the specific needs of her sister. Two family members commented that they were not happy with the level of access their family member had to the GP service.

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### Summary: I have the best possible health

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Personal outcome <i>fully present</i> for:	<b>9</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>8</b> out of 21 residents

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## I have continuity and security

In the meetings with residents, the interviewers heard on many occasions that although permanent staff were appropriately trained, there was a lack of continuity in personnel, and for this reason some staff did not know residents very well.

There were many reports of insecurity about the future of the service, and the possibility of the service being closed. Awareness of the desirability of moving to a more modern community-based option, as set out in the *Time to move on* report, was not evident.<sup>18</sup>

A key worker system had been put in place, but some key workers spent very little time with the resident they were assigned to. At the time of the survey, only nurses could be key workers, even though trained social care staff with expertise in key working and person-centred planning practice were available, working in care assistant roles.

There were several reports of people having been moved around the campus in various reconfigurations of the services. One resident reported she had been moved again to a different bungalow and she had no choice in the matter.

*'They told me it was better, but I don't know.'*

A family member who visited a resident several times a week expressed confidence in his key worker, but was concerned about the change she saw in him during the three days a week when this key worker was off duty, when he appeared withdrawn and unhappy.

There were several reports of day services being removed without consultation.

There were many reports of events not happening because of staff, transport or equipment not being available. These were often events that people really looked forward to, in the bleakness of boring, uneventful days.

Overall, the whole area of safeguarding in Áras Attracta is relatively weak and low-key. While some people were kept safe, many could have been supported to keep themselves safe. For example, the poster relating to the Designated Person<sup>19</sup> (vulnerable persons) was displayed, but there was no other guidance to residents about what they should do if they felt unsafe. The National Advocacy Service for People with Disabilities was not advertised nor mentioned by relevant staff or any of the people in the sample, although it had been used by some of the residents.

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### Summary: I experience continuity and security

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Personal outcome *fully present* for: **0** out of 21 residents

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Effective organisational support *fully present* for: **0** out of 21 residents

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<sup>18</sup> Health Service Executive, 2011. *Time to move on from congregated settings: a strategy for community inclusion*.

<sup>19</sup> The Designated Person is responsible for receiving concerns or allegations of abuse, collating information, ensuring the appropriate manager is informed and necessary actions identified, ensuring all reporting obligations are met, supporting the manager and others in addressing the issues, and maintaining appropriate records. (HSE, 2014. *Safeguarding vulnerable persons at risk of abuse – national policy and procedures*. p.41)

## Personal choices – having a say in your own life

The *personal choices* category gathers together the personal outcome measures that relate to the choices that people have in important aspects of their lives.

### **I choose my personal goals *and* I choose where I work or how I spend my day *and* I choose where and with whom I live**

There was no evidence of an adequate person-centred planning process being in place for the individuals in this survey. Where preferences were known to relevant staff, there was little evidence that these were being worked on, and only limited efforts were made to make these available.

When asked by the interviewers, even residents with complex non-verbal communication were able to express information about their interests and preferences – for example, loving contact with a dog, loving fast noisy boisterous sporting activity, liking fast movement, liking quiet places, liking particular music, and so on.

While there is a *My Plan* file for residents and this has comprehensive documentation, it has a strong health and procedure-driven focus, and is not at all centred on individual residents' overall perspectives or preferences. Professional-led healthcare was the priority.

The staff nurse created residents' plans and had access to them. The healthcare staff were limited to completing daily charts and had no meaningful access to the residents' plans or any role in their creation. In some instances, plans are locked away with access restricted to nursing staff.

There were several instances where new therapies were provided (for example, reflexology, dog therapy and hydrotherapy), without first exploring if these were what residents really wanted – for example, more personal contact with others.

Most of the residents in the sample had no day service, and none had a job or volunteered on or off campus. Apparently just one person in the sample went to the day service on campus. As a result, almost all spent the whole day in their residential setting, with the same group of residents, other than occasional outings as a group, or when they attended medical appointments or went on family visits – and this was the case regardless of their age, level of disability, or personal preference. Staff rostering and staff availability seemed to determine the residents' daily routine.

The fundamental idea of residents having a meaningful choice in how they spent their day was absent for all those in the sample, regardless of their age, level of disability, health, personal interests or engagement with others. Such choice did not seem compatible with a setting where basic care and supervision were determined by organisational schedules, rosters and procedures rather than by individual residents' personal preferences.

While some people in the sample had high support needs, others were much more able, but were not allowed to exercise independence in daily activities.

One parent said that their family member was quite independent earlier in her life – travelled independently, engaged verbally with others, looked after her own personal care needs, and participated in chores in her group home and family. This has now completely changed, and the person needs full support. There was no medical reason for this resident’s decline.

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**Summary: I choose my personal goals**

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Personal outcome <i>fully present</i> for:	<b>3</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>2</b> out of 21 residents

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**Summary: I choose where I work or how I spend my day**

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Personal outcome <i>fully present</i> for:	<b>0</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>0</b> out of 21 residents

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**Summary: I choose where and with whom I live\***

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Personal outcome <i>fully present</i> for:	<b>0</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>0</b> out of 21 residents

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\* The personal outcome *I choose where and with whom I live* (on an equal basis with others) is a fundamental human right set out in Article 19 of the UN Convention on the Rights of Persons with Disabilities (adopted in 2006).

## I realise my personal goals

This personal outcome requires that residents have achieved one or two things that are important to themselves in the recent past, and that this has been acknowledged by significant people in their lives. In this survey, many of the goals attained were short-term goals or related to one-off events, and achieving them made only a marginal improvement to the resident’s quality of life. For example, one person went to a music event in the town; for another person, their health had stabilised; a third person had a 30th birthday party in the hall on the campus. It was difficult to rate any of these goals highly.

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**Summary: I realise my personal goals**

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Personal outcome <i>fully present</i> for:	<b>12</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>9</b> out of 21 residents

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## I choose my daily routine

This personal outcome includes having choices regarding when you get up, go to bed, and have your meals, choosing what you eat, choosing to prepare a snack or participate in food preparation, taking part in household chores, having a shower or bath at the time you prefer, going for a stroll, watching TV and listening to music.

Because of the institutional structures that are in place, it was virtually impossible for any of the residents interviewed to choose their own routines for the day, regardless of their level of disability. All food was prepared in central kitchens, and was delivered to several of the houses/units by trolley. Residents had to indicate their food choices the day before. Some

people used the centre’s canteen. A family member said the cost of meals is included in the service fee they pay. People had very limited if any access to small kitchens in units or in the bungalows. Some were locked and accessible to staff only; they were very small and not designed to be used by residents. A person using a wheelchair or a person of short stature could not reach the toaster or other kitchen appliances across a counter.

One resident said she did not know she could go into the kitchen via another door, as the main door was locked for someone else’s safety.

A visual timetable and menu boards were present, but not individualised to the person’s preferences.

People could not do their own laundry, even if they preferred to do so.

Another person said she would like to do some house work, as she had always done this in her previous life and she did not have much else to do, but this was the contract cleaners’ work, and she did not want to interfere.

The people in the survey were observed to stay in the same location much of the time, and did not move between locations.

A family member observed that she had noticed that people did not go out around the grounds or into the town.

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**Summary: I choose my daily routine**

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Personal outcome *fully present* for: **0** out of 21 residents

Effective organisational support *fully present* for: **0** out of 21 residents

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## I use my environment

This outcome requires that people can use and access the environments they frequent. This includes the sitting room, laundry, bathroom and kitchen (including access to equipment), have access to transport to get places, and that there are reasonable accommodations and adaptations in the places they spend their time or want to visit.

Many areas in the centre were locked or out of bounds to residents. There were keypad locking systems in place for getting into and out of some units. For example, the doors into units 1 and 2 were locked with a code, that was available only to staff.

One man liked to go for a wander along corridors, to the large sports hall, and maybe outside the building; he was allowed to do this if relevant staff knew where he was, but he had no verbal communication or means to inform staff, and could only go if staff were with him, which was rarely possible. This person had no day service, and spent most of his day in one place. A behaviour support plan was put in place to manage this.

There was little evidence of adaptive devices to assist people use their environment.

A resident who liked to listen to radio and music was dependent on staff to supply this. Another resident could not turn the TV or radio on or off. A third resident could not get into the kitchen to access equipment they needed. There were no adapted switches on TV remote control or radio/music player or mobile phone, no lowered kitchen counters, no motorised wheelchairs or other personalised technology.

One resident enjoyed using an iPad, but had access to it possibly once per week, during ‘activation’ time.

One man had to leave his walking aid outside his shared bedroom, because there was no space inside the room – he then needed staff assistance to move around.

People were conditioned to stay in immediate supervised areas (unspoken rules) or they needed staff assistance to move around. ‘I’m not allowed.’ This however did not include entering other residents’ bedrooms, staff office, or some unsafe areas.

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**Summary: I use my environment**

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Personal outcome *fully present* for: **2** out of 21 residents

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Effective organisational support *fully present* for: **1** out of 21 residents

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## Belonging: Participation in the community

People live in communities, not in services, and community connections are vitally important for health and well-being, and are part of what it means to be human. The *participating in the community* category gathers together the personal outcome measures that relate to community involvement, participation and a sense of belonging.

### **I live in an integrated environment *and* I participate in the life of the community *and* I interact with other members of the community**

Many of the opportunities that residents might have for engagement with the local community in Swinford are lost as local services that some residents could access are provided in the centre. In fact, community presence was virtually shunned.

- ▶ Mass was provided on-site in the gym on Wednesdays for the ‘convenience’ of the people surveyed, even though the Catholic Church was within walking distance for some.
- ▶ A hairdresser came in once or twice weekly.
- ▶ A doctor attends twice weekly.
- ▶ Traditional music sessions were held on-site.
- ▶ A voting box was provided on-site at election time.
- ▶ Meals are provided in a large central canteen.
- ▶ The swimming pool and the Áras Walk are all on site.

A number of staff suggested this provision of services internally was good practice for disability services.

Some staff members were aware of people’s interests, which was recorded in their files, but little action was taken to provide community experiences. There was little obvious awareness of the positive social benefits of going out to religious services, or to a hairdresser in the town, of spending time in an ordinary place, or just a different place, and meeting other people there, even if it was less convenient or even cost a little more. Staff availability,



time and money-saving and organisational convenience were the determining factors, over and above the capacity or individual preferences of residents.

The choice of engaging more in the local community was simply not available, and residents' money had to be spent on internal services. There was also resistance to changing this practice linked to long established local arrangements, such as contracts with local providers.

One woman loved to have her hair and nails done before she came into Áras Attracta, and had a favourite hairdresser in her town; she no longer had any choice about this activity. Another man loved Irish music and really enjoyed a session when he went out to a local venue, but the session was now arranged internally on occasion, with friends of staff providing the music. The GAA football ground was across the road, but two men who loved GAA had not been there.

Another woman who used to go to the shops and library in her home town, reported that she would be brought to the local library and back by staff; she said she wanted more time to browse and look around the shops. One person remarked 'I used to go to Mass and I'd meet people there.' A younger person's birthday party was held on site, with staff and residents present, while this person really enjoyed being out in the local town with family and their friends.

While it was argued that having a GP visit the campus was better than going to the surgery 'where you would have to wait for hours', many people were observed sitting in the service for many hours with nothing to do.

A family member said she remarked to staff that she did not see people from Áras Attracta out around the area much. The staff response was that people had health sensitivities which prevented this. Recently, she has noted people out walking around the grounds more or in buses. Family members commented:

*'They bring you on the bus once a week, then you come back.'*

*'He enjoys a drive on the bus, they sometimes stop for ice cream, but not always.'*

Some staff visited particular locations in the community based on which ones would accommodate groups, as opposed to individual choice – for example, a particular garden centre.

While these outcomes are challenging to support in that they require that the person be satisfied with the *amount of* contact or presence in community, they were almost non-existent among the residents interviewed.

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**Summary: I live in an integrated environment**

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Personal outcome *fully present* for: **0** out of 21 residents

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Effective organisational support *fully present* for: **0** out of 21 residents

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**Summary: I participate in the life of the community**

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Personal outcome *fully present* for: **0** out of 21 residents

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Effective organisational support *fully present* for: **1** out of 21 residents

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**Summary: I interact with other members of the community**

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Personal outcome <i>fully present</i> for:	0 out of 21 residents
Effective organisational support <i>fully present</i> for:	0 out of 21 residents

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**I perform different social roles**

Social roles are situations in which we interact with other members of the local community – for example as customers, club members, church-goers – and other situations in which we interact with the local community or community group.

Activity coordinators have been introduced to some areas, but this was still being developed with no structured timetables and limited numbers availing. On observation, the nature of many activities are child-focused and do not reflect an adult population. A large amount of children’s toys suitable for under-fives had been purchased recently in one location for residents’ use. Much of the work carried out in the day service also seemed childlike in its nature. Some people did go shopping in the local community during the visit, facilitated by the activity coordinator.

A parent of a man who was non-verbal was not included in an assessment of his most valued roles. The valued roles were decided by the relevant staff and formed the agenda for his My Plan and subsequent timetable. The parent said that the highest role (determined following this assessment) was totally wrong and she explained why.

Another man had evident social roles in his life when he was home on visits, but these were not known about or supported within the service.

A family member noted ‘... continue with the positive work in place around the ‘This Is Me’ books ... however, make sure that they are individualised, living and breathing documents and not just something pretty, without the person or family being really involved, and on a once off basis’.

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**Summary: I can perform different social roles**

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Personal outcome <i>fully present</i> for:	1 out of 21 residents
Effective organisational support <i>fully present</i> for:	0 out of 21 residents

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**I choose services**

People living outside Áras Attracta make their own choices regarding their hairdresser, their clothes shopping, their bank, their GP and dentist, and so on. These are all services available in the town, but these choices are unavailable to people living in Áras Attracta.

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**Summary: I choose services**

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Personal outcome <i>fully present</i> for:	0 out of 21 residents
Effective organisational support <i>fully present</i> for:	0 out of 21 residents

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## Personal relationships

The *personal relationships* category gathers together the outcomes that relate to close, nurturing and reciprocal personal relationships.

### I have friends

There was little evidence of people in the sample having a friend, either inside the campus or outside, or being supported to have a visit from a friend or to visit a friend outside.

*‘They say we are friends, but we’re not – we just live in the same place.’*

There was evidence that some staff did not understand this outcome; a staff member said ‘I am his friend’. Staff are paid to be there, and as such, they cannot be considered friends; nor are such relationships reciprocal.

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#### Summary: I have friends

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Personal outcome <i>fully present</i> for:	<b>4</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>0</b> out of 21 residents

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### I have intimate relationships

For the purposes of the survey, intimate relationships include any close personal relationship, including those with a partner, parent or relative, or a spiritual relationship.

There was little evidence of anyone in the sample being supported to learn about or have an intimate relationship.

Other outcomes like privacy, community integration and rights also impact on this outcome – for example, if a person has a friend in the outside world, how do they stay in touch, or do they have a private place where they can be with them when they visit.

The whole area of friendships and intimate relationships is compromised by rules and regulations, lack of privacy, lack of community access, the person being treated as an eternal child, and so on.

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#### Summary: I have intimate relationships

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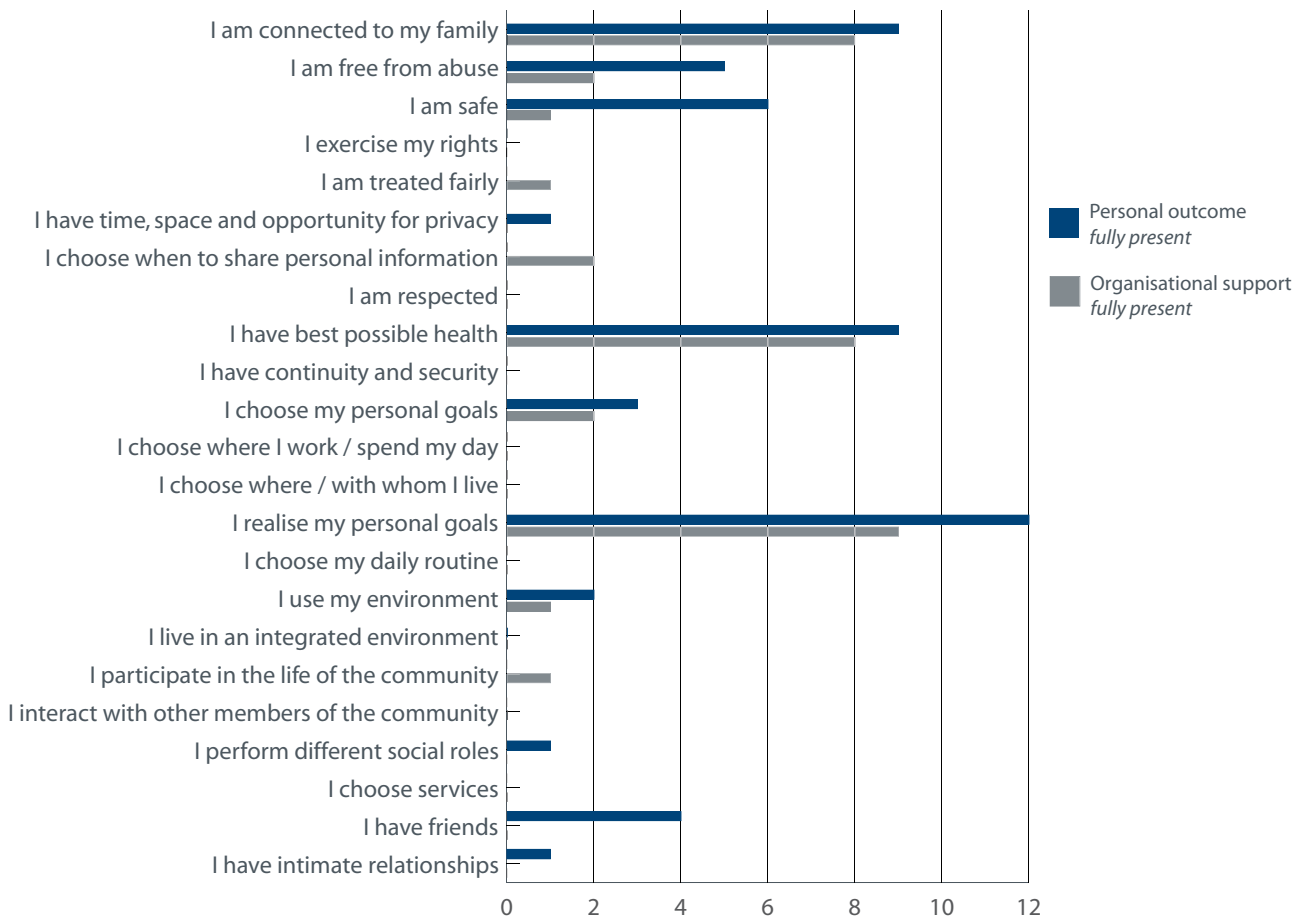
Personal outcome <i>fully present</i> for:	<b>1</b> out of 21 residents
Effective organisational support <i>fully present</i> for:	<b>1</b> out of 21 residents

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### 4.3 Discussion of the survey findings

The seven members of the POMs information gathering team spent a cumulative total of 19 days on-site at Áras Attracta, interviewing residents, family members, and the staff who knew the residents best. For each of the residents who participated in the survey, the 23 personal outcomes and organisational supports were scored as *fully present* or *not fully present*. The results are summarised in figure 4.1.

**Figure 4.1** Summary of Quality of Life survey scores



#### Personal outcomes fully present

The average number of personal outcomes *fully present* was 2.5. Two residents had no outcomes *fully present*, while one had 6 outcomes *fully present*.

The outcomes most often *fully present* were *I realise my personal goals* (12 residents), *I have the best possible health* (9 residents), and *I am connected to my family* (9 residents).

There were twelve outcomes that were not scored as *fully present* for any of the residents in the sample. These included *I exercise my rights*, *I am treated fairly*, and *I have continuity and security*, as well as three of the five outcomes relating to belonging in the community. Outcomes relating to personal choice were also particularly low.

## Organisational supports fully present

The average number of effective organisational supports scored as *fully present* for the surveyed group of residents was 1.2. In other words, each person, on average, had effective organisational supports in place to achieve one of the 23 outcomes. The supports most commonly in place were *I realise my personal goals* (9 residents), *I have the best possible health* (8 residents), and *I am connected to my family* (8 residents).

Of the 23 organisational supports, 12 were not in place for anyone in the sample.

The pattern of organisational supports in place generally followed the pattern for personal outcomes, except that there were fewer supports in place than there were outcomes.

Three residents had no organisational supports in place, while the most any person had was four organisational supports in place.

## Comparison with the National Survey

The Outcomes Network of Ireland and the Delivering Outcomes to People project undertook and published a *National Survey of the Quality of Life of People with Disabilities in Ireland*<sup>20</sup> using the Personal Outcome Measures. In all, 27 service providers participated in the survey, and a representative sample of 300 individuals were selected from the 5,365 eligible adults in those services. The present survey replicated the methodology of that study, adapted for the Áras Attracta service.

The national study included people living in various settings, including living at home, living independently, living in a community house, and living in a campus setting. Those living in a campus setting scored lowest, averaging 6.5 personal outcomes scored as *fully present*, compared to 14.8 for those living independently. There was also variability based on the type and level of disability. For example, those assessed as having a mild or moderate intellectual disability had on average 10.0 outcomes scored as *fully present*, while those with a severe or profound intellectual disability had 6.8 outcomes scored as *fully present*.

As set out in Table 4.3, the Áras Attracta outcomes compare poorly with the National Survey findings.

**Table 4.3** Comparison of average number of personal outcomes scored as fully present in the 2007 National Survey and the Áras Attracta sample

<b>Average personal outcomes fully present</b>	<b>National Survey</b>	<b>Áras Attracta</b>
For the total sample	9.8	2.5
For those living in a campus	6.5	2.5
For those with a mild/moderate ID	10.0	2.8
For those with a severe/profound ID	6.8	2.1

<sup>20</sup> McCormack and Farrell, 2007

The findings of the National Survey point to a correlation between service setting and quality of life. It found that twice as many people living in a campus setting achieved fewer than 10 outcomes compared to those living in community housing. In the case of Áras Attracta, this is even more pronounced. The setting or model of service used is not determined by direct support workers, and in many cases not even by service managers, but primarily by the funding agency, which may be influenced by competing priorities.

It is also evident that, typically, a person with a more severe learning disability will experience a lower quality of life. While this is true on average, it is not true individually – there are many individuals with a severe intellectual disability who have a better quality of life than some individuals with a mild or moderate intellectual disability. In the National Survey, outcomes for individuals with a severe/profound disability ranged from no outcomes to 17 outcomes scored as *fully present*. Services that focused on improving people’s quality of life over two or more years achieved significantly higher outcomes on average.

### Each person’s priorities for action

Not all personal outcomes are equally important to every person. As part of the information-gathering, interviewers sought to establish what were each resident’s three top priorities – based on conversations with the person and those who knew them well, and also on documentation. These priorities might be influenced by what residents think they can achieve, by their present experiences and frustrations, and perhaps by their limited experiences to date. But for each resident, their priorities are a good place at which to start planning positive change.

Table 4.4 shows the number of residents who chose each personal outcome as a priority. It was not possible to ascertain the priorities of one resident.

**Table 4.4** Priorities for Action as indicated by people in the sample.

<b>Personal outcome measure</b>	<b>Number of residents for whom this is a priority / 21</b>
I exercise my rights	4
I have best possible health	4
I have continuity and security	4
I am connected to my family	5
I am free from abuse, neglect, mistreatment and exploitation	5
I am safe	5
I have time, space and opportunity for privacy	6
I choose where and with whom I live	6
I participate in the life of the community	6

## Summary

The key points that emerged from the analysis of the data were:

- ▶ Twelve of the 23 personal outcomes were not scored *fully present* for any of the residents in the sample.
- ▶ Twelve of the 23 personal outcomes had no effective organisational supports scored *fully present* for anyone in the sample.
- ▶ Among the survey participants, the average number of personal outcomes scored as *fully present* among the surveyed residents was 2.5, indicating a very poor quality of life.
- ▶ The average number of effective organisational supports scored as *fully present* among the participants was 1.2, indicating a lack of supports in place.
- ▶ One of the residents surveyed had no personal outcomes and no organisational supports scored as *fully present*.

The personal outcomes most frequently scored as *fully present* were *I realise my personal goals, I am connected to my family, and I have the best possible health*, with effective supports also strongest for these.

The personal outcomes most frequently prioritised by those interviewed related to:

- ▶ Living arrangements: *I choose where and with whom I live and I have time, space and opportunity for privacy.*
- ▶ Community participation: *I participate in the life of the community*
- ▶ Personal protection: *I am connected to my family, I am free from abuse, neglect, mistreatment and exploitation, and I am safe.*

It must be kept in mind that while the meetings with residents and key others in their lives were rigorous and the interview team probed extensively, the POMs assessment is based on a once-off visit and represents a 'snapshot' view of the quality of life at Áras Attracta.







# PERSPECTIVES: RELATIVES AND STAFF

We also listened to and sought the views of the relatives of residents and of the staff who provide residents with day-to-day support.

## **Relatives of residents**

**Chapter 5: Relatives' perspectives on services in Áras Attracta** presents what we learned from listening to the views of residents' relatives – what they thought of the services their family members receive in Áras Attracta and what they felt might be the best way to improve the quality of service and to prevent any abuse of residents.

## **Staff members**

**Chapter 6: Staff perspectives on services in Áras Attracta** presents what we learned from our engagement with staff members. We invited all staff members to take part in group meetings and to respond to a questionnaire survey, with a view to learning from their experience of work at the centre, and to listening to what they have to say about how we can ensure that residents are safe and protected, and how they can realise their full potential.



# 5

## Relatives' perspectives on services in Áras Attracta

As a Review Group, we wanted to know what relatives of residents thought of the service being offered at Áras Attracta, and what they felt might be the best way to improve the quality of service and prevent any abuse of residents. In order to do so we invited relatives to attend a group meeting and we followed this up with a questionnaire survey.

### 5.1 Eliciting relatives' perspectives: the approach we took

#### Group meetings

An invitation to the group meetings went to the named relative of each person living in Áras Attracta. It explained the context and the purpose of the meetings, and outlined the background to the establishment of the independent Review Group. It explained that the meetings were being held to:

- ▶ Explore relatives' experience of care and services in Áras Attracta.
- ▶ Examine how informed they were about events in Áras Attracta.
- ▶ Discuss their views of what caused the behaviour, attitudes and practice demonstrated by some staff.
- ▶ Explore how the unacceptable behaviours and attitudes which had caused concern could be prevented in the future.

The invitation stressed that relatives could raise any other issues they wanted at the meeting. Relatives were also informed that if they were unable to attend the meetings, or would like to speak to the Review Group in private, alternative methods of expressing their views were available. They could do this by email, post or phone, or by way of a private one-to-one meeting with a member of the Review Group.

The meetings were facilitated by Review Group members and took place in March 2015. Thirty-seven relatives in total attended the two group meetings, and three families held private meetings with Review Group members.

Discussion at the group meetings focused on the following areas:

- ▶ The quality of care provided by Áras Attracta, including in Bungalow 3 (the main focus of the *Prime Time Investigates* programme).
- ▶ The role of management and leadership in the provision of services.
- ▶ The prevention of mistreatment and abuse of residents.
- ▶ Ways to improve services in Áras Attracta.

Detailed written records of the meetings were made by members of the Review Group's specialist consultants. These records did not attribute comments to particular individuals, and this was clarified at the outset to those attending the meetings. The views and opinions expressed by relatives at the meetings have been woven into the findings (see below) in a way that protects the anonymity of the relatives and residents involved.

The detailed notes from the group meetings were coded and analysed by the specialist consultants, and themes were then cross-checked and agreed with the members of the Review Group who facilitated the meetings.

## Questionnaire survey

The questionnaire survey was developed following the group meetings, with a view to reflecting the content and outcomes of the discussions that emerged at the meetings. It was designed to enable the Review Group to receive, in a confidential manner, any additional views and comments regarding the services provided in Áras Attracta. It also gave relatives a further opportunity to suggest solutions and proposals for improving the available services. The eight-item questionnaire included comment sections which gave relatives an opportunity to elaborate their views on these matters.

In June 2015, the questionnaire was distributed to the named relative on file in Áras Attracta for each person living there. Because of the sensitive context in which the survey was being conducted, and in order to respect assurances given to relatives at the group meetings, no attempt was made to track the returned questionnaires or identify respondents – the questionnaires were anonymous. For that reason we do not know how many relatives participated in both the group meetings and the questionnaire, or indeed how many participated in neither.

The topic areas covered in the questionnaire were:

- ▶ Management in Áras Attracta.
- ▶ Communications and information.
- ▶ Involvement in personal planning.
- ▶ Staff training.
- ▶ Healthcare needs of people living in Áras Attracta.
- ▶ Safety and protection of people living in Áras Attracta.
- ▶ Educational and recreational activities.

Ninety-five questionnaires were distributed – one each to the named relative of each person living in Áras Attracta – and 39 were returned completed, a response rate of 41 per cent. Basic statistical analysis was carried out on the questionnaires returned, and the open-ended comment sections were coded to identify emerging themes. A member of the Review Group's specialist consultants carried out the preliminary coding and performed the thematic analysis on the comments returned. The main themes that emerged were then agreed through discussion with the members of the Review Group.

## 5.2 Findings of the group meetings and questionnaires: the emerging themes

The findings of the group meetings and questionnaires are presented here, gathered under the themes that emerged.

### Management of bungalows and units

**Table 5.1** Respondents' view of quality of management of bungalows and units in Áras Attracta

Quality of management was regarded as ...	... by % of relatives
Very good	44%
Good	36%
Fair	18%
Poor	2%
Very poor	0%

Almost four in five respondents in the survey felt that management in the bungalows and units was either *good* or *very good*. Sixteen respondents<sup>20</sup> made additional comments about management. Five of these were very positive and commented on the helpful, approachable and professional attitude of staff. They remarked, in the main, about how happy and animated residents are, and how they are 'well looked after'.

*'We feel that the bungalow which my brother resides in is well managed and (management staff) is approachable at all times.'*

Another group of respondents felt they were not in a position to comment about management in the bungalows and units for a variety of reasons. These included the short time they had spent in the bungalows on visits, a lack of familiarity with new members of staff, and the fact that they only occasionally met with management staff on their visits. Six respondents raised concerns about the effects of what they perceived as poor management. These related to the effects of staff shortages on the services available, a lack of effective communication regarding important decisions being made about their relative, and the limited range of pastimes available.

*'Sometimes when we call there would be nobody in the bungalow. But I understand (it was) due to cutbacks; but nevertheless (that's) not good enough.'*

In contrast to the results of the survey, relatives attending the group meetings were much more critical of management in Áras Attracta. They made a clear distinction between managers in the bungalows and units and what they termed 'senior' management in the service. The latter, they felt, should be providing leadership and management, and were responsible for the overall management of the service, including recruitment, training and supervision of staff, rather than the day-to-day management of service delivery. Many of these relatives expressed a deep distrust and lack of confidence in senior management. Some of this was related to how they perceived management had dealt with them since the *Prime Time Investigates* programme.

<sup>20</sup> In this chapter 'respondent' refers to a person who participated in the survey; a 'relative' is a person who attended a group meeting.

However, there was a deeper distrust related to how a perceived lack of vision, oversight and basic management capacity had allowed the abuse and mistreatment of residents to occur in the first place.

*'Most of the staff are the loveliest people. Senior management 'don't care', but individual members of staff are very caring.'*

They felt the quality of management had deteriorated over time.

*'In the past there was good governance, structures, activity programmes and a vision for Áras Attracta (but not now).'*

They remarked that basic management systems regarding the monitoring and supervision of staff did not seem to be in place. They felt that there was a need to develop and implement certain policies and procedures (for example, those relating to behaviours that challenges) in order to deliver a good quality service, and that this did not seem to be happening. They remarked that staff morale was low and that staff did not seem to have faith in the ability of senior management to provide the leadership required. They felt that a comprehensive review of services in Áras Attracta needed to start with how the service had been managed.

*'The review needs to start with management. Who is managing the managers?'*

A number commented that senior managers were too 'desk-bound', and needed to be seen more 'on the floor', and have much higher visibility in day-to-day service delivery. Some relatives, while recognising the difficulties involved in managing a service such as Áras Attracta, contended that there needed to be ongoing, careful auditing of the quality of management and of the support provided.

Relatives also identified a number of management measures that they felt were critical to rebuilding their trust in the service. These included putting in place effective staff supervision and appraisal procedures, and enhancing staff competence in managing behaviours that challenge. They felt that it would be helpful if management would clarify the role of the key worker. A number of relatives felt that, because of the abuse and mistreatment that had occurred in Áras Attracta, there was a need to put a new senior management team in place.

## Communications and information sharing between Áras Attracta and relatives

**Table 5.2** Respondents' view of communications and information

<b>Quality of communications and information was regarded as ...</b>	<b>... by % of relatives</b>
Very effective	29%
Effective	55%
Neither effective nor ineffective	0%
Ineffective	8%
Very ineffective	8%

Most respondents felt communications and information sharing with Áras Attracta were *effective or very effective*. Twelve respondents made additional comments about communications and information sharing. Four of these were very positive and related to positive experiences they had where healthcare, care planning and activation issues were the subject of the communication.

*'Myself or my brother are always kept informed about any medical matters and updated on any outcomes or changes in treatment.'*

A further three respondents had a negative experience of communications with Áras Attracta. A number of these referenced the slowness of the service in communicating regarding a resident's healthcare or a critical incident that had occurred. Another commented on the quality of service provided by a key worker.

*'We find communication and information-sharing poor. We have found in the past some staff slow to communicate information regarding our relative's care, and critical incidents which have occurred in the past.'*

An additional five respondents had a mixed experience of communications in Áras Attracta. A number of them praised the effectiveness of communications regarding healthcare, illness, and critical incidents that had occurred, but were more critical of communications relating to care planning. One respondent complained that different elements of the service had different addresses for correspondence with them. Another felt that communications had improved since the broadcast of the *Prime Time Investigates* programme.

*'We were never shown his care plan and it was only shown to us recently because we were concerned about his health. With regard to healthcare decisions we would be happy enough with this.'*

Despite the generally positive picture of communications that was found in the survey, a small number of relatives at the group meetings were highly critical of communications between staff in Áras Attracta and families. One felt that there were major communications difficulties in the service between the various layers of management (senior, middle and junior) and that this translated into poor communications with relatives. Another felt that there needed to be improved communications with families about the complaints procedure and how it could be activated.

Criticism was expressed by another relative about the way in which they had been informed about the broadcast of the 'Inside Bungalow 3' *Prime Time* programme, and what they perceived as the insensitive language used by a senior manager. A number of relatives complained about the way in which the recent 'contract for care' had been issued. In one case there was no prior notification of, or involvement in deciding, the content of the contract, and in the other case the contract was issued to a parent who had been deceased for over a year. Relatives also noted the large number of residents who did not seem to have any contact with any other family members.

## Involvement by relatives in developing and reviewing the personal plan of a resident

**Table 5.3** Respondents' involvement in developing and reviewing the personal plan of a resident

Level of involvement	% of relatives
Very involved	26%
Moderately involved	32%
Undecided	3%
Somewhat involved	26%
Not involved	13%

The majority of respondents, 58 per cent, felt they were *moderately involved* or *very involved* in planning for their family member. Fifteen respondents made additional comments about their experience of involvement in personal planning for their relative. Most of these were positive and praised the key worker system, and the annual review of the plan.

*'I will hold my hands up and say that I have been aware and made some input, but all the work was done by the key worker, who is excellent.'*

A number of respondents were satisfied with their level of involvement, mainly because they lived in close proximity to the site and were in regular weekly contact with their family member. Other respondents commented on the difficulty in being involved to the extent they would like because of the long distances involved in travelling to Áras Attracta, or because of personal health conditions which restricted their ability to travel.

*'I live in the UK and I can't travel any more because of heart problems.'*

Two respondents were critical of the key worker system. One noted that the key worker was not assigned to his family member's bungalow, and this meant the key worker did not see them every day and sometimes not even every week. They felt this limited the key worker's knowledge of their family member and their input to the development of the personal plan and the monitoring of its implementation. The other respondent had no faith in the key worker system contributing in any meaningful way to the delivery of person-centred care.

*'I was never asked to be involved in the personal plan. I was unaware it existed until recently when my daughter asked me to ask Áras Attracta to see it. When I viewed it the content was inaccurate. The activities mentioned did not occur.'*

Although the involvement of relatives in personal planning was not a major focus of the group meetings, a number of relatives commented on their experience of personal planning in Áras Attracta. There was general recognition of the importance of families being involved in personal planning, and the positive impact this could have on the quality of service received by a family member. It was also recognised that this posed a difficulty for residents who did not have regular contact with family members, or who did not have an advocate. A number of relatives commented positively about the open-door policy that applied for visits, and the recent improvement in communication with key workers in developing personal plans and conducting annual reviews. They also praised staff members who acted as advocates for residents.



*'There have definitely been improvements; they're pulling up their socks. There's been much more communication with the key worker and this is the first year there's been an annual review in quite a while.'*

However, a number of relatives remarked that there was still some confusion about the role of the key worker, and that family members had not been adequately consulted before the recent issuing of 'contracts of care'.

*'Clarify the role of the key worker. There is some confusion regarding the role.'*

One relative recommended that a family/relatives' association should be formed in Áras Attracta.

## Staff competency and training

**Table 5.4** Respondents' views on staff training

Staff were regarded as ...	... by % of relatives
Very well trained	31%
Well trained	39%
Undecided	28%
Poorly trained	3%
Very poorly trained	0%

Seventy per cent of respondents felt that staff were *well trained* or *very well trained*.

Twelve respondents made additional comments regarding training. Many of these related to the ability of staff to deal appropriately with behaviours that challenge. A number felt that the provision of training was not the fundamental issue. One commented that training could not rectify a situation where a member of staff was unsuitable for work with people with intellectual disabilities in the first place. Another felt the core issue was the lack of opportunity and support for the positive transfer of training skills into the workplace.

*'From talking to the Director of Services, training is ongoing and Studio 3 is on site. However it's not so much that people are trained but that programmes are in place which work in tandem with this training.'*

Other respondents were more positive in their comments and praised the care and support their relatives received from staff members. Some stressed the need for ongoing training and recognised positive outcomes for their relatives that were related to training received by staff.

*'I do know that staff in the unit are doing extra courses to assist in residents' daily activity.'*

A small number were very negative in their comments about staff training. One felt that many of the nursing staff seemed poorly trained to deal with people with an intellectual disability and with behaviours that challenge. This, they felt, was also true with regard to care staff and agency relief staff. Another relative felt that the behaviour depicted on the *Prime Time Investigates* programme spoke for itself, and provided graphic evidence that only a minority of staff were adequately trained to deal with behaviours that challenge.

*'After what has happened in Áras Attracta I don't really know if any are trained and if so how well trained. Maybe a minority are well trained.'*

The training of staff did not in itself emerge as a major issue in the group meetings with relatives. Some incidental references were made however to staff attitudes and behaviours when relatives discussed the quality of care provided in Áras Attracta. As noted previously, relatives often made a clear distinction between senior management and management at bungalow and unit level. While they were often critical of senior management, they sometimes praised the caring attitude of individual members of staff. They were very clear in their recognition of the need for policy and for staff training in the area of behaviours that challenge.

*'In the bungalow our brother was well treated. The only issue was another resident who was very challenging and since he left, our brother is much less stressed.'*

Relatives suggested that in the recruitment of new staff there should be a greater focus on their ability to deal with behaviours that challenge.

## Residents' healthcare needs

**Table 5.5** Respondents' views on healthcare needs (including nutrition, access to GP and hospital services, access to allied health services such as dentistry and optician services)

<b>Residents' healthcare needs were regarded as ...</b>	<b>... by % of relatives</b>
Being met	89%
Undecided	3%
Not being met	8%

The overwhelming majority of respondents thought the healthcare needs of their family members were being met in Áras Attracta, and most of the comments made by respondents in the survey were positive. They referred to the proper administration of medications, timely access to hospital services, and recent improvements in food and nutrition. Relatives also welcomed recent changes in the provision of allied health services.

*'To my knowledge medication is monitored and on occasions in the past when hospitalisation has been necessary, we were always fully informed. Hospitalisation was generally due to chest infections becoming more serious..... As far as I know, improvements have been made in relation to diet and the quality of food being served.'*

However, a small number of respondents had concerns about dental services and the availability of GP services.

*'Generally yes (I believe my relative's healthcare needs are being met) but there was an incident where my family member was becoming physically unwell and I asked for a GP to attend on three occasions and this did not occur until my relative became so unwell it ended in pneumonia.'*

Although the healthcare needs of residents were not a major focus of discussion in the group meetings, a number of relatives commented on how these needs were being met in Áras Attracta. Some positive comments were made about how medical matters were dealt with, and about improvements that have been introduced to meet the nutritional needs of residents better.

*'Since the report emerged, some residents have put on a lot of weight, and this reflects greater attention being paid to the nutritional needs of residents. The food has improved, with a greater number of healthy options being offered. The timing of meals is now more natural for residents...'*

However, a number of concerns were also raised in the discussions about healthcare services. These related to perceived shortcomings in medical services and nutrition. One related to the effect of staff shortages on medical appointments.

*'....Áras Attracta has been short-staffed since 2007 and that (means) residents are not taken to medical appointments due to lack of staff.'*

Another relative, in contrast to the remarks reported previously, spoke about the short time given to residents to eat their breakfasts, and the presence of an over-regimented regime with regard to daily life, including at meal times.

## Residents' safety and protection

**Table 5.6** Respondents' views on safety and protection

<b>Residents were regarded as ...</b>	<b>... by % of relatives</b>
Safe and protected at Áras Attracta	80%
Undecided	20%
Not safe and protected at Áras Attracta	0%

Perhaps surprisingly, given the context of the survey, 80 per cent of respondents felt their family member was safe and protected in the service.

Fifteen respondents added comments. Two reported that they were completely confident that their family member was safe and protected.

*'Yes, I believe my brother is safe and enjoys a good quality of life in his current home.'*

The majority were confident but expressed some level of reservation or concern relating to the ongoing safety and protection of their family member. One issue raised was the ageing resident population in Áras Attracta, and another was the impending retirement of staff members who had developed relations with these residents over a long period of time. Another respondent commented that their confidence was dependent on effective staff training and supervision measures being put in place to ensure abuse of residents could not happen again. Yet another felt there was need for more security on the site. Quite a few respondents were confident about their family member's safety and protection but emphasised the need for relatives to be vigilant. One suggested the installation of a CCTV system.

*'Whenever we visit – which is most often unannounced – my brother always seems well cared for and happy. Sometimes his clothes could be more tidy but I understand it's not easy to keep everyone looking tidy and clean all the time. Other than that I have no concerns for his safety.'*

One respondent was very concerned about the safety of their family member and how they were protected in the service. The family member had been the victim of peer physical bullying, and as the incident was not witnessed by a member of staff, the respondent felt it was unclear what measures could be taken to ensure their family member was safe. A number of respondents spoke about the need to review the mix of residents in particular bungalows, particularly where some residents displayed behaviours that challenge or where there was wide divergence in the ability level of residents.

*'As I have stated already we are worried about my brother's quality of life at the moment in the bungalow he is in. We feel as a family that residents with very challenging behaviour should not be housed with residents of less challenging behaviour. My brother is no longer the happy and carefree person he was. He is no longer getting the individual attention he (was) used to.'*

Safety and protection was a major theme in the group meeting discussions. Some of those who attended were relatives of residents directly involved in what happened in Bungalow 3. Despite this, quite a few relatives commented positively about their experience of Áras Attracta and praised the staff and the standard of care experienced by their family member.

*'Our son has always been well cared for. He's been here since 1991.'*

*'We have nothing but praise for Áras Attracta ... and have never found anything but the best of care.'*

A number of relatives expressed shock and disbelief at what had happened in Bungalow 3, and had serious concerns about how the safety of their family member could be secured. Some relatives felt that it was difficult to believe that the abusive behaviour was confined to just one bungalow.

*'I wrote a letter in December 2014 to the Director of Services in Áras Attracta regarding where else the suspended staff had worked in other than Bungalow 3. I still haven't received an acknowledgement or a reply.'*

One person commented that the culture in the different bungalows varied, and some bungalows were more positive than others.

Relatives also discussed the factors that might have led to the abusive behaviour by staff. They referred to the vulnerability of family members and how this left them more likely to be abused, particularly if they had poor verbal communication skills. They also spoke about the added vulnerability of residents who did not have ongoing contact with a family member or an advocate.

However, relatives located the reasons for what happened in Bungalow 3 firmly at the feet of management and staff. They referenced what they perceived as negative attitudes among some members of management and staff towards people with an intellectual disability. They spoke about the absence of appropriate policies and procedures to deal, in particular, with behaviours that challenge, and also felt that staff rostering arrangements might have been a contributing factor.

Because staff were often assigned to the same bungalows over a long period of time, they felt this allowed 'cliques' to develop and might have fostered some of the bullying and abusive behaviour experienced by residents.

They also noted what they saw as a management culture which did not take complaints raised by members of staff seriously.

*‘Staff complaints should be listened to and taken seriously ... when staff complain they get moved on.’*

Relatives also identified measures they felt were needed to ensure the safety of their family members. They felt that all residents should be treated equally and recommended a number of actions to ensure the safety and protection of residents. They commented on the need for greater on-the-ground oversight and management of staff, and the need for more comprehensive assessment of staff performance. They felt that inspections from HIQA and other agencies should in the future be unannounced, and that formal quality assurance schemes such as ISO could be used to improve services. A number felt that there was a need to introduce CCTV in public spaces to reassure relatives in the short-term. They also recommended a review of rostering arrangements to see how these could be improved to promote the safety of residents. There was also a suggestion that each bungalow should have information on public display regarding the Confidential Recipient, Leigh Gath.

A number of relatives expressed concerns about the ethical issues that the *Prime Time Investigates* programme gave rise to, including the breach of confidentiality involved and the manner in which the researcher accessed and made public information about some of the residents in Bungalow 3.

There was no agreement among relatives that residents were any safer or better protected since the broadcast of the *Prime Time Investigates* programme and the publication of the subsequent HIQA inspection reports.

## Educational and recreational activities

**Table 5.7** Respondents’ views on the education and recreation programme at Áras Attracta

<b>The education and recreation programme at Áras Attracta was regarded as ...</b>	<b>... by % of relatives</b>
Very good	37%
Good	41%
Fair	19%
Poor	3%
Very poor	0%

Almost four in five respondents in the survey thought that the current activation programme was either good or very good.

Fourteen respondents made comments about the activation programme, half of which were positive and half negative. Many recognised the positive impact a good quality programme would have on the lives of residents, but complained about the limited range of activities available.

*‘We were happy enough with the programme up to a few years ago. The recreational activities were few and far between (now). Maybe this was due to funding but we think it is very important for residents to have stimulation.’*

*It gives them something to look forward to and keeps their minds and bodies active. However, it seems to be improving again and we hope it will continue.'*

One respondent emphasised that staff needed to be trained to understand the importance of activation.

*'(I don't want) to have my relative sitting all day without any form of stimulation. More activities/excursions (are needed). (We need) better trained staff who understand the activities that can be enjoyed by people with learning disabilities.'*

One respondent complained about over-use of the TV; another about the additional charges that were attached to certain activities (such as music), which could be prohibitive. A number of relatives were not aware of the activities their family member was involved in, and a number felt that the activation programme was no longer relevant to their family member because of their age.

*'(The programme) does not apply to my relative because of her age.'*

Some respondents commented about the effect of staff shortages on the activation programme.

*'My brother really enjoys social outings, trips to the pub and restaurant and bus trips. In order for these trips and social interactions to continue, there needs to be adequate staffing levels. Staff shortages means that my brother and his fellow residents miss out on what's important in their lives – hence not achieving their goals and not reaching their full potential.'*

However, three respondents commented positively on the recent improvements in the programme following the appointment of additional staff with responsibility in this area.

*'Additional activation service means that my brother will have a broader chance of things to do.'*

In the group discussions, activation was recognised as an important factor in enhancing the quality of life of residents. Relatives commented on the need for a wide range of activities and the need for a stimulating physical and social environment for their family members. One relative commented that a comprehensive activation programme could impact on behaviours that challenge and lead to a safer environment for both residents and staff. A number complained that the activation programme had 'faded' since Áras Attracta had opened and had not evolved to meet the changing needs of an older population of residents.

*'As people have aged the activities haven't changed. The amount seems to have diminished – for example, five hours a fortnight.'*

One relative proposed greater links with the local community, and wondered if transition year students from the local schools could be involved in the activation programme. Another commented on the lack of activities at the weekends and during holiday periods.

*'Residents have a lot of 'down time' and not enough activities. The workshop was closed for two weeks in the summer. It is 'very boring' for residents at the weekends. It would be good if the residents could even go out for a walk.'*

## 5.3 Discussion of the views and opinions of relatives

The views and opinions of relatives have a critical contribution to make in any discussion on how service quality can be assured and improved in Áras Attracta. Relatives have a unique perspective on the services provided, and can provide valuable insight into many aspects of services that impact significantly on the lives of residents.

The picture that emerges from the group discussions with relatives and from the questionnaire survey is one in which the status quo (Áras Attracta as a congregated setting) is very much accepted by relatives. The transition to community living was not being actively discussed at the time of the meetings or the survey, and hence did not feature significantly in the input from relatives. Relatives assumed that Áras Attracta would continue in its current form, at least for the medium term, and almost all of the discussion and feedback from relatives related to the service as it is currently configured. In all of the engagement with relatives outlined in this section, only one reference was made by relatives to promoting independent living in the community.

With this in mind, at one level the results from the survey show that many relatives are confident in the services that are currently provided. Almost 90 per cent are confident that the healthcare needs of residents are being met, while 80 per cent believe management is doing a good or a very good job, and a similar number are happy with communications with the service. Almost 80 per cent are satisfied with the activation programme provided and the measures in place to ensure residents are safe and protected. Although only 70 per cent believe that staff are trained adequately for the task involved, and a smaller number, 58 per cent, was pleased with their level of involvement in personal planning, these figures still paint a picture of a service that has the confidence and trust of a sizeable majority of relatives. This picture was supported by many positive comments and observations made by relatives at the group meetings.

However, a significant minority of relatives has serious concerns about many aspects of the services provided to residents. This group includes, but is not exclusively made up of, those whose family members were the victims of abusive behaviour in Bungalow 3. In the survey, over 20 per cent of respondents rated management as only fair or poor, 16 per cent were dissatisfied with communications by the service, and almost 40 per cent were dissatisfied with their level of involvement in personal planning. Twenty-nine per cent were ambivalent about whether staff members were adequately trained to carry out their responsibilities, and one in five did not know if their family member was safe in Áras Attracta. Over 20 per cent of respondents believe that the activation programme is only fair or poor. These results are perhaps not surprising given the context of the work of the Review Group and the timing of the group meetings and the questionnaire survey. This followed the broadcast of the *Prime Time* programme and the issuing of a number of HIQA inspection reports that were highly critical of services in Áras Attracta.

## Recommendations from relatives

Individual relatives have their own personal experience of services in Áras Attracta, and their views on what improvements are needed will be coloured by that experience, and may be particular to their family member. However, it is clear from the group meetings and the survey results that there are many common concerns. The improvements that relatives recommend to address these issues are eminently sensible, and the changes they propose are relatively straightforward and easy to implement. In essence, they can be characterised as follows:

- ▶ Improve personal planning by putting an effective key worker structure in place – one that engages with relatives in a professional manner for the development and review of personal plans.
- ▶ Ensure that staff are adequately trained to work with people with intellectual disability, and in particular to deal effectively with behaviours that challenge.
- ▶ Develop communications with relatives that are accurate, respectful, effective and sensitive to the needs of both residents and relatives.
- ▶ Improve management standards, at a strategic level by providing strong leadership and vision for developing the service, but also operationally by developing effective systems to properly support, motivate, supervise and appraise staff.
- ▶ Develop an activation programme based on residents' needs, which is age- and ability-appropriate, is ambitious in terms of outcomes for participants, and which will enable participants realise their full potential.
- ▶ Ensure that people who live in Áras Attracta are safe – by implementing the above improvements, and by creating an open culture in which all members of staff are encouraged and supported to take responsibility for ensuring the safety of residents.

The implementation of these recommendations would go a long way towards rebuilding the trust of relatives in the services provided in Áras Attracta.

The comments of relatives in relation to staff training need to be viewed in the context of the comprehensive training programme delivered to staff and with which relatives would not have been familiar. Details of this are contained in chapter 8.



# 6

## Staff perspectives on services in Áras Attracta

A key part of our work as a Review Group was to seek the views of staff at all levels in Áras Attracta: from nurses and nurse managers, from healthcare assistants, from allied professionals and from other staff (including maintenance, administration, stores staff and instructors). To do this, we invited all staff to attend group meetings and we followed this up with a questionnaire survey.

We also invited members of the senior management team to a separate meeting to elicit their views.

### 6.1 Eliciting staff perspectives: the approach we took

#### Group meetings

The invitation to the group meetings was sent to all staff working in Áras Attracta. It explained the context and the purpose of the meetings, and outlined the background to the establishment of the Review Group. It explained that the following five themes would provide a focus for the meetings:

- ▶ Empowerment of Áras Attracta residents – focusing on how to afford them choice and opportunity for involvement.
- ▶ Quality of care and quality of life – looking at the overall shared vision of care and life in Áras Attracta, including safety and welfare.
- ▶ Leadership, management, culture and change.
- ▶ Staff training and professional development.
- ▶ Facilities, services, equipment and general environment, including catering, transport and security.

The invitation stressed that contributions at the meetings would not be attributed to individuals, and that there would be a further opportunity following the meetings for staff members to give their views and opinions in an anonymous survey.

The meetings with staff took place in March 2015. They were facilitated by Review Group members, and the discussion focused on the themes outlined above. Detailed written records of the discussions were made by members of the Review Group's specialist consultants. In total, 71 members of staff attended the six group meetings, approximately 29 per cent of the total workforce – see Table 6.1 for a breakdown of these by staff grouping.

**Table 6.1** Breakdown of staff who attended the discussion group meetings

	<b>Number of staff</b>
Staff nurses	22
Nurse managers – CNM1s and CNM2s	9
Healthcare assistants	14
Allied professionals	6
Other staff (including staff administration, maintenance staff, stores staff, instructors)	20

The detailed notes from the group meetings were coded and analysed by specialist consultants, and themes were then cross-checked and agreed with the members of the Review Group who facilitated the meetings.

## Senior management meeting

Four members of the senior management team attended a meeting which was facilitated by two members of the Review Group. It focused on leadership, management and change in Áras Attracta, and on the quality of life of residents. A detailed written record of the meeting was made, and the major themes that emerged have been integrated into this report.

## Questionnaire survey

The questionnaire survey of staff followed the group meetings and was distributed to staff in June 2015. The questionnaire was based on the content and outcomes of the discussions at the group meetings. The identity of respondents was not tracked – the questionnaires were anonymous.

The topic areas covered in the questionnaire were:

- ▶ Providing leadership and direction.
- ▶ Records and communications.
- ▶ Enabling and sustaining independence.
- ▶ Meeting staff needs.
- ▶ Meeting the healthcare needs of people living in Áras Attracta.
- ▶ Ensuring that residents are safe and protected.
- ▶ Lifelong learning.
- ▶ Working in partnership with other professionals and the local community.

Forty-seven questionnaires were completed, which gives an overall response rate of 21 per cent. Table 6.2 gives a breakdown of the returned questionnaires by the various staff groups.

**Table 6.2** Breakdown of staff who participated in the questionnaire survey

	<b>Number of staff</b>
Staff nurses	25
Nurse managers – CNM1s and CNM2s	2
Healthcare assistants	11
Allied professionals	1
Other staff (including staff administration, maintenance staff, stores staff, instructors)	8

Of the 47 staff who responded, 80 per cent had worked for five years or more in Áras Attracta and 18 per cent had worked there for less than two years.

## 6.2 Themes and issues that emerged from the group meetings

In the course of the staff group meetings a number of dominant themes emerged – these are summarised here. Commentary from the senior management meeting is incorporated here (indented text) where relevant to the theme under discussion.

### Leadership, management, culture and change

#### Lack of confidence in senior management

Many staff members expressed a lack of confidence in the leadership provided by senior management at Áras Attracta<sup>21</sup>. They believe that senior management lacks vision regarding services in Áras Attracta, and for that reason there is huge uncertainty regarding its future. Some commented that Áras Attracta is ‘in limbo’, particularly as the future of organisations delivering services in congregated settings is uncertain, and these staff members do not sense that senior management has a viable action plan for moving residents into the community.

A small number of staff were more positive and saw the appointment of the new Director and new senior management team and the establishment of new centres as opportunities to bring about strategic change based on a social model of care. Many staff feel that the focus of current senior management has been mainly on crisis management, as a response to the publication of the various HIQA reports and the broadcast of the *Prime Time* programme.

Staff mentioned the sense of confusion and uncertainty regarding the future of the service, which they believe is not helped by inconsistency and lack of focus from senior management. Indeed some staff believe that all the most important decisions are made off-site by HSE management at a more senior level, over which local management has very little influence.

<sup>21</sup> Staff used the term ‘senior management’ to describe managers above the level of Clinical Nurse Manager 1 (CNM1) and CNM2, and ‘management’ to refer to the work of the various grades of CNM working at unit or bungalow level.

Senior management described a situation where the service had been in crisis since early 2014. Since then there had been a relentless focus on implementing HIQA compliance measures and, more recently, on efforts to deal with the fallout from the broadcast of the *Prime Time* programme. They believed the service has just emerged from this crisis phase. The senior management team agreed that the restructuring and establishment of the new Clinical Nurse Manager 3 positions provided an important opportunity to improve the service, including the further development of the role of the Clinical Nurse Manager 2 position.

## Communication issues

Many staff members felt that the current crisis-driven approach by senior management is having an impact on the quality of communication between management and staff. They described the rather cumbersome way in which management decisions are taken and communicated, and suggested that the establishment of staff forums might improve matters.

Some staff reported that it is very difficult to absorb the quantity of information distributed by management through text, email, and memos. They also commented on the changing and often contradictory content of communications. They feel overwhelmed by the number of new policies being introduced, by changes of emphasis from one policy to the next, and also by the increasing burden of paperwork, which they felt could be mitigated by the introduction of an ICT-based system to replace the current paper-based system.

## Following the *Prime Time* programme

Some staff spoke about a negative 'culture of blame' which has developed in Áras Attracta following the broadcast of the *Prime Time* programme. Some felt that management and staff at every level were reluctant to take responsibility for what happened, and a culture of disrespect has developed, which needs to be addressed.

Many members of staff see themselves as victims in all that has happened since the *Prime Time* programme.

Senior management also spoke about feelings of guilt and responsibility for the situation that arose in Bungalow 3.

Staff spoke about the support (or lack of it) they have received from senior management, from their managers at CNM level, and from their colleagues since the *Prime Time* programme was broadcast. Some spoke about feeling isolated and having a sense of shame about what had happened. Many felt a lack of support from senior managers and that, in the absence of formal support from management, they have had to rely mainly on informal support from their colleagues to deal with the situation.

Senior management described a situation where there were poor relationships between staff and the management team. No process of performance management was in place in Áras Attracta – none existed in the HSE at the time – and this did not help matters. There were also fraught relationships between senior management and the two unions representing staff, and this was further compounded by rivalry and competition between the unions.

Some staff had availed of the Employee Assistance Programme in the immediate aftermath of the *Prime Time* programme and reported varying degrees of success. Others commented that the contribution of the psychologist from Western Care immediately before the programme was broadcast was positive and a source of support to staff, as well as to residents.

### **The role of clinical nurse managers (CNMs)**

Some staff members spoke about the importance of the role of the CNM as a middle manager in supporting staff, and that this would be particularly critical if a structured approach for support and supervision of all staff is to be introduced, which many staff would welcome. Such an approach is now in place at middle management level but not yet for other staff.

Other staff members, however, felt that the role of the CNM1 is not clearly defined at the moment. They felt that a 'collegiate', and sometimes a friendship relationship, has in some cases replaced the professional management relationship that is required between CNMs, staff nurses and healthcare assistants.

The nature of the relationships between CNM2s and other staff was also an issue of concern for senior management. They agreed that this relationship is too informal and is more a colleague-to-colleague than a manager-employee relationship. It was also suggested that the non-supernumerary status of the CNM2 posts can cause difficulties in establishing their role as managers. A first-time manager course is available to all newly appointed CNMs, but there may be the need to provide 'refresher courses' to managers at this grade. In addition, senior management believe there is a need to build collegiality and uniformity of practice among managers.

### **Lack of consistency at senior management level**

Staff felt that senior management needs to engage more with staff and be more visible in the units and bungalows, so that they could get a better sense of current service delivery issues. Staff also criticised senior management for what they saw as a lack of consistency in their relations with staff.

They were also critical of the lack of consistent, standardised practices and procedures across the units and bungalows, which in some cases led staff to 'writing their own book' in relation to these issues. Some staff felt that senior management did not have procedures in place for debriefing after serious incidents had occurred. Others criticised the lack of consistency in the way in which sick leave was addressed by different managers.

### **Issues with staff rostering**

Some staff were critical of the 'line' rostering system for nursing staff which is used in Áras Attracta. A number described this as 'staff-centric' rather than focused on the effective delivery of services for residents. Others commented on the lack of discussion with staff regarding how they were rostered, and complained about a 'cosy cartel' who received preferential treatment when it came to rostering. A suggestion was made that a new rostering structure could be piloted.

Senior management believed the current 'balance' of the rostering system favoured the staff and their family arrangements over the provision of a quality service to residents. While there are very valid arguments for non-rotation of staff (to provide greater continuity of support and to develop relations with families), local arrangements such as the trading of shifts mean that management had effectively lost control over rostering.

## Some improvements in senior management

Some staff complimented senior management on some recent developments:

- ▶ Staff can now express concerns about services more easily and be taken seriously.
- ▶ Each new centre now has a clear management structure with better channels of communication.
- ▶ There is a complaints procedure in place and a Designated Person at CNM2 grade has been appointed to deal with complaints and allegations of abuse.

## Staff training and development

Most of the staff who attended the meetings had attended the training provided over the past year, and welcomed its introduction. However, they felt there had been a lack of investment until recently in staff training. Staff recognise the need for continuous professional development and are aware of how training and development can improve their confidence, their understanding and practice, and the standard of care they provide. They value the recent training they have received from Studio 3 on managing behaviours that challenges. They also value recent training on safeguarding vulnerable adults, and would welcome specific training on the key worker role. They identified autism and dementia and also communication as areas that require additional training. They would welcome training inputs from allied health professionals such as social workers and occupational therapists.

Staff acknowledged that, because of staff shortages, it can be difficult to get released from frontline duties to attend training. Also, there is no provision for staff members who have attended training to share what they have learnt with their colleagues. One suggestion from staff was that bungalow- or unit-based training might be a way to overcome this. Staff also said that they would welcome more on-the-job training opportunities such as mentoring and shadowing, which they felt might be very effective ways to learn and improve practice.

Senior management appreciates the role of training in bringing about fundamental culture change in the service. They also noted the difficulty in ensuring effective transfer of learning from training into practice. One of the difficulties, they felt, related to the absence of effective supervision and staff appraisal. Áras Attracta is linked closely with the Department of Nursing and Social Care of Galway Mayo Institute of Technology (GMIT), and receives regular updates on what training opportunities are available.

The focus of training in the recent past has been on managing behaviours that challenge and on the protection of vulnerable adults, and such training has been mandatory for all staff. Release for staff training depends very much on whether the roster can support such release.

In the past, some members of staff were supported in undertaking external courses, but the HSE is no longer in a financial position to offer such support.

Some staff proposed that a formal system needs to be developed to support the introduction of a reflective practitioner approach to service development. They also highlighted the need for review of the induction and orientation programme to ensure it is effective – for all new staff, including agency staff. Joint training opportunities that included site visits to other organisations delivering services to people with intellectual disability would also be welcomed.

## Empowerment of people who live in Áras Attracta

There is a growing awareness of the importance of involving residents in decision-making regarding everyday activities such as rising times, food and meal times, and personal hygiene. This is often done informally by staff members, but staff feel the involvement of residents in making decisions is under-developed. It is also acknowledged that some members of staff have difficulty fully understanding this concept and integrating it effectively into their practice.

### Advocacy for residents

Residents can act as self-advocates, and the 'Voices and Choices' group in Áras Attracta and the advocacy group in Roscommon facilitate this.

There are also opportunities for family members to act as advocates for residents and this is welcomed by staff – for example, in the annual review process. About 40 per cent of families are actively involved in the annual review of personal plans. However, the ageing of the resident population and of their immediate family members has impacted negatively on family involvement. The current Family and Friends Group limits itself to mainly fundraising activities. Where there is a high level of involvement of families (for example, in the case of families of residents in respite care), there tends to be improvement in the quality of care provided and the quality of life of residents. Sometimes, however, there may be a conflict of interest between the wishes of residents and their families, and this can be difficult to manage.

Staff recognise that independent advocates can also ensure that residents are involved meaningfully in decisions that affect them. There has been an increase in the use of independent advocates, but this service still has limited availability. Staff also see a role for themselves to act as advocates for residents as part of their everyday practice.

## The role of the key worker

The key worker role is an important one in ensuring that the voice of residents is reflected in decisions relating to the nature of support that they want or need. All residents have now been assigned a key worker and a link worker, who is available when the key worker is not on duty. The key worker holds responsibility for communication with the resident's multi-disciplinary support team and for the development and annual review of the resident's personal plan. The key worker is also responsible for ensuring that the personal plan is understood and implemented by all staff. However, the establishment of the key worker role has proved difficult, mainly because of rostering practices, and the role requires further development and resources to ensure it works effectively. Training is now being provided to assist staff in the key worker role.

## Greater choice for residents

Arising from the work of the activation team, there are increased opportunities for residents to exercise choice and be involved in activities. Improved transport facilities have also helped, as they allow a greater range of external activities to be available to residents.

Some residents now have easier access to their personal money, and this also promotes choice. However, formal communication systems need to be introduced for non-verbal residents – some staff recommended the Picture Exchange Communication System (PECS)<sup>22</sup> for this purpose.

## Vulnerability of non-verbal residents

Non-verbal residents are more vulnerable and often require support to ensure they have a meaningful input into decision-making – such support can come from staff, from family members or from an independent advocate. Some staff suggested that the introduction of the Personal Outcome Measures (POMs)<sup>23</sup> system would ensure that residents' views and opinions are reflected in decisions made about their lives.

## Quality of care and quality of life

### Some improvements in the quality of care

Staff feel the quality of care has improved in Áras Attracta over the past year. Examples of these improvements include:

- ▶ Adaptations to the physical environment to better reflect residents' preferences.
- ▶ Individualised packages of care for some residents that better meet their needs.
- ▶ An enhanced activation programme is available to a greater number of residents – including greater involvement of the healthcare assistants.

<sup>22</sup> PECS is an alternative form of communication designed to supplement or replace speech or writing for people with a language impairment.

<sup>23</sup> POMs is a quality system which helps identify key life choices and wishes – this was the model used in the Quality of Life survey outlined in chapter 4



However, there remains a need to develop a definite schedule for the activation group to ensure maximum use of the service. The types of activities provided for residents have changed over time to reflect the ageing of the population. Music therapy, relaxation and a Fit for Life<sup>24</sup> area are now available for residents, although there is still concern about the low number of residents involved in the activation programme.

There is a growing awareness among staff of the need for a social model of care to underpin service delivery, and staff recognise the importance of basic values such as respect and empathy when working with residents.

### Some points of concern

The way in which respite care is organised is causing concern to staff, as does the way in which behaviours that challenge are dealt with. Staff noted that the training provided by Studio 3 was very effective for dealing with behaviours that challenge. But they also recognised that the service was still in transition in this matter, and that it is just starting to develop plans for residents deemed to have behaviours that challenge.

There is a growing awareness of safeguarding issues and the importance of effective management of the greater risks associated with enhanced activities for residents and greater openness in the bungalows and units. A considerable amount of training has taken place and staff are confident that they know the procedures to follow if a resident is mistreated or abused.

Staff felt that the quality of care provided to residents and the quality of life they enjoyed were negatively impacted in the following ways:

- ▶ By the reduction (in the past) of the number of bungalows (which they believed was driven by financial cutbacks) and the resultant overcrowding.
- ▶ By ongoing staff shortages and the consequent over-use of agency staff.
- ▶ By the reported high level of sick leave.

Overcrowding and the comings and goings of various staff as they perform their duties throughout the day mean that life in the bungalows can seem chaotic, with up to eighteen people present in a bungalow at any one time. Staff commented that this is not conducive to the development of a supportive, stress-free home environment for residents, or a pleasant work environment for staff.

Staff felt that the mix of residents with very different capacities and needs in some bungalows can also impact adversely on the quality of care provided, and on the quality of life residents enjoy. Staff also felt there should be separate accommodation for residents receiving respite care.

Some staff believe that there is an over-reliance on nursing staff and an under-utilisation of healthcare assistants, and that a more appropriate professional skill mix might make it less difficult to implement a social model of care. Staff see the benefits of a social model of care and agree that residents need increased individualisation, personalisation and choice. They also believe that clarification and direction is required from senior management as to the roles of different staff in implementing such changes.

<sup>24</sup> Fit for Life is a practical and interactive programme which promotes physical activity and heart health.

Staff believe that the publication of the HIQA inspection reports and the broadcasting of the *Prime Time* programme have led to greater choice being available to residents. However, the paperwork burden on staff has increased hugely because of the current reporting requirements, and this can adversely affect the time available to provide personal services to residents.

## Why were residents mistreated and abused in Bungalow 3?

Staff identified a combination of factors that they felt contributed to the mistreatment and abuse of residents in Bungalow 3, some of which are highlighted above. In addition staff noted that the absence of management oversight in Bungalow 3 also acted as a contributory factor, as they believed that this allowed for the development of a culture dominated by a 'clique' that facilitated the mistreatment and abuse of residents.

Staff felt that there were very high stress levels among staff in Bungalow 3, and that this was related to inadequate staffing levels. They also noted the large number of agency staff working in Bungalow 3, and felt that this was inappropriate, as many of the agency staff were not experienced in working in such an environment, and had not received safeguarding training.

Staff also felt that overcrowding in Bungalow 3 was an issue. Some spoke about a situation where a relatively large number of residents were enclosed in a small area day and night, with nothing to do by way of an activation programme. Others commented on the mix of residents in the bungalow, that many of them had behaviours that challenge, and how this impacted on the relationships between residents. Residents had no say in who they would like to live with.

Some staff felt that the staff in Bungalow 3 were not adequately trained to meet the needs of the residents. They also noted that what happened was hurtful for members of staff who were not involved and were doing their best to promote the rights and dignity of residents across Áras Attracta. Others commented that staff also have a responsibility to identify issues of poor practice and ensure that they are dealt with.

Staff felt that the combination and degree of behaviours that challenge that presented in Bungalow 3 were difficult to deal with, and it was claimed that some members of staff had been assaulted by residents there a number of times. Some staff described Bungalow 3 as having a 'brutal' atmosphere and culture, and many commented that Bungalow 3 is still a difficult place to work in.

Some staff believe that Bungalow 3 was neglected by management. They described it as the 'forgotten bungalow' and it was described as a 'closed situation'. In addition, there was a lack of movement of staff which, because of the line rostering system in use, also contributed to the development of a 'clique' and a culture that supported bad practice in the bungalow. It was noted that abusive behaviour was unique to Bungalow 3, and that the staff involved behaved differently when working in other bungalows or units.

Senior management believed that the reasons why residents were

abused and mistreated in Bungalow 3 are complex and multi-faceted. One manager believed that a range of issues impacted on the situation, including the high level of autonomy afforded those working in Bungalow 3 and their disrespectful attitude towards the residents. Rostering and the absence of some staff on annual leave might also have contributed. This manager also believed that it was important that the staff involved take individual responsibility for their actions.

Senior management also indicated that if a process of performance management had been in place, the abusive behaviour might have been identified, and perhaps more probing questions could have been asked of staff members. Senior management did not believe that staff shortages contributed to the situation. They did, however, identify the mix of residents in Bungalow 3 as a contributory factor. The failure to train staff adequately was also identified as an issue.

Staff commented that the situation has improved in the months since the *Prime Time* programme, and that better resources are now available – including a recently-appointed nurse specialist with expertise in behaviours that challenge.

Staffing levels have improved, and the preventive measures now in place are also proving to be effective. This has led to a more open culture in the bungalows, as mentioned previously. Staff training has developed a greater awareness of the procedures that must be followed in the event that neglect and abuse are suspected, and of the responsibilities of individual staff members. Staff recognise that it will take time for these changes to bed down in the service.

The training that staff have received has led to an increased awareness of the possibility of peer abuse among residents. Staff suggested that the Designated Liaison Officer post, which is currently part-time, may need to be made full-time – this post was put in place to deal with complaints and allegations of abuse. The quarterly Restrictive Practice Audits (carried out by the clinical nurse specialist) indicated that the restrictive practices have reduced by two thirds since the introduction of the measures described above.

## 6.3 Findings from the questionnaire survey

The findings of the questionnaire survey are presented thematically.

### Leadership and direction

#### Arrangements for staff support and supervision

Just over a fifth of respondents (21 per cent) thought that arrangements for staff support and supervision in Áras Attracta were *good* or *very good*.

**Table 6.3** Ratings for the arrangements for staff support and supervision

<b>Arrangements for staff support and supervision were regarded as ...</b>	<b>... by % of staff</b>
Very good	4%
Good	17%
Fair	36%
Poor	26%
Very poor	17%

### Critical view of management

Thirty-nine respondents made additional comments about management in the service and how this might have contributed to the situation that arose in Bungalow 3, and most of these were very critical of management. Many respondents commented about the lack of management support for staff and inadequate supervision of staff. They often related this to the fact that managers were simply not present and visible in a meaningful way at the point of service delivery. Others commented that this absence of managers meant that management were not in control in some areas, including Bungalow 3, and that management failed to take responsibility for the quality of service being delivered. More regular visits only began following publication of the HIQA inspection reports.

Respondents felt that when new staff are appointed, management is often slow to listen to new ideas and suggestions for improvement. Even when managers did take action, some respondents felt it was inadequate.

Some respondents commented that managers sometimes displayed favouritism and cronyism in the decisions they made, particularly regarding the rostering of staff.

### Need to have management in bungalows

Respondents felt that it was important that CNMs should work alongside staff in each bungalow. They reported that some bungalows, including Bungalow 3, did not have managers based in them. They took the view that when managers work in the bungalows it allows for proper supervision, and this is enhanced where the CNM is motivated, and has the right professional background and experience.

Many respondents also reported that even when managers were present, they did not listen to, or take action in relation to concerns raised by staff, or in relation to staff suggestions on how to improve matters.

### Oversight of service provision

Roughly a fifth of respondents (19 per cent) believe that general oversight of service provision is *strong and accountable* or *fairly strong and accountable*.

**Table 6.4** Staff's view of oversight of service provision by management

<b>Oversight of service provision was described as ...</b>	<b>... by % of staff</b>
Strong and accountable	4%
Fairly strong and accountable	15%
Neither strong and accountable, nor weak and unaccountable	43%
Fairly weak and unaccountable	26%
Very weak and unaccountable	11%

One respondent, while placing responsibility for what happened in Bungalow 3 squarely on the shoulders of the staff involved, also commented that lack of adequate management and supervision of staff working there contributed to the circumstances in which residents were mistreated and abused. Other respondents felt that management has displayed little leadership or sense of direction in overseeing service provision, and that many staff were left to manage situations as best they could.

### **Appropriate qualifications for managers**

Some respondents emphasised the need for managers to have appropriate qualifications in intellectual disability and experience (in particular) of dealing with behaviours that challenge. Others thought there was a need to bring in 'new blood' from the outside to enhance the management team, and that all new management appointments should be from outside the current staff complement. They believed that managers should broaden their knowledge and perspective, and in order to do this they should be encouraged to visit other intellectual disability services, to attend external training and development events, and to become involved in regional and national groups.

### **Review of rostering**

A number of respondents suggested that management needed to conduct a fundamental review of the 'line' system of rostering. They argued that staffing should be based on service need and that rostering should be carried out by management at CNM1 and CNM2 level. Rotation of staff should be fair, open and transparent, and it should ensure that there is a balance of staffing on each line, including a proper mix of experienced and new staff.

### **Suggestions for change in management practice**

Most respondents made suggestions for changes in management practice which they felt could impact positively on the current situation for residents and staff in the service. Many of these were proposed to address the issues already outlined above. They were made in the context of respondents noting that there had been improvements in management practice over the past while, and that Áras Attracta had the potential to improve and to provide residents with an excellent level of support.

Many respondents suggested that managers at all levels, including senior managers, needed to spend time in the bungalows and units regularly and to oversee the day-to-day work of staff: 'managers need to manage'. With such a presence on the ground, managers could get to know the strengths and weaknesses of the service, and familiarise themselves more with the needs of residents.

Respondents also felt that managers need to become proactive and imaginative in how they think about improving service provision and work with staff – rather than simply reacting to the latest problem to surface.

They also commented that managers need to be clear about their own role and the role of the various professionals delivering the service – particularly the respective contributions made by nursing and care staff. And they need to roster staff in a transparent and fair way that takes into account the needs of both residents and staff.

A number of respondents commented that management also needs to provide leadership in determining the future of services in Áras Attracta, and to ensure that staff are meaningfully involved in this process.

Finally, many respondents also stressed the need for management to listen to the views and opinions of staff. They also need to support effective communications between nursing and care staff, and between nursing staff on different lines in the same bungalow or unit.

## Communications and record keeping

The majority of respondents felt that the quality of communications and record keeping in Áras Attracta might have contributed to what happened in Bungalow 3.

They described a situation where information was mainly transmitted by 'word of mouth' and where staff were frequently misinformed. They noted that team meetings were infrequent, seldom minuted, and focused on the needs of staff rather than those of residents. ICT infrastructure (including basic communication channels such as a direct telephone line), was very poor or non-existent, and, where PCs were available, staff were not trained to use them effectively.

Effective communications were also made more difficult because of the line rostering system, especially if staff were permanently on the same line. This made it difficult to ensure a consistent approach to providing care for residents.

## General communications

The general communications system in Áras Attracta was believed to be *effective* by only 17 per cent of respondents.

**Table 6.5** Staff's view of general communication systems

<b>General communications systems at Áras Attracta were described as ...</b>	<b>... by % of staff</b>
Very effective	0%
Effective	17%
Neither effective nor ineffective	30%
Ineffective	35%
Very ineffective	18%

## Record keeping

Respondents felt that record keeping was often duplicated, and that it was difficult for staff to get time to maintain records or become familiar with personal plans or new policies because of the challenges of the work. Just 26 per cent of respondents *agree* or *strongly agree* that they have sufficient opportunities to become familiar with and implement policies.

**Table 6.6** Staff's view of policy implementation opportunities

<b>In relation to policy implementation, do you think that you have sufficient opportunities to become familiar with policies and to implement these effectively into your practice?</b>	<b>% of staff</b>
Strongly agree	2%
Agree	24%
Neither agree nor disagree	28%
Disagree	26%
Strongly disagree	20%

Respondents suggested that incident reports were not always completed, sometimes because staff felt that they seldom led to any action by management. This in turn created a situation where record keeping was seen as a 'tick the box' exercise with no role in improving the service provided.

At other times incident reports were not completed because a staff member did not want to be perceived as being unable to deal effectively with behaviours that challenge. Respondents felt that this led to a failure to analyse behaviours that challenge and to consider how they might be dealt with effectively.

Many of the staff recommendations for improving communications and record keeping related to the issues outlined above. While they felt that many aspects of record keeping and communications warranted fundamental change, respondents also recognised that there have been improvements recently.

A number of respondents commented that the current nursing documentation is inefficient because it leads to duplication of records and requires multiple files to be maintained on individual residents. This needs to be radically reviewed.

Respondents recommended that a computerised system of record keeping should be introduced, and that CNMs (including those who are newly appointed) should be trained to use this effectively.

There needs to be clear agreement as to the respective roles of nursing and care staff in record keeping. Respondents recommended that, in future, critical incident reports should be completed collaboratively by both a nurse and a manager working together, and that clear criteria should be established for review of such reports. They also recommended greater use of centre and team meetings. Residents, where appropriate, could attend some of these meetings to present their views on different issues.

A number of respondents recommended that time be allocated officially for record keeping and that a quiet 'office space' be made available for this activity.

Finally, respondents recommended the continued use of SMS texting as a means of communications – as long as this is done in a timely and appropriate manner. They also felt that informal communication continues to be important and should be taken seriously by management.

## Enabling and sustaining independence among residents

### Key working

As we have seen, respondents recognised the value of the key worker role for the way in which it enables the voice of residents to be heard. All residents have now been assigned a member of the nursing staff as a key worker and a healthcare assistant as a link worker.

**Table 6.7** How staff rated particular factors that facilitate the implementation of key working

<b>Factors that facilitate the implementation of key working</b>	<b>Very poor</b>	<b>Poor</b>	<b>Neutral</b>	<b>Good</b>	<b>Excellent</b>
Availability of relevant training	10%	27%	20%	41%	2%
Competence among all staff	2%	23%	40%	33%	2%
Organisational support	16%	33%	40%	11%	0%
Roster arrangement	33%	23%	26%	19%	0%
Communication between staff	5%	26%	33%	30%	6%
General understanding of the key worker role	9%	18%	25%	43%	5%



Table 6.7 shows the value that respondents placed on particular factors based on the contribution they made to the implementation of key working:

- ▶ Almost half of respondents believe that the greater understanding of the key worker’s role has been an important factor in facilitating the introduction of the system.
- ▶ The specific training they have received is believed by 43 per cent of respondents to have facilitated the introduction of the key worker system.
- ▶ On the other hand, 56 per cent of respondents believe that the rostering arrangements have acted as a barrier to key working.
- ▶ Almost 40 per cent believe that the lack of organisational support provided for key working has also acted as a barrier to its introduction.

### Personal plans

In the survey, staff were questioned about specific aspects of the development of personal plans for residents. Of those who responded, 55 per cent said they believed that residents are involved in an inclusive and meaningful way in the development of their own personal plans. While 46 per cent believe that the layout and content of personal plans are accessible to the person at the centre of the plan, one in four believes that this is not the case. Half of the respondents believe that the day-to-day implementation of personal plans is monitored on a regular basis, but one in four believes that this is not the case.

Respondents were also surveyed on how personal plans are reviewed, and the extent to which residents, family members and other relevant professionals are involved in the process.

**Table 6.8** Staff view of how effectively personal plans are reviewed

<b>Do you agree that personal plans are reviewed in an effective and professional way which includes the person at the centre of the plan (where appropriate), members of all relevant professions, advocates, and family members?</b>	<b>% of staff</b>
Strongly agree	2%
Agree	45%
Neither agree nor disagree	27%
Disagree	25%
Strongly disagree	0%

Almost half of respondents (47 per cent) *agree* or *strongly agree* that personal plans are reviewed in a professional and inclusive way.

### Does the rostering system meet resident’s needs?

Staff were surveyed about their levels of satisfaction with their current duty roster, and the majority reported that they were *satisfied* (42 per cent *satisfied* and 11 per cent *very satisfied*).

When asked whether or not the rostering system met residents’ needs, 76 per cent of respondents answered *yes* or *sometimes*.

**Table 6.9** Rostering and residents’ needs?

<b>Does the rostering system allow for the needs of residents to be met?</b>	<b>... by % of staff</b>
Yes	29%
Sometimes	47%
No	24%

Many respondents commented on how inadequate staffing levels negatively affect the quality of service delivered to residents. When there are staff shortages, activities for residents are curtailed. Staff shortages also lead to the use of agency staff who may be unfamiliar with policies and procedures and who may not be familiar with individual residents. There is a high daily turnover of staff, sometimes at short notice, and staff may work in a number of different bungalows each day. All of these factors impact on the continuity of care for residents.

Some respondents felt that the rostering system is inflexible, and the combination of a ‘line’ roster for nursing staff and a different roster for healthcare assistants means that there are often staff shortages in the early morning and in the evening. Some respondents commented on the very long working day and the impact this can have on staff motivation and stress levels. This in turn impacts adversely on residents.

### **Lack of independence as a contributing factor to mistreatment and abuse**

Respondents also commented specifically about how lack of independence among residents might have contributed to the mistreatment and abuse of residents in Bungalow 3. They noted the absence of a key worker system in Bungalow 3, and also observed that when residents were moved into Bungalow 3 following the closure of other bungalows that they had no say in where they lived or who they lived with – both of which are key quality of life measures (see chapter 4).

Inadequate staffing levels also meant that residents’ wishes regarding activities were not delivered on.

Some respondents felt that set routines predominated and care had become institutionalised in Bungalow 3. The environment was not one that was open to promoting and sustaining the independence or welfare of the residents. The focus was more on preventing and reacting to severe behaviours that challenge, and there was no involvement of the multidisciplinary team in supporting residents to lead more independent lives.

Some respondents did acknowledge that improvements have been implemented in the past year, and that all of these have impacted positively on the capacity of residents to lead independent lives.

## Residents’ rights and family involvement

In addition to the recommendations outlined previously regarding staffing levels and reductions in the number of residents in each bungalow, respondents also recommended that a residents’ rights committee should be established and a residents’ rights policy developed.

They also suggested greater involvement by family members and advocates in relation to decisions that affected the daily lives of residents. They felt that staff would benefit from additional training in how to help residents develop the life skills they would require for community living, and that for residents, development and training in such skills should take place in the community rather than on site in Áras Attracta.

## Meeting staff needs

### How staff rate the training programme

A substantial training programme has been delivered recently in Áras Attracta, and respondents have different views about this. On the positive side, 64 per cent of respondents felt that the availability of relevant courses has been *good or excellent*, and 71 per cent rated the quality of the training as *good or excellent*. In relation to opportunities to transfer what they have learnt into their practice, 60 per cent rated them as *good or excellent*. However, 62 per cent were critical of the release arrangements for training, and 45 per cent rated opportunities to reflect on their practice as *poor or very poor*. The support available in the workplace to develop skills and competencies was rated by 42 per cent of respondents as *poor or very poor*.

**Table 6.10** Summary of how staff rate different aspects of the staff training programme

Different aspects of the staff training programme	Very poor	Poor	Neutral	Good	Excellent
Availability to you of relevant courses	4%	16%	16%	48%	16%
Release for training	30%	32%	18%	20%	0%
Quality of training provided	0%	4%	25%	55%	16%
Opportunities to transfer learning to practice	0%	14%	26%	51%	9%
Support in the workplace for skill and competency development	12%	30%	21%	33%	4%
Opportunities to reflect on your practice	25%	20%	30%	23%	2%

A number of staff commented that the availability of training opportunities and courses has greatly improved since 2014. They also said that the lack of emphasis on continuous professional development in the past might have contributed to the situation in Bungalow 3. For many years ongoing staff training was very limited, usually relating to manual handling, non-violent crisis intervention<sup>25</sup> and fire safety.

<sup>25</sup> Training disseminated by the Crisis Prevention Institute.

Respondents noted the lack of suitable professional development opportunities – and even where these were in place, staff were not encouraged to attend, partly because of rostering pressures. In cases where management offered staff members time off in lieu for attending training courses, staff found that they could not redeem this time off, again because of rostering pressures.

Respondents also suggested specific areas that might be covered in training courses, including autism, dementia, stress management and mindfulness. One respondent recommended training related to values and the rights of residents, while other suggestions were broader in nature. One respondent commented that a formal training needs analysis should be conducted to identify areas needing attention, and that a suite of courses to support the changes under way in the service could then be developed.

### Staff involvement in the change process

Staff were also surveyed on their involvement in the change process that is currently under way in Áras Attracta. The results in Table 6.11 show that two thirds of respondents (67 per cent) felt *involved* or *very involved* in the change process.

**Table 6.11** Involvement in the programme of change

<b>The extent to which they were involved in the programme of change was described as ...</b>	<b>... by % of staff</b>
Very involved	19%
Involved to a certain degree	48%
Neither involved nor uninvolved	12%
Not very involved	19%
Not at all involved	2%

### Supervision and feedback on performance

The majority of respondents, 81 per cent, said that they would benefit from supervision and support in their work.

**Table 6.12** Respondents' attitudes to supervision and support

<b>Do you feel you would benefit from supervision and support for your role?</b>	<b>% of staff</b>
Yes	81%
Don't know	12%
No	7%

An even greater number, 86 per cent, felt that they would benefit from feedback on their performance at work, while 7 per cent were uncertain about this, and the remaining 7 per cent felt they would not benefit from feedback from their managers on their work.

## Meeting the healthcare needs of residents

### GP service provision

Table 6.13 sets out the proportions of residents that staff believe have adequate access to GP services. While 44 per cent of staff believe that *all residents* have adequate access to GP services, 9 per cent believe that *no residents* have such access.

**Table 6.13** Access to GP Services

<b>Proportion of residents that have adequate access to GP services was estimated to be ...</b>	<b>... by % of staff</b>
All residents	44%
Three quarters of all residents	20%
Half of all residents	18%
A quarter of all residents	9%
No residents	9%

These results were reflected in many of the comments of respondents. Some of them queried the effectiveness of the arrangements for medical care, which is currently provided by a rotation of three local GPs who provide two 2-hour clinics for residents each week (on Mondays and Wednesdays), and who also provide an on-call service. Some respondents believe that the clinics are often rushed, and that sometimes not all residents presenting at the clinic are seen by a GP.

A number commented that the time of the clinic coincided with meal times for the residents.

Some respondents felt that the model of service delivery is institutionalised and does not necessarily meet the health needs of residents – for example, there is a long gap between a Wednesday clinic and the following Monday clinic.

Respondents believe that effective communications between the three GPs about individual patients can be difficult, although the introduction of the ISBAR<sup>26</sup> system has helped alleviate this problem.

It can be difficult to assess the medical needs of those who present with behaviours that challenge, and often these residents were only assessed in an emergency. Also, there are no policy guidelines that identify who has the responsibility to contact GPs in out of hour situations.

A number of respondents commented about the input of the psychiatry team in Áras Attracta. They believed that following the HIQA reports the review of residents' medications was too severe in the way it reduced the drug regime of some residents, and that this increased the levels of behaviours that challenge. They thought that greater follow-up from the psychiatry team in these situations would have been helpful.

<sup>26</sup> ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a model created to improve safety in the transfer of critical clinical information.

This information was referred to the psychiatry team and we were advised that in relation to the comments regarding reductions in medication there are two circumstances in which a person with an intellectual disability might receive psychotropic medication: (1) for the treatment/management of mental illness and (2) in the management of challenging behaviour. We were advised that all decisions to reduce medication are made following appropriate clinical review and also in consultation with the Clinical Nurse Specialist (CNS) in Behaviours that Challenge and the Psychology project team on site who develop and review the client's behaviour support plans/interventions. Reviews are often done jointly with the CNS or support psychology project team member who is working closely with the patient. This liaison provides a further opportunity to alert the team should there be an issue in relation to challenging behaviour. The psychiatry team stated that they fully support the use of non-medical multidisciplinary interventions for challenging behaviour in preference to psychotropic medication and they will continue to endeavour to reduce the amount of psychotropic medication prescribed for challenging behaviours and to follow best practice guidelines in terms of reduction of same.

Respondents also recommended changes which they felt would improve the GP service. A number felt that residents should have access to a GP of their choice in line with the HIQA standards. Many felt that either the hours of the current clinics should be extended, or that residents should be able to access a GP any day they needed to, as is normal in the wider community. This would relieve pressure and mean that clinics were less rushed and residents' needs were better met. Respondents would welcome more GP visits to the units and bungalows to assess residents with mobility problems.

The comments on GP Service provision were put to the general practitioners and the following points were made in response.

When Aras Attracta opened in 1988 it was agreed with the Western Health Board that the residents would not have the ability to choose a GP, go to the pharmacy to collect their medications and then take them as prescribed. This is why the residents were not allocated a specific GP, but like any institution they received their care from the medical officer on duty.

The GP service is available to 100 per cent of the residents and the patients presenting at the clinic is determined by the staff caring for them. The clinics have changed over the years. In recent years it has become harder to deal with all the requests presented, in the time available. The GP usually comes back after his days' work to see anybody who clinically needs to be seen. He is also available during normal working hours throughout the week on duty for any medical issues that arise with any patient. He may discuss on the phone with the nurse the clinical presentation, give advice that can be carried out without his attendance, be available for call-back, but he has never refused to see a patient.

Residents are seen at the clinics at the request of the nurse on duty who brings any concerns they have to the doctor's notice. Calls to the bungalows and units are based on the nurses calling the doctor.

Áras Attracta has been covered 24 hours every day by the GPs since it opened including all week-ends all emergencies have been seen too as

they arose. GPs insist it is imperative to have SRNs on duty in bungalows and units. Nurses must remain to have a central role in the medical service to the residents. Crucially, the handover of care is not at all satisfactory – the staff usually have little knowledge of what happened the previous day and this is due to the rota system as the same person is not usually on two days in a row.

It is imperative that an SRN be responsible for emergency calls and he/she has medical knowledge and should have a senior position in staffing.

Outside of normal hours, there is a rota of GPs who provide emergency cover. There is always somebody available, even though this is unpaid work for and by the GP members of the rota who are not MOs to Áras Attracta. This is a service for urgent medical problems only. All Áras Attracta policies, protocols, required notifications (for example, fall without injury, bruising whose cause is of known or of unknown cause but not requiring urgent attention) should cease at 6pm.

On the question of clinics coinciding with meal times: the clinic times were arranged over 20 years ago, at times the GP could be spared from his surgery. For more than 17 of those years there was no clash, until recently when outside organisations came in and decreed a change in meal times, thus eroding time that the patients and staff were free to attend the clinic. There was no consultation with the GPs.

## Nutrition and meal times

When respondents were asked about assessment of the nutrition needs of residents, 78 per cent of them *agreed or strongly agreed* that all residents are assessed using a recognised tool to ensure that they have a healthy, balanced diet, and that this assessment is reviewed every three months.

One respondent commented that the Dietetics Service should be arranged to provide full-time cover to residents. Another commented that, like many of the other allied health professional services that were reintroduced into Áras Attracta in 2014, the Dietetics Service was focused more on residents of the units initially, and had limited provision for residents of the bungalows.

Meal times are not set following consultation with residents according to 74 per cent of respondents.

## Allied health professionals

Respondents felt that residents have mostly adequate access to psychiatry, physiotherapy, dietetics and speech and language therapy services. They have less adequate access to dental, optical and chiropody services. They have least adequate access to psychology and social work services.

Many respondents believe that multidisciplinary working has improved greatly in more recent times. However, they also think there are still deficits in this aspect of service delivery. They felt that there should be regular multidisciplinary team meetings to review personal plans, and to provide support to nursing and healthcare staff to follow up on the recommendations. Behaviour support plans also need to be put in place,

evaluated and modified regularly, and this work should be done by the relevant staff working with residents rather than by Studio 3. Respondents also felt that the clinical nurse specialist dealing with behaviours that challenge should come to the bungalows to work with highly challenging clients, and review with staff how to deal with different situations that might arise.

Respondents also commented on the provision of other allied health services:

- ▶ Access to psychology services needs to be improved and a referral pathway developed for staff to access this support on behalf of residents.
- ▶ Greater input from social work would be welcome.
- ▶ Chiropody services need to be expanded to cater for the growing demand of an ageing population.
- ▶ Audiology is a very important but a neglected part of service provision.
- ▶ Dental services should be provided on site, especially for residents with mobility problems (one respondent).
- ▶ The speech and language service needs to be expanded because, at the moment, it is available mainly to non-verbal residents (one respondent).

Respondents also suggested that residents should be able to choose their own chiropodist, dentist and optician.

## Ensuring that residents are safe and protected

### Abuse, mistreatment and respect

The vast majority of respondents (98 per cent), reported that they would know what to do if a resident was being abused, mistreated, or treated unkindly or disrespectfully by a colleague.

In commenting on this question, the majority of respondents referred to the safeguarding training they had received, and also said that they were very familiar with the relevant policies and procedures.

### Behaviours that challenges

Only 46 per cent of respondents felt they had the skills required to deal with behaviours that challenge, and many of these respondents indicated that this was because of training they had taken and their extensive experience of dealing with residents with behaviours that challenge. Among the training courses that they found useful were those provided recently by Studio 3, and also training in CPI's Managing Actual and Potential Aggression (MAPA) approach.<sup>27</sup>

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<sup>27</sup> Managing Actual and Potential Aggression training, developed by CPI, an international training organisation.



**Table 6.14** Respondents' knowledge of behaviours that challenge

<b>Do you feel you have sufficient skills to work with residents when they engage in behaviours that is considered challenging?</b>	<b>% of staff</b>
Yes	46%
Don't know	24%
No	30%

Many respondents also noted the need for ongoing training and professional development in this area. Respondents who were not confident about how to deal with behaviours that challenges referred to the absence of adequate or appropriate training courses. They also related their lack of confidence to a lack of experience of dealing with this type of behaviour. Some respondents acknowledged that they felt uncomfortable working in areas where there was behaviours that challenges, and a number said they felt fear in such circumstances.

### **Use of restraint**

One in nine respondents believed that inappropriate physical restraint was used. Respondents commented on how different factors impacted on the safety and protection of residents in Bungalow 3. In addition to the issues outlined previously, a number of respondents commented about a 'culture' that might have developed among some staff in Bungalow 3, which they felt was the result of the same staff working together in the same location over a long period of time. This, combined with a challenging environment, a lack of effective management, and isolation from the rest of the service, allowed bad practices to develop. These remained unchallenged by management, and were reinforced by a bullying environment where newer staff were not properly inducted to the bungalow, and where certain bad practices became the norm.

A number of respondents noted the importance of the safeguarding training that has already been provided, and the need for staff to be familiar with relevant policies and procedures.

### **Programme of activities and lifelong learning for residents**

The current programme of activities (including educational, training, employment, and recreational activities) was rated as *good* or *very good* by 42 per cent of respondents.

Respondents noted the lack of emphasis on activation across the service prior to the broadcast of the *Prime Time* programme. Any activities that were available for residents at that time were very limited, and often consisted of bus trips or walks. A number of respondents commented that the activation programme in Bungalow 3 was even more limited than that available to other residents because of lack of interest from the staff and the pressures on the service previously outlined.

Respondents also commented on the extent to which the current activation programme supports residents to link in with lifelong learning opportunities in the local community. A third of respondents *agreed* that residents were facilitated to access lifelong learning opportunities.

**Table 6.15** Access to lifelong learning opportunities and activities in the local community

<b>It is important that residents are facilitated to access opportunities and activities available in the local community. Please indicate your view on the extent to which this happens in Áras Attracta.</b>	<b>% of staff</b>
Strongly agree	0%
Agree	33%
Neither agree nor disagree	36%
Disagree	22%
Strongly disagree	9%

Many respondents commented on the recent improvements in the activation programme. They noted the establishment of the activation team, the development of planned individualised and closely monitored programmes for residents and projects such as the recent Louisburgh holiday programme, which the residents enjoyed very much. They also noted the need to protect these developments from the impact of staff shortages.

### **Recommendations relating to lifelong learning**

Respondents also made recommendations about how the lifelong learning programme could be improved. A number commented on the need for adequate transport to enable opportunities in the community to be accessed fully. This is especially relevant as opportunities in Swinford are limited (because of its size), and residents need to travel further to larger towns in the locality. One respondent recommended the establishment of a garden project on site. Another suggested the expansion of the current programme in Centre 3. A number of respondents stressed the need to give residents a greater say in what activities they are involved in.

Other respondents recommended that residents should have greater control over their money, and that the activation programme needs to be age-appropriate. For example, a programme could be developed for active retirement for older residents. Respondents also remarked that the programme needs to be enhanced at weekends – not curtailed, as often happens now because of reduced staffing levels.

### **Working in partnership with other professionals and the local community**

Áras Attracta’s level of working in partnership with the local community was rated as *low* or *very low* by 59 per cent of respondents.

A number of respondents emphasised the existing links that have been forged with the local community, including the work of the Parents and Friends Association.

Many respondents also recognised the importance of residents having strong links with the local community. They also noted, however, that residents in Bungalow 3 had less interaction with the local community than many other residents.

## Scope for partnership with the local community

Many commented on the scope that exists for Áras Attracta to work in partnership with the local community. Some links have already been made and these can be built upon. Examples noted were the active ageing group, the gardening club, the local craft group, and links with a local artist and with some alternative therapy practitioners. They proposed enhancing partnerships in the community by inviting community and voluntary groups to engage with residents in Áras Attracta – for example, by recruiting volunteers to help build a sensory garden, and inviting local schools to place Transition Year students in the service as part of their work experience. Respondents suggested that there should be a greater emphasis on ‘open days’ and ‘family days’.

Many respondents also wished to see residents becoming more involved in community life in Swinford. They suggested that residents should be joining local clubs and voluntary groups, such as the Active Retirement Association, Weight Watchers, the choir, the Men’s Shed, adult education courses, the walking group, the knitting club, and various local sports clubs. They could be attending football matches, going to the cinema, going to bingo, joining the library and attending art classes. They should have opportunities to go on holidays, to go to a pub or restaurant, to order ‘take-aways’, to go to dances and live concerts, to go on shopping trips, and so on. They could attend services in the local church more rather than on site. They could use the local GP service, the pharmacy, the hairdresser and the beautician in the community rather than on site.

A number of respondents also recommended that, where possible, residents could be working in the local community. They noted that this approach has already been adopted locally by the Western Care Association.<sup>28</sup> Residents should be supported to secure appropriate employment, and use should be made of the supports available – for example, through the National Learning Network.<sup>29</sup>

A number of respondents noted that it might take time to develop this approach to partnering in the community as the events depicted in the *Prime Time* programme have meant that the service is now seen in a negative light locally.

## Other issues that staff raised

### The future for residents

Many respondents emphasised the need to develop a person-centred service where residents would be supported to live full independent lives, with their homes in the community. However they also felt that the placing of current residents of Áras Attracta in the community needs to be properly planned and resourced, and could be based on the many examples of good practice that already exist in the local area – for example, those of the Western Care Association. Respondents also identified possible resistance to such a move from some members of staff, from some residents’ families, and

<sup>28</sup> Western Care Association is headquartered in Castlebar, Co. Mayo, and aims to empower people with a wide range of learning and associated disabilities in Co. Mayo to live full and satisfied lives as equal citizens.

<sup>29</sup> National Learning Network is a non-governmental organisation which provides training and specialist support to people who, for a variety of reasons, may find it difficult to gain employment.

indeed from some residents. However, some respondents believe that the service is already moving in the right direction – one where staff are more positive about the future, and where residents are much more involved in decisions regarding their care.

Respondents also noted that moving to live in the community will not be possible for all of the current residents. They foresee a situation in which older residents will remain in the equivalent of a nursing home on the present site, and other residents will live in bungalows (also on the current site), but in much smaller groups. Some residents whose behaviours that challenge are an issue will live in single occupancy accommodation.

Respondents also commented about the type of service that Áras Attracta needs to become to be able to deliver the changes outlined above. They remarked on the need to transform its ethos, to professionalise its approach, and to develop its potential to deliver the best possible care for people with an intellectual disability, one where people's basic human rights are fully realised.

Other respondents were more ambivalent or uncertain in their view of the future. And some were despondent about what the future might hold for residents and staff, particularly if the necessary changes are not implemented.

### **Impact of the *Prime Time* broadcast on staff**

Respondents were also given an opportunity to comment on any other aspect of their experience in Áras Attracta that they wished to bring to the attention of the Review Group. Many reiterated points recorded earlier in this chapter. Others used it as an opportunity to record their own personal feelings about what happened in Bungalow 3 and how it affected them. Respondents commented about feeling shocked, horrified and embarrassed about what they saw on the programme. Others commented about how all staff are now 'tared with the same brush' and have been the victims of abusive comment on social media. Some respondents commented on how 'exposed' they felt following coverage in the broadcast and print media of what happened in Bungalow 3. They also mentioned how stressful their working environment had become following the broadcast of the *Prime Time* programme.

Others emphasised how what happened in Bungalow 3 has been felt by all residents and their families and by staff, and how it will continue to affect many of them for years to come.

## **6.4 Discussion of the views and opinions of staff**

Taken all together, the outcomes of the group meetings and the findings of the staff survey give a rich picture of the working environment at Áras Attracta and give some background to factors that might have contributed to the abuse and mistreatment of residents in Bungalow 3. They also present a staff and management perspective on what needs to happen to ensure that residents are safe and protected, and can be supported to live full and independent lives where their rights are fully respected and realised.

From the outset it is important to recognise that this account, despite the depth and range of its insights, is partial, owing to the low response rate.

The account includes many divergent and sometimes contradictory views, but this is to be expected where so many individuals come from such diverse backgrounds and roles.

### **Critical account by staff**

The account given by staff is highly critical of many aspects of the service, and this is consistent across the meetings and in the survey. Some of the criticism relates to historical issues that pre-date the HIQA inspections and the broadcast of the *Prime Time* programme, while others relate to more recent developments. The main targets of staff criticism were:

- ▶ The lack of leadership by senior management at Áras Attracta.
- ▶ The history of poor training provision.
- ▶ Inadequate communications systems and poor record-keeping.
- ▶ The rostering system.
- ▶ Overcrowding in the bungalows and unsuitable mix of residents.
- ▶ The inadequate way in which residents with behaviours that challenge were treated.
- ▶ The lack of support and supervision provided for staff.
- ▶ The inadequacy of some of the healthcare arrangements for residents.
- ▶ The low level of connection the service has with the local community.

Senior management recognised the shortcomings in the service and identified particular issues and areas for development and improvement including supervision, the development of effective middle management, and transfer of learning from training into practice. They also believe that Áras Attracta has turned a corner and, with the new structures and management team in place, it can now focus on a radical reorientation of the service to align it with national developments and strategy.

### **Some positive aspects**

Where they felt it was merited, some staff also highlighted positive aspects of the service, including:

- ▶ Recent training courses on safeguarding and on managing behaviours that challenge.
- ▶ The establishment of the new activation team, and a growing confidence among staff about their practice.
- ▶ A greater awareness about the inclusion of residents in decision making.
- ▶ Some improvement in staffing levels.
- ▶ Greater involvement of allied health professionals in care delivery.

## Hope for the future

Despite low staff morale across the service, many staff members still expressed a sense of hope and optimism, albeit conditional, about the future. They identified a set of issues which, if effectively addressed, would assure that residents could realise their full potential. These issues have been outlined in detail already in the various sections of the chapter. Many of them reflect areas of concern also raised by relatives and by residents themselves.

**Table 6.16** Measures to ensure that residents at Áras Attracta are safe and protected

<b>Leadership and management</b>	Enhance the leadership and management of the service and provide a strong, clear direction for its future by: <ul style="list-style-type: none"> <li>▶ Developing appropriate management structures.</li> <li>▶ Designing and implementing effective systems to deliver services and properly support and supervise staff</li> </ul>
<b>Training and development</b>	Ensure that a comprehensive training and development programme is available to staff on an ongoing basis (with adequate release from duties), to ensure the development of good practice, particularly in that relating to safeguarding and dealing effectively with behaviours that challenge.
<b>Improved rostering</b>	Introduce a rostering system that is transparent and fair, that ensures continuity of care for residents, and that provides adequate staffing levels to support the effective implementation of the new activation programme and person-centred approach to care. It should also ensure that staff can be released for training when required, without any negative impact on quality of care.
<b>Improvement in communications and record-keeping</b>	Computerise the recording system, improve communications and introduce and support a team approach to service delivery – including sector and team meetings with multidisciplinary participation.
<b>Support for person-centred care</b>	Continue to support and develop the initiatives aimed at supporting person-centred care, including: <ul style="list-style-type: none"> <li>▶ Strengthening of the key worker role in personal planning.</li> <li>▶ Promoting greater involvement by residents, family members and advocates in decision making.</li> <li>▶ Developing a residents’ rights policy and a residents’ rights committee.</li> <li>▶ Providing education for residents on their human rights and on how to bring forward any complaints they have.</li> </ul>
<b>Provisions for primary care</b>	Review the provisions for primary care to ensure they are appropriate, person-centred and adequate to meet the residents’ health needs.
<b>Activation programme</b>	Enhance the current activation programme to maximise learning and work opportunities on site and particularly in the community. The programme should be based on people’s needs, be age-appropriate, and be ambitious in terms of outcomes for participants. In particular, it should enable residents to develop the life skills required for independent living in the community.

The members of staff and senior managers who participated in the meetings and survey have highlighted these issues in the belief that some of them can be addressed in the short-term, while understanding that others may require a longer timeframe.

# D

## MANAGEMENT REVIEW

### Review of work under way

Since the *Prime Time* programme was broadcast, Áras Attracta has been the subject of a number of different reviews and inspections (from the HSE and HIQA), and these have all included recommendations for improvements in practice at the centre.

**Chapter 7: Management review questionnaires** presents the findings of two management questionnaires that we prepared: one for senior management and one for local management at the unit and bungalow level.

Our main purpose here was to take all the recommendations of the various inspections and reviews that had taken place since the *Prime Time* programme, and to establish how many of these have been implemented to date.

### Person-focused assurance framework

We used a person-focused assurance framework as a guide to our work in reviewing management practices and structures at Áras Attracta. This was a bespoke framework that we developed to capture information on the organisation, its management, and the day-to-day supports and practices in place to provide a person-focused service within each bungalow and unit.

This person-focused assurance work was carried out in the autumn of 2015 by an Assurance Team consisting of two members of the Review Group (including the chair) and a specialist consultant.

**Chapter 8: Person-focused assurance Part 1: Profile of Áras Attracta** presents the first part of the person-focused assurance work, which consisted of a profile of the three centres of Áras Attracta:

- ▶ The residents – age and gender profile, degree of disability, connection with family members, and so on.
- ▶ Physical characteristics of the different centres – their size and the living facilities they offer.
- ▶ The staff – how many there are and how they are rostered, as well as details of their levels of qualifications and training.

**Chapter 9: Person-focused assurance Part 2: Thematic review** explores the organisational and management supports and practices in Áras Attracta through the following themes:

- ▶ How residents are kept healthy and safe.
- ▶ How residents spend their day and learn new skills.
- ▶ What the residents need from the people who support them.





## 7

# Management review questionnaires

One of the terms of reference under which the Review Group was established explicitly required us to:

*Review the programme of work already under way at the Centre on foot of reports from HIQA, HSE audits and reports to establish their effectiveness, identify any gaps and make recommendations for future improvements (See Appendix 1).*

In order to achieve this, we decided to ask the current management at Áras Attracta to report on the extent to which the recommendations from a series of inspections and reviews had been implemented. This process was entirely based on self-reported progress by managers in Áras Attracta, and was not validated by the Review Group.

Áras Attracta was the subject to the following inspections and reviews by HIQA and the HSE, some of which were carried out before and some after the broadcast of the *Prime Time* programme in December 2014.

**Table 7.1** Reviews/inspections of Áras Attracta

<b>Title of inspection / review</b>	<b>Carried out by</b>	<b>Date</b>
Review of High Dependency Clients (Units 1 and 2)	HSE	November 2013
Review of Service in line with HIQA Standards – ‘Mock Audit’	HSE	November 2013
Compliance Monitoring Inspection report	HIQA	February 2014
Dietetic Assessments, Unit 2	HSE	March 2014
Critical Incident Investigation	HSE	April 2014
Compliance Monitoring Inspection report	HIQA	May 2014
Assurance Report	HSE	August 2014
Compliance Monitoring Inspection Report Unit 1 and Unit 2	HIQA	September 2014
Service Improvement Report	HSE	December 2014
Compliance Monitoring Inspection Report Centre 2	HIQA	January 2015
Compliance Monitoring Inspection Report Centre 3	HIQA	January 2015

Taken together, these reviews/inspections included a total of 192 recommendations, all of which were to be addressed by Áras Attracta.

## 7.1 Our approach to the task

The Review Group undertook an analysis of all recommendations made up to the end of January 2015 (in the inspections and reviews cited in table 7.1). Reviews and inspections that were still ongoing in January 2015 and which were not in the public domain were excluded, as were five HIQA inspections that continued until August 2015. The analysis involved a comprehensive review of all recommendations, which we then categorised by thematic grouping. When we eliminated duplicate recommendations (where the same recommendation was present in more than one review or inspection) we were left with a total 158 recommendations. The thematic groupings of recommendations are:

- ▶ Ensuring residents are safe and protected.
- ▶ Meeting healthcare needs.
- ▶ Lifelong learning.
- ▶ Enabling and sustaining independence.
- ▶ Meeting staff needs.
- ▶ Leadership and direction.
- ▶ Records and communication.
- ▶ Developing partnership working.

These themes correspond directly to the sub-themes in the person-focused assurance framework outlined in chapter 9.

Following the process of analysis, two questionnaires were developed:

- ▶ **Senior management questionnaire:** the first questionnaire was for the Acting Director of Services and it included questions relating to all 158 recommendations.
- ▶ **Local management questionnaire:** the second questionnaire was for the nurse managers of each of the bungalows and units (as configured at the time). This was based on the senior management questionnaire, and was developed following consultation with the Acting Director of Services about which questions were relevant to the bungalow and unit managers. In total, there were questions relating to 74 recommendations on this questionnaire.

The questions in both questionnaires asked participants to report on whether each listed recommendation had been implemented, partially implemented, or not implemented. They were also asked to give reasons for partial or non-implementation, an outline of progress, a description of any barriers to full implementation, and an expected date for full implementation.

Both questionnaires were issued twice, the first time in May 2015, and again in October 2015. The intention of this was to afford both the Director of Services and nurse managers in the bungalows and units the opportunity to indicate changes, developments and progress that had taken place in the intervening months. Changes in personnel, however, meant that different people completed the May and October questionnaires, and for that reason we have used only the responses to the October questionnaires in this review.

- ▶ The Acting Director of Services who completed the May senior management questionnaire returned to his substantive post at the end of May 2015. The October questionnaire was completed by the Director of Services who had been appointed in mid-July 2015.
- ▶ Following discussions with HIQA, Áras Attracta was reorganised from one single centre into three separately designated centres, and the management structure changed to reflect that, with three new clinical nurse managers 3 (CNM3) being appointed in autumn 2015, one for each centre. These new nurse managers completed the October local management questionnaire.

## 7.2 Senior management questionnaire

The senior management questionnaire given to the permanently appointed Director of Services included 158 unique recommendations. Analysis of the data returned in the October senior management questionnaire indicated that almost two thirds (61 per cent) of the recommendations have been implemented, with just over a third (37 per cent) partially implemented or yet to be implemented. It is reported that the majority of the partially implemented recommendations have a completion date in 2016. The following six, however, have a longer time-scale:

- ▶ The computerisation of documentation.
- ▶ Training of residents, families and staff in relation to the key worker role.
- ▶ Improved accessibility to advocacy services.
- ▶ Improvements in personal space.
- ▶ The development of links with the community.
- ▶ Site-wide structural changes to ensure compliance with fire arrangements – risk assessments are in place to demonstrate management of this.

**Table 7.2** Senior management questionnaire: summary

<b>Summary: Senior management questionnaire – all recommendations</b>	
Implemented	<b>97</b> out of 158 (61%)
Partially implemented	<b>58</b> out of 158 (37%)
Not applicable	<b>3</b> out of 158 (2%)

The responses provided by the Director of Services to the recommendations are outlined below, by thematic grouping. The number of recommendations implemented or partially implemented is indicated for each thematic group.

### Safety and protection

In relation to issues of safety and protection, 18 recommendations were explored. It was reported that all these recommendations are ‘complete and in place’ (fully implemented), with the exception of these two:

- ▶ The Infection Control Policy, which requires review.
- ▶ Site-wide structural changes are necessary to ensure compliance with fire arrangements. It is stated however that risk assessment is in place to demonstrate management of these.

## Health and well-being

In relation to meeting the healthcare needs of residents, it was reported that 38 of the 39 recommendations are implemented.

The recommendation reported as partially implemented:

*The current arrangement for General Practitioner services is regarded as not adequately meeting the needs of residents. A meeting was convened in December 2015 to discuss and manage outstanding issues in relation to the provision of these services, but the outcome is not yet clear.*

## Lifelong learning

There were four recommendations made in relation to the provision of lifelong learning opportunities for residents in Áras Attracta, of which just one is recorded as implemented.

The recommendations reported as partially implemented were:

- ▶ The urgent provision of the development of an individualised meaningful programme of day activities for all residents in Áras Attracta.
- ▶ Similarly the recommendation to provide opportunities for residents to participate in activities in accordance with their interest, capacities and developmental needs.
- ▶ The provision of access for residents to facilities for occupation and recreation.

The response to these recommendations was:

*With the social model of care roll-out, it is envisaged that a more meaningful, person-centred approach to day activities will develop. This has begun in bungalows 9 and 16. Eight residents are now immersed in the Social Care Model.*

## Enabling and sustaining independence

There were 32 recommendations grouped under the theme of enabling and sustaining the independence of people living in Áras Attracta. (One recommendation was not applicable as it related to the arrival of new people, and no new admissions have taken place recently).

The recommendations relating to enabling and sustaining independence are grouped below according to key themes.

### Key workers

The following recommendations relating to key workers were reported as partially implemented:

- ▶ Areas for improvement have been identified by management, and a review of the associated policy is required to allow all grades of staff to become key workers, including healthcare assistants.<sup>31</sup>

<sup>31</sup> It is understood that this recommendation has been implemented since the completion of the questionnaire.

- ▶ Parallel to this, a recommendation was made that management must also ensure that key workers have a clear understanding of the key worker role, and that they play an active role in the person's care plan. It is acknowledged that training is required both for residents, families and staff to gain clarity on the role of the key worker. It is reported that this is ongoing and the recommendation is currently partially implemented.

## Assessments, reviews and care planning

The following recommendations relating to assessments, reviews and care planning were reported as partially implemented:

- ▶ Recommendations regarding annual comprehensive assessments and reviews for residents - it is reported that these are undertaken, but it was acknowledged that they 'need to be better managed and planned' and will be reviewed in 2016.
- ▶ Standardisation of approach was recommended. It was reported that the implementation of a standardised approach will be strongly impacted by the programme of Support Intensity Scale (SIS-A™)<sup>32</sup> assessments, now complete, which will shape the direction of care and provide a framework for putting in place the requirements to meet the support needs of each resident. The expected timeframe for implementation is 2016.
- ▶ In relation to care plans, it is reported that these are in place for residents, but the current emphasis is on the medical aspects of care with insufficient consideration given to the social context. It was also recommended that their layout be reviewed in order to present an organised logical description of all care provided to individuals, and that they be made available in accessible or 'easy read' format to the residents and their representatives, where appropriate. The response to this is that these areas will be reviewed in 2016.
- ▶ There were two recommendations made in relation to the frequency of care plan reviews. In response, it is acknowledged that reviews are not held frequently enough, but this situation will be positively influenced by the roll-out and strengthening of the key worker model in 2016.
- ▶ The provision of appropriate healthcare for residents in the context of their personal plan was also recommended. The response to this is that, although annual medical check-ups are completed, the provision of GP services is the subject of ongoing discussions with senior members of regional management and should be resolved in 2016.

## Complaints procedures

The following recommendation relating to complaints procedures was reported as partially implemented:

- ▶ An effective, accessible and age-appropriate complaints procedure was recommended together with an appeals procedure. The response to this is that a review of the complaints policy is currently under way, and draft 'easy read' versions of the policy and procedures are in preparation.

<sup>32</sup>The Supports Intensity Scale – (SIS-A)™ is an assessment tool that evaluates practical support requirements of a person with an intellectual disability.

## Advocacy services

The following recommendation relating to advocacy services was reported as partially implemented:

- ▶ It is noted that advocacy is an ongoing issue and will be 'completed' for all residents in the near future. Inclusion Ireland have started working with residents to develop a self-advocacy service; however, no time-line for implementation is indicated.

## Communication needs

The following recommendation relating to communication needs were reported as partially implemented:

- ▶ Two recommendations were made in relation to assisting and supporting each resident at all times to communicate in accordance with their needs and wishes, and to implement methods of non-verbal communication aids. The response to these recommendations was that they are not implemented; however it is stated that with the change to the social model of delivery, focus will be placed on developing the skills and abilities for residents to become more independent in their daily lives. This will include a focus on communication skills, and programmes such as TEACCH, PECS and LÁMH<sup>33</sup> will be introduced where appropriate with the assistance and input of the speech and language therapist. No time-line for implementation is identified.
- ▶ The provision of access to telephone, television, radio, newspapers and internet was recommended. It is reported that residents have free access to the first four of these but do not have internet access. It is expected that this recommendation will be implemented in 2016.

## Community links

The following recommendation relating to community links was reported as partially implemented:

- ▶ To provide residents with supports to develop and maintain personal relationship and links with the wider community in accordance with their wishes. In response, it is acknowledged that this area requires considerable input and although some minimal improvements have been made, there is room for substantial further development. No time-line for implementation is indicated.

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<sup>33</sup> TEACCH: Treatment and Education of Autistic and Related Communication Handicapped Children – this is a service, training and research programme for individuals of all ages and skill levels with autism spectrum disorders.

PECS: Picture Exchange Communication System is a alternative form of communication designed to supplement or replace speech or writing for people with a language impairment.

LÁMH: a manual sign system designed for children and adults with intellectual disabilities and communication needs in Ireland.

## Privacy, dignity and security of possessions

The following recommendation relating to privacy, dignity and security of possessions was reported as partially implemented:

- ▶ The privacy and dignity of each resident should be respected in relation to (but not limited to) their personal living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. The response to this recommendation is that all residents of bungalows now have their own/adequate space, but reduction in the numbers living in Centre 1 are currently being worked on. The expected date of implementation in relation to this is 2017. It was also noted that an intimate care plan and policy articulate the requirements in this area.

## Staff needs

Twenty recommendations were made in relation to meeting staff needs. It is reported that of these, six are fully implemented and 14 are partially or yet to be implemented, many concerning the ongoing roll-out of training programmes.

The following recommendations relating to staff needs were reported as partially implemented; many of these have an implementation date of 2016:

- ▶ In relation to ensuring staff have access to appropriate training, including refresher training and opportunities for continuous professional development, it is reported that the training schedule is in the process of being redrafted, and incorporates mandatory and desirable elements. It is also reported that training plans will be specific to groups of residents.
- ▶ Key worker training has been undertaken by 60 per cent of staff including healthcare assistants and social care workers – further training is still needed in this area.
- ▶ Although staff have received training in safeguarding, this training remains outstanding for residents and families.
- ▶ Studio 3 training has been delivered to the majority of staff in Centre 2, and three staff members have completed a ‘train the trainer’ course in order to cascade this training further, and so that they can act as mentors on approaches and techniques.
- ▶ In relation to restrictive practices, there is now a Restrictive Practice Group in place which meets and reviews all restrictive practices and procedures. The aim is to define restrictive practices and to reduce and eventually eliminate their use from the service.
- ▶ The HSE has developed a national policy and guidelines on open disclosure. This has yet to be implemented in Áras Attracta.
- ▶ All nursing staff have completed the ongoing medication management training. Plans are in place for nurses to undertake a ‘train the trainer’ programme in Safe Administration of Medication (SAM), which will be provided for some non-nursing staff.
- ▶ The service has just commenced using an e-auditing system and is a pilot site for HSE disability services.

- ▶ A number of policies, procedures and guidelines are in need of review and it is acknowledged that training is needed in relation to some of these.
- ▶ Risk assessment training has been availed of by a number of frontline staff, but further roll-out is planned for 2016.
- ▶ Daily incident report review meetings attended by the clinical nurse specialist (behaviours), psychologist and social worker, are now being held, and a monthly organisation risk register review takes place. It is planned to develop a risk register for each of the centres.
- ▶ It is reported that all staff will receive support and supervision in 2016, and performance management will also be introduced (see Leadership and Direction, immediately below).

## Leadership and direction

There were 32 recommendations regarding leadership and direction and it was reported that 20 of these are implemented ('completed and in place'); 11 are to be implemented in 2016, and there is one with no clear timeline for implementation.

The following recommendations relating to leadership and direction were recorded as partially implemented:

- ▶ In relation to the introduction of a system for structured supervision of all staff – it is reported that a request has gone to procurement to implement this, and performance management has commenced for senior management. It is stated that this will be fully implemented in 2016.
- ▶ The recommendation that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of residents, and to the statement of purpose and layout of the centre, is currently partially implemented with an identified implementation date of 2016. Similarly, a review of the relationship between rostered hours, residents' activities, staff skill mix, and residents' dependencies is subject to ongoing review, but expected to be fully implemented in 2016.

It is noted that all residents have now had the benefit of having an independent Supports Intensity Scale – A™ assessment. This data is being analysed to ensure that the skill mix of staff is appropriate to the number and assessed needs of residents; that the relationship between rostered hours, skill-mix and residents' dependencies is appropriate; and the numbers of staff on duty reflects periods of resident activity and is directly related to residents' needs.

- ▶ It was recommended that there be a reduction in movement of frontline staff to increase stability in the bungalows and units. It is reported that this is being worked on and is implemented for Centre 1, day services and the two new Social Care Houses, but has yet to be completed in Centres 2 and 3 – however, the implementation date is expected to be early in 2016.
- ▶ The development of an e-rostering system has not as yet been fully implemented, but it is expected that this will evolve from the placement of staff teams in each bungalow and unit in 2016



- ▶ In relation to the recommendation that the issue of role identification (badges) be explored, it is suggested that with the plans in place to reduce the numbers of residents in the houses and to create a more homely atmosphere, knowledge of grades will not be necessary.
- ▶ Although documented evidence of planned audits with assigned responsible staff has not as yet been fully implemented, it is reported that the e-auditing system will enable the roll-out of this in the first quarter of 2016.
- ▶ It was recommended that regular team meetings be held, with dates agreed for the calendar year, agendas circulated in advance, staff offered the opportunity to submit items, and minutes recorded and circulated. It is reported that regular meetings are being held (at centre level), but it is believed that these are not currently effective. However, the process of arranging 'house' meetings is being rolled out, and it is expected that these will be in place in 2016.
- ▶ In relation to the preparation in writing, adoption and implementation of all the policies and procedures set out in Schedule 5 of the *Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013*, it is reported that the Schedule policies, procedures, protocols and guidelines (PPPG) are completed and in place but require updating and review. In order to do this the Policies, Procedures and Guidelines Group is to be re-established and will review all necessary policy documents. However, no time-line has been identified for this.
- ▶ It was recommended that Áras Attracta ensure that the requirements of Schedule 6 of the *Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013* are met. These relate inter alia to adequate private and communal accommodation; suitable rooms; safe and secure storage; baths, showers and toilets of a sufficient number to meet the needs of residents; laundering facilities etc. It is reported that 'through the process of the opening of social houses and decongregation the service will be able to ... comply'. The implementation date is identified as 2016.

## Records and communication

Of the ten recommendations made in this area, it was reported that three are implemented, and seven are partially implemented.

The following recommendations in relation to records and communication were reported as partially implemented:

- ▶ There were two recommendations that a single Action Plan be put in place prioritising actions with achievable deadlines. In response, it is reported that the service has just commenced using an e-auditing system and is a pilot site for HSE Disability Services. It is expected that this will be rolled out in all areas of the service in March 2016.
- ▶ The establishment of a group including Senior Management representatives to review record keeping and develop guidelines was recommended. It was also recommended that training and regular audit should follow this. It is expected that this will be rolled out in March 2016.
- ▶ It was recommended that a computerised documentation system be implemented within the service. This is being considered but it is not expected to be in place before 2017.

- ▶ It was recommended that there must be a regular programme of audit of policies, procedures, protocols and guidelines (PPPG) to ensure continuous quality improvement. In addition the annual schedule of audits should include date completed, date for review, and timescale for actions to be completed. Identified risks must be assessed and recorded appropriately, and incorporated into an overall programme of the monitoring and implementation of recommendations from audits. Learning from audits must be shared throughout the organisation. The response to these recommendations is that it is expected that the e-auditing system will support this, and will be in place in March 2016.
- ▶ Implementation of recommendations in relation to ensuring that the number of staff and their qualifications are appropriate to the assessed needs of residents, the statement of purpose and the size and layout of the designated centre are expected to be in place in 2016.

### Partnership working

There was one recommendation concerning partnership working and referral of residents to appropriate services such as dietetics, speech and language therapy, dentistry etc – in order to support each resident to achieve adequate nutritional intake. This recommendation was reported as implemented and that key workers are actively referring people to the allied health professional as appropriate.

### Summary of findings: senior management questionnaire

Responses provided by the Director of Services to the senior management questionnaire indicate that almost two-thirds of the recommendations have now been implemented, with the majority of the remainder to be implemented in 2016. The Review Group itself has not verified whether or not recommendations have been implemented.

**Figure 7.1** Thematic recommendations implemented/partially implemented, as reported by the Director of Services

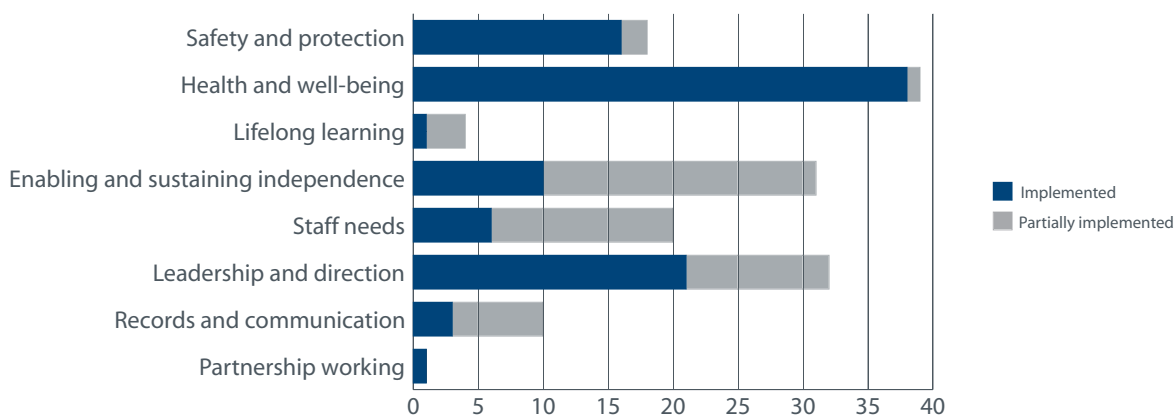


Figure 7.1 highlights that most attention is required in the areas of enabling and sustaining independence, meeting staff needs, and leadership and direction; and that most progress has been made in the areas of meeting healthcare needs and ensuring that residents are safe.

## 7.3 Local management questionnaire

A questionnaire was issued to the new CNM3s of the three centres when they commenced work in Áras Attracta in autumn 2015. The managers were external appointments and came to Áras Attracta with a diverse range of experience and knowledge.

The questionnaires put to the centre managers addressed 74 of the recommendations that were also included in senior management questionnaire. These were grouped under the same themes as in the senior management questionnaire, but did not include any recommendations concerning records and communication, as these were not considered relevant by the Director of Services at the time.

As noted elsewhere in this report, the three newly designated centres are very different in character, and the support needs of residents vary considerably within each. The responses of the managers of each of the three centres are summarised below.

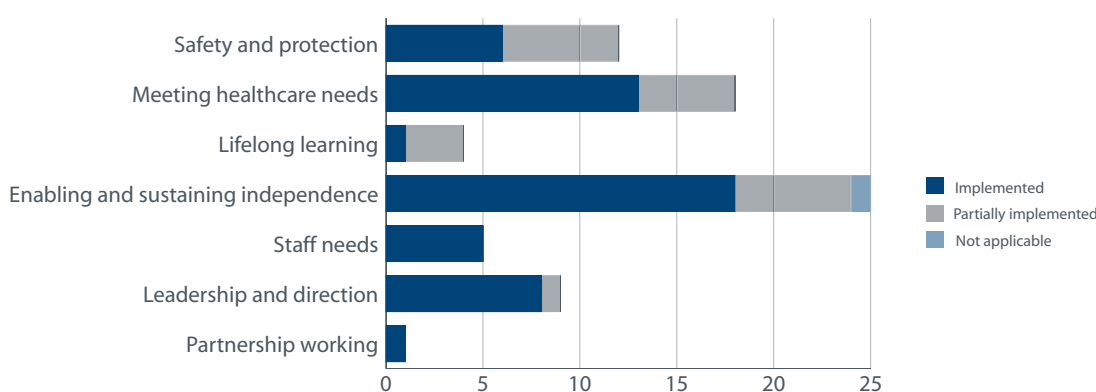
For all three centres, recommendations relating to new admissions were regarded as *not applicable*, as there have been no new admissions to Áras Attracta for some years.

### Centre 1: management review of recommendations

Centre 1 consists of two units and caters mainly for older residents, some of whom have greater medical needs than residents in the other centres. See chapter 8 for a more detailed profile of the three centres.

Of the total of 74 recommendations, 52 are reported as having been implemented, 21 have been partially implemented, and 1 was not applicable.

**Figure 7.2** Thematic recommendations implemented/partially implemented, as reported by Centre 1 Nurse Manager



The recommendations that were reported as partially or not implemented are detailed below.

## Safety and protection

The recommendation which concerned ensuring that the risk management policy includes hazard identification and assessment of risks throughout the centre was reported as implemented, and the lifestyle risk assessment form was reported as partially implemented

- ▶ In relation to fire safety, drills and procedures, the recommendation was to ensure that staff, and as far as practicable residents, are aware of the procedure to be followed in the case of fire. It was reported that training is ongoing in this area.
- ▶ In relation to fire evacuation routes, it was recommended that these were to be displayed in prominent places in 'easy read' format, and individual fire evacuation plans updated to alert staff to the amount of time required to evacuate each resident. It was reported that wheelchair assistance is in place, and that training in this area is ongoing, and so partially implemented. This also applied to making adequate arrangements for evacuating all residents and bringing them to safe locations – reported as partially implemented.
- ▶ On the subject of restrictive procedures, it was recommended that every effort should be made to identify and alleviate the cause of residents' behaviour; that alternative measures should be considered; and that the least restrictive procedure for the shortest duration, should be used. It was reported that measures are in place to address this recommendation, but that reviews are ongoing.
- ▶ Behavioural support plans were to be made explicit and regularly reviewed with support from the clinical nurse specialist (CNS) in putting them into practice. Referrals are reported as ongoing to the CNS, with support being a continuing requirement.

## Health and well-being

- ▶ In relation to the administration of medication, there was a plan to work with GPs to update this into a concise and logical format, and the use of audits – this was partially implemented.
- ▶ A review of the drug prescription sheet to include senior management, pharmacy representatives, and GPs is reported as partially implemented and ongoing.
- ▶ Implementation of recommendations relating to nutrition, snacks and hydration are reported to be the subject of ongoing review and training, and therefore partially implemented, as is the ongoing use of food diaries.

## Lifelong learning

- ▶ Regular checks of day activity recording sheets by a supervisor to ensure their validity were recommended. It was reported that the Activation Coordinator checks these, but this requires time, and audits are also required.
- ▶ The provision of opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs was reported as improving, but the drive to engage and broaden social involvement of residents in the wider community is recorded as partially implemented.

- ▶ Access for residents to facilities for occupation and recreation was reported as partially implemented, and the outcome of the SIS-A™ assessments was awaited to further establish abilities and interests (for occupation and recreation).

## Enabling and sustaining independence

- ▶ A recommendation to review and strengthen the role of the key worker in person-centred planning was in train, but reported as partially implemented.
- ▶ Arrangements to meet the assessed needs of each resident were reported as partially implemented. It was stated that increased person-centred approaches to activation were required to ensure optimal engagement for 'high dependency' residents.
- ▶ It was recommended that each resident should be provided with appropriate supports, and at the time, Centre 1 was awaiting the outcome of the SIS-A™ assessments.
- ▶ In relation to healthcare, the need for enhanced GP resources was highlighted, as was the need for the availability of a GP of choice for residents.
- ▶ Although some 'easy read' versions of documentation were available, it was highlighted that assistive technology would be of benefit to residents to enable access to these.
- ▶ Communication aids were being worked on at the time by the speech and language therapists so that communications would be improved.
- ▶ On the question of personal space, privacy and dignity, not all residents have single room occupancy, and where they share, their beds are segregated by screens; this recommendation was therefore reported as partially implemented.

## Staff needs

- ▶ It was reported that staff training is ongoing in relation to education about notifiable events and accountability in providing evidence of a safe service; and therefore partially implemented.

## Leadership and direction

- ▶ The recommendation regarding the preparation in writing, adoption and implementation of all policies and procedures set out in Schedule 5 of the *Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013* was reported as partially implemented. The policies have been reviewed but updating was not complete.

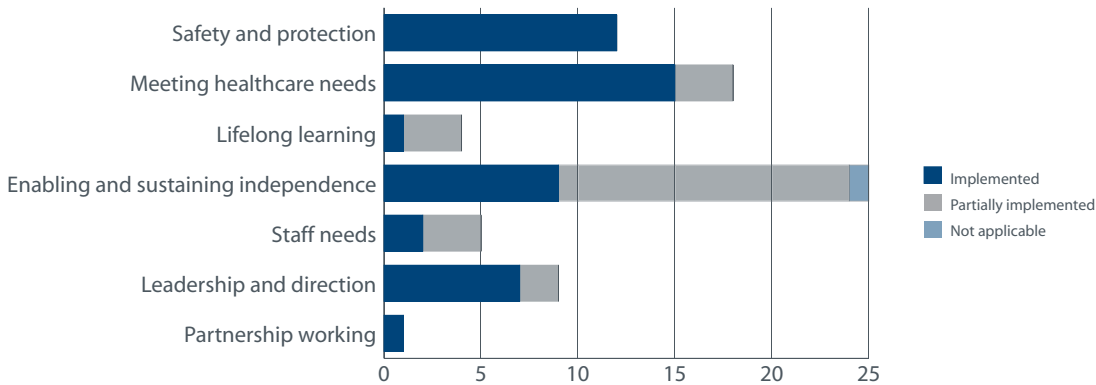
## Centre 2: management review of recommendations

Centre 2 is made up of bungalows rather than units, and caters mainly for residents with behaviours that challenge. Included in the bungalows is one singly-occupied bungalow, and a dedicated apartment within a bungalow. There are two recently reopened bungalows for residents whose supports are based on a social model of service delivery. These residents are regarded as being in transition to living with support in the community.

The support needs of residents in Centre 2 are therefore quite diverse.

Of the total of 74 recommendations, 46 are reported as having been implemented, 27 have been partially implemented, and one was not applicable (related to new admissions).

**Figure 7.3** Thematic recommendations implemented/partially implemented, as reported by Centre 2 Nurse Manager



The recommendations that were reported as partially or not implemented are detailed below.

### Safety and protection

- ▶ In relation to fire safety management and the frequency of fire drills, it was reported that these were conducted at least twice annually; however, it was acknowledged that the frequency was to be increased ‘in the near future’.

### Health and well-being

- ▶ Documenting nutritional assessment findings, and putting in place a care plan that clearly outlines how each risk factor is addressed and reviewed every three months or more frequently if indicated, was reported to be in progress and due for completion ‘in the near future’.
- ▶ Examination of the nutritional component of the ‘My Way Plan’ and the incorporation of a comprehensive nutritional pathway was recommended. This was reported to be still in progress and to be reviewed with the dietetic team and person-centred planning facilitator.
- ▶ The definition of clear roles for all staff regarding appropriate nutrition and hydration of residents is ongoing, with further training opportunities to be explored to assist in this area.

### Lifelong learning

- ▶ It was recommended that a programme of individualised meaningful day activities be developed for all residents urgently. It was reported that this is envisaged with the roll-out of the social care model, and a more meaningful person-centred approach to day activities would develop. This process had commenced in one bungalow.
- ▶ The provision of opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs, was also reported as contingent on the roll-out of the social model of care, which had just commenced in the centre.

- ▶ Access for residents to facilities for occupation and recreation was similarly contingent on the roll-out of the social model of care which had just commenced.
- ▶ It was reported that reviews are ongoing in relation to the use of restrictive procedures, and referrals are made to the CNS in devising behavioural support plans and putting them into practice, and Studio 3 training has been provided for staff.

## Enabling and sustaining independence

- ▶ As recommended, it is reported that the key worker model of service is in place; however, identified areas for improvement were noted. A review of the existing policy was due to be conducted to allow all grades of staff to become key workers, and not just to nursing staff, as at present.
- ▶ In relation to the recommendation that key workers have a clear understanding of their role and play an active role in the residents' care plans, a review of the allocation of key workers was to be undertaken once the 'core groupings' of staff per bungalow had taken place. It was noted that ongoing training is required for residents, staff and families in this area and therefore this recommendation was partially implemented.
- ▶ In relation to comprehensive assessments, although annual reviews take place, it was noted that these need to be better managed and planned.
- ▶ It was recommended that the layout of personal care plans be reviewed so that they present an organised and logical description of the care provided to the individual. It was reported that although care plans are in place, they are focused on medical aspects of care, with insufficient attention to the social context.
- ▶ Although care plans are reviewed, it is reported that reviews are not held frequently enough and will be a subject for discussion at team meetings.
- ▶ It was expected that the role of the key worker would be reviewed and strengthened with a view to effecting the improvements in each plan, once the allocation of key workers to residents has been made more consistent.
- ▶ The provision of appropriate care and supports in line with residents' assessed needs was dependent on the outcome of the SIS-A™ assessments and therefore partially implemented
- ▶ Annual medical check-ups take place for all residents, and consultations take place with GPs throughout the year; however, it is recognised that access to GPs is currently not sufficient, but was being addressed by senior management at the time.
- ▶ Personal plans in an accessible format were not available to all residents, but it was hoped that this would be completed 'in the near future'.
- ▶ 'Easy read' versions of documentation relating to residents (for example, personal plans) were not available, but it was expected that this would be completed 'in the near future'.
- ▶ Access to advocacy services and information about rights 'will be completed for all residents in the near future'.

- ▶ Supporting residents to communicate in accordance with their needs and wishes was reported as partially implemented. It was reported that in light of a change to a social model of care delivery, the focus would be on residents developing skills and abilities to become more independent. This would include focusing on communication skills using appropriate programmes and assistance from speech and language therapists, and would include the use of non-verbal communication aids.
- ▶ It was acknowledged that considerable input and review is required in supporting residents to develop and maintain personal relationships and links with the wider community.

### Staff needs

- ▶ Educating staff on notifiable events and accountability in relation to providing evidence of a safe service was to be discussed at all team meetings. In addition, cultural issues, values for practice, dignity and respect were to be included in safeguarding training, and it was planned that this would also be discussed at team meetings.
- ▶ In relation to use of restrictive procedures, it was reported that a restrictive practice group was in the process of being established and that a human rights committee would be established in 2016.
- ▶ Medication management education training was being audited to determine how many nurses had completed this and how many still needed to undertake it.

### Leadership and direction

- ▶ The recommendation concerned the provision of documented evidence of planned audits, with assigned responsible staff. It is reported that Incident Report Review meetings are taking place on a daily basis, Safeguarding meetings taking place weekly, and Safeguarding Oversight meetings with external representation taking place monthly. However some of the audit tools are still in development – with the help of an external agency and IT expertise.
- ▶ Evidence of robust risk assessments and regular evaluations of more complex presentations were recommended. This recommendation is reported as partially implemented. Risk assessments are in place for many residents; however, the situation is being reviewed with a view to strengthening the process and its documentation, and external input has been sought to assist this.

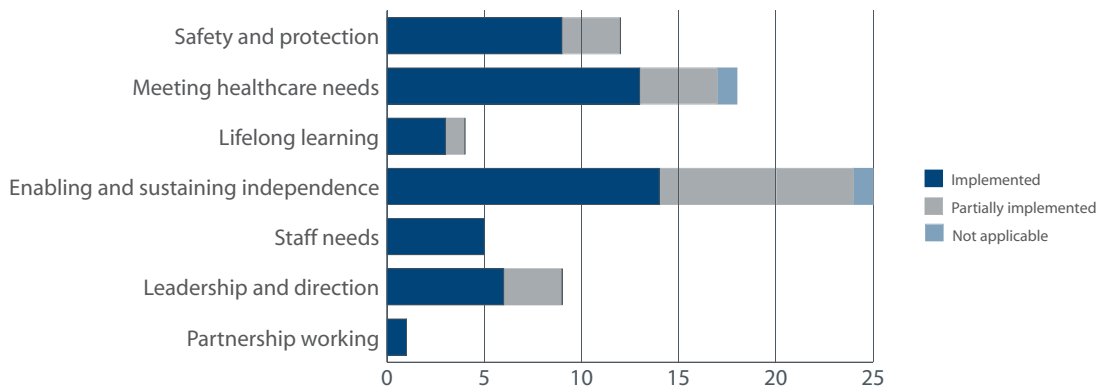
## Centre 3: management review of recommendations

Centre 3 consists of bungalows mainly catering for residents with fewer support needs than in the other centres.

Of the total of 74 recommendations, 34 are reported as having been implemented, 38 partially implemented, and 2 were not applicable.



**Figure 7.4** Thematic recommendations implemented/partially implemented, as reported by Centre 3 Nurse Manager



The recommendations that were reported as partially or not implemented are detailed below.

### Safety and protection

- ▶ Ensuring that residents are safe and protected: the recommendation which concerned ensuring that the risk management policy includes hazard identification and assessment of risks throughout the centre was reported as implemented – however, the lifestyle risk assessment form was reported as partially implemented.
- ▶ In relation to fire safety management and fire drills, the recommendation was that drills be held at suitable intervals, and that staff, and as far as practicable residents, are aware of the procedure to be followed in the case of fire. This was reported as partially implemented – that training, review of Personal Emergency Evacuation Plans (PEEPs), and health and safety checks to ensure all equipment is working are ongoing.
- ▶ In relation to fire safety knowledge and the list of evacuation methods required and associated risk for each resident, the monitoring of mobility and capacity is ongoing. Fire drills are reported as being partially implemented.
- ▶ In relation to fire evacuation routes, it was recommended that these were to be displayed in prominent places in ‘easy read’ format, and individual fire evacuation plans updated to alert staff to the amount of time required to evacuate each resident. It was reported that training in this area is ongoing, and the Director of Services is to ensure that regular fire drills take place. The review of each resident’s PEEP is recorded as not implemented.
- ▶ The recommendation about making adequate arrangements for evacuating all residents and bringing them to safe locations, is reported as partially implemented, with ongoing training and reviews.
- ▶ A further two recommendations reported as partially implemented were in relation to the use of restrictive procedures, and the identification of residents’ behaviour, the consideration of alternative measures, and the use of the least restrictive procedure for the shortest duration. Reviews in this area are being undertaken, and referrals to the clinical nurse specialist are ongoing for assistance with the design and implementation of behaviour support plans; however, support is an ongoing requirement.

## Meeting healthcare needs

- ▶ In relation to the administration of medication, it was reported that there was a plan to work with GPs to update this into a concise and logical format. The use of audits, staff supervision, observation of practice and ongoing training for nurses were reported as partially implemented.
- ▶ The secure storage of medication, documentation and other management-related activity is under review, with a view to moving it out of the living room area, in order to create a more home-like environment.
- ▶ Review of the drug prescription sheet with the input of pharmacists and GPs is partially implemented.
- ▶ Opportunities for residents to access a GP of their choice is recorded as partially implemented.
- ▶ All staff are to be educated around meal times – partially implemented; however, environmental changes are needed to enhance meal times in the bungalows, as space can be restrictive.
- ▶ The preparation of some meals in the bungalows is under consideration, but residents have not been assessed in the area of meal preparation.
- ▶ In relation to clear definition of roles regarding appropriate nutrition and hydration, ongoing training is being delivered by the dietitian and the speech and language therapist.
- ▶ It was recommended that there should be a clear record of nutritional intake of both fluids and food, which must be audited and regularly reviewed as part of care planning for each resident. It was reported that the use of food diaries was partially implemented. Dietetics are involved in the review and follow-up, and are working closely with nurses and healthcare assistants.
- ▶ The implementation of practices in relation to ordering, receipt of, prescribing, storing, disposal and the administration of medicines was recommended in order to ensure that prescribed medicine is administered to the person it is intended for, and no other resident. It was reported that in preparation for transition to the community, Áras Attracta is considering SAM training for designated healthcare assistants and social care workers.

## Lifelong learning

- ▶ Programmes of individualised meaningful day activities for residents are reported to be in place; however, it was planned that the Director of Services was to meet the day service to adopt the aims of the *New directions* report.<sup>34</sup>
- ▶ It was reported that audits are required to ensure full implementation of the recommendation to conduct regular checks of day activities by a supervisor to ensure their validity.
- ▶ Access for residents to facilities for occupation and recreation is partially implemented, as the outcome of the SIS-A™ assessments are still awaited. At that point it is expected that the information gained will establish residents' abilities and interests in this area.

<sup>34</sup> HSE, 2012. *New directions: review of HSE day services and implementation plan 2012–2016 – personal support service for adults with disabilities.*

## Enabling and sustaining independence

- ▶ In relation to the full implementation of the key worker model of service delivery (with the key worker acting as a single point of contact for the resident, their family and support group; as a resource to the resident; and as a designated person to a resident), it was reported that all residents had been assigned a key worker. However the work concerning relatives was in development.
- ▶ It was recommended that management ensure that key workers have a clear understanding of their role in relation to the resident and their care plan. Each resident had been assigned a key worker and link worker, however the system was being reviewed to ensure that the key worker worked in the bungalow in which the resident for whom they are key worker lives.
- ▶ It was reported that the role and responsibilities of the key worker were in development by the Director of Services. The role will include monthly reports to be reviewed by the Director of Services, and the 'reasonability' of preparation of residents to move to the community.
- ▶ A recommendation was made to put in place arrangements to meet the assessed needs of each resident. This was reported as partially implemented, but it was acknowledged that all personal plans should be reviewed so that they are more focused on life enhancing experiences, community based activities and social integration, and advance planning of community activities.
- ▶ Appropriate care and support tailored to the residents' disabilities, assessed needs and wishes, was recommended. This was reported as partially implemented as the outcomes of the SIS-A™ assessments were awaited to inform the accurate identification of needs, and the fulfilment of wishes in the future.
- ▶ In relation to the provision of appropriate healthcare and personal plans, it was reported that enhanced GP resources were needed; that residents should have the possibility of accessing a GP of their choice in the community, and they would be supported in this.
- ▶ Personal plans are available to the residents in accessible format; however, access to technology may be considered in the future to increase access.
- ▶ An 'easy read' version of the Charter of Rights has not been developed, thus reported as not implemented, and 'easy read' information about Voices and Choices, is partially implemented.
- ▶ Assistance and support to residents in communication is reported as partially implemented. Work is ongoing by the speech and language therapist on the development of communication passports for each resident to support their communication. In addition, the speech and language therapist is to assess each resident to develop a communication aid to enhance their communication.
- ▶ It is reported that the privacy and dignity of residents is upheld, promoted and respected at all times; however, not all residents have single room occupancy, and the 'knock on doors' strategy needs to be enhanced, and all

residents need to be educated in the area of privacy. It is also reported that rooms have not been personalised to the individual residents' choice, and residents are not offered the choice of having a television in their bedroom – which could enhance their privacy and choice in viewing.

- ▶ Ensuring that each resident uses and retains control over their clothes and has adequate space to store personal possessions and property was a recommendation reported as partially implemented. This was also the case in the use of in-house laundry facilities. It was reported that personal possession check lists are to be reviewed by the Director of Services.
- ▶ The provision of supports to residents to develop and maintain personal relationship and links with the wider community in line with their wishes were reported as partially implemented. It was reported that person-centred plans are to be reviewed, and the key worker and the link worker will be involved in compiling a plan to identify goals such as integration into community living, and the promotion of independence and a sense of achievement.

### Meeting staff needs

- ▶ In relation to educating staff about notifiable events and accountability to provide evidence of a safe service, many procedures are in place. However training in regulation and compliance was partially implemented; and a supervision framework to support and enhance staff practice is reported to be in development.
- ▶ In relation to the use of restrictive procedures, the centre is moving towards a restraint-free environment – referrals are made to the clinical nurse specialist for advice on behaviours that challenge; low arousal techniques and Studio 3 training has been undertaken by all staff. However it is noted that the reduction in numbers living in the bungalows is partially implemented, and a low arousal environment is partially implemented.

### Leadership and direction

- ▶ It is reported that the key worker model of service delivery had been implemented with a key worker assigned to each resident in the location in which they work. However the off duty roster was under review to ensure greater consistency.
- ▶ It was recommended that audits of the management of key risk factors to provide evidence of evaluation of effectiveness of risk mitigation interventions (including falls, assaults, nutrition, pressure sores, and anything that could be construed as a risk factor) were to be carried out. It was reported that this recommendation was partially implemented.
- ▶ The recommendation regarding the preparation in writing, adoption and implementation of all policies and procedures set out in Schedule 5 of the *Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013* was reported as partially implemented. The policies have been reviewed but updating was not complete at that time.

## Summary

The three centres report differing numbers of recommendations as having been implemented or partially implemented. It is important to note that there were variations in interpretation and approach to the responses – some responses were reported as both ‘implemented’ and ‘partially implemented’, and this gave rise to some difficulty in classification. The ‘partially implemented’ responses often referred to programmes of ongoing training and development, that are in train but not yet complete.

The four major themes identified as requiring the most attention by the three centre managers are

- ▶ Enabling and sustaining independence of residents.
- ▶ Meeting health and well-being needs of residents.
- ▶ Ensuring the safety and protection of residents.
- ▶ Providing residents with opportunities for lifelong learning.

These results are somewhat at variance with the results of the senior management questionnaire where enabling and sustaining independence of residents (21 not fully implemented), meeting staff needs (14 not fully implemented), and leadership and direction (14 not fully implemented) were the main themes.

It appears from the responses received in late 2015 from the Director of Services and the nurse managers that there has been a shift in thinking in relation to some aspects of the supports provided to people living in Áras Attracta, with a move towards a more personalised service, and a more reflective approach on the part of management. However, although progress is under way, it is slow in some key areas.



# 8

## Person-focused assurance, part 1: *profile of Áras Attracta*

Part 1 of the person-focused assurance work was essentially an information-gathering exercise in which the members of the Assurance Team brought together information relating to eight bungalows and two units at Áras Attracta.

The content of this chapter comes from written and verbal information supplied by Áras Attracta management in autumn 2015.

In line with the reconfiguration of the bungalows and units into three designated centres during the course of the Review Group's work, the findings are presented for each of these three centres in turn.

Respite users or those who attend Day Services were not included.

While different in character, the three centres all have the same general Statements of Purpose although they do reflect differences in staffing complements.

### 8.1 About Centre 1

#### Profile of the residents

There were 40 residents living in Centre 1: 19 women and 21 men. Their age profile is shown in Table 8.1.

**Table 8.1** Age profile of residents in Centre 1

Age	Number of residents
40 years or under	2
41–59 years	15
60–79 years	20
80 years or over	3

All 40 residents have been living in the centre for six years or more.

Thirty-five residents had contact with their families, although the contact was described as minimal in some instances. None of them had contact with an advocate, but access to an external advocate could be arranged if necessary.

Residents' degree of disability is shown in Table 8.2.

**Table 8.2** Degree of disability of residents in Centre 1

Degree of disability	Number of residents
Mild	2
Moderate	19
Severe	19
Profound	0

## Physical characteristics and facilities

The 40 residents in Centre 1 were accommodated in two units. The centre had nine single bedrooms, and the remaining bedrooms were shared, with up to four residents in some bedrooms.

### Facilities

- ▶ There were eight bathrooms/shower rooms available to residents.
- ▶ Centre 1 had seven separate toilets for residents to use, a ratio of approximately six individuals to each separate toilet.
- ▶ Laundry facilities were available in both units but were not used by residents.
- ▶ Kitchen/cooking facilities were also available but were not used by residents.
- ▶ Apart from their bedrooms, a separate quiet area was available to residents in one of the units.
- ▶ Computer access was available for the use of staff but not for the residents.
- ▶ Residents had access to transport provided by Áras Attracta.

## Profile of staff

### Staff numbers

The staffing information<sup>36</sup> provided to the Review Group indicated that Centre 1 had a staff complement of 77 or 64.5<sup>37</sup> whole-time equivalents (WTEs), including 44 HSE employees (57 per cent) and 33 agency staff (43 per cent) – as of mid December 2015. The fortnightly requirement for support hours for 39 residents<sup>38</sup> is 3,954 support hours (50.8 WTEs).

The skill mix was calculated as 38 per cent nursing staff and 62 per cent healthcare assistants. This calculation included four healthcare assistants, allocated as a specific resource to the activation team for this centre, and five supernumerary WTE nursing management positions, four at CNM2 level and one new position at CNM3 level (the person commenced duty at the beginning of October 2015). This represents a new management and governance structure for the centre and in general these managers are not involved in frontline support provision. No social care workers or social care leaders were allocated to this centre.

<sup>36</sup> Owing to data inconsistencies/errors, the staffing information was submitted three times by the management team.

<sup>37</sup> These figures do not include any provision for sick leave, training leave, administrative leave and the like.

<sup>38</sup> Excluding one short-term respite user.



All staff members have up-to-date job descriptions and most have worked in the centre for between six months and two years.

Staffing was managed for Centre 1 as a whole, rather than by the unit, although this is expected to change.

Rostering was generally based on a fixed line system and shift patterns mainly consisted of 11-hour paid shifts during the day and 11.14-hour paid shifts at night. Twilight shifts from 5.30pm to midnight were also a feature of the rosters.

Newly appointed team members for the activation programme were not an integral part of staffing arrangements.

None of the staff working in Centre 1 received formal supervision.

A personal laundry service was available seven days a week (9.30am to 6pm) and clerical support was provided Monday to Friday (9am to 5pm). Cleaning services were provided on a contract basis.

### Staff qualifications

The qualifications<sup>39</sup> of the nurses in Centre 1 at the time of the assessment are shown in Table 8.3.

**Table 8.3** Nurses' qualifications (Centre 1)

Qualification	Number of nurses
Registered Nurse Intellectual Disability (RNID)	19
Registered General Nurse (RGN)	6
Registered Psychiatric Nurse (RPN)	5
RGN and RCN	1
RGN, RCN and RNID	1

Approximately 80 to 90 per cent of healthcare assistants had completed or were undertaking a QQI/FETAC Level 5 course.

<sup>39</sup> A number had other qualifications including: B.Sc. in Public Administration, BA in Public Management, Certificate in Healthcare Management, Certificate in Nursing Elderly People, Diploma in Social Care in Mental Health, Certificate in Management Development, Higher Diploma and Bachelor Degree in Nursing, Stress Management Skills and European Computer Driving Licence.

## Training record

Table 8.4 summarises the relevant training provided to staff (HSE and agency)<sup>40</sup> from 1 January 2014 to 9 October 2015.

**Table 8.4** Training programmes undertaken by HSE and agency staff members in Centre 1

Training programme	Number of staff trained	
	HSE (53 total staff)	Agency (36 total staff)
Adult protection training	52	35
CPI training	18	3
Key worker training	11	1
Studio 3 training	5	15
Trust in care training	14	0

There has been a relatively low focus on key worker and trust in care training and no evidence of any in-service training on values, de-congregation or the rights-based social model of support.

## Handover mechanisms

The Review Group also sought information on the handover mechanisms used between staff when changing shifts or rosters. These were described as a combination of verbal and written communication.<sup>41</sup>

## 8.2 About Centre 2

### Profile of residents

There were 26 individuals living in Centre 2: 7 women and 19 men. Their age profile is shown in Table 8.5.

**Table 8.5** Age profile of residents in Centre 2

Age	Number of residents
40 years or under	3
41–59 years	13
60–79 years	10
80 years or over	0

The length of time residents had lived in the bungalow they currently live in was:

- ▶ Less than six months: 6 (all of whom had moved from another bungalow)
- ▶ Between six months and 5 years: 10
- ▶ Over six years: 10

<sup>40</sup> Including one staff member on contract from Western Care.

<sup>41</sup> Details given included: morning and evening meetings, daily nursing notes, day/night report book/activity reports, unit communication book, diary and roll call, and a handover of drug keys and panic alerts/pagers.

There had been considerable movement within the centre over the last year or so. One resident moved to a single-occupancy bungalow, another was given a self-contained apartment within a bungalow, and some bungalows have been closed and others reopened.

Twenty-four residents had contact with their families, and three had contact with an advocate.

Residents’ degree of disability is shown in Table 8.6.

**Table 8.6** Degree of disability of residents in Centre 2

<b>Degree of disability</b>	<b>Number of residents</b>
Mild	2
Moderate	4
Severe	18
Profound	1
Dual diagnosis	1

## Physical characteristics and facilities

The 26 residents in Centre 2 were accommodated in five bungalows, one of which was a single occupancy bungalow.

### Facilities

- ▶ Everyone had their own bedroom – there were 26 single bedrooms in use.
- ▶ Centre 2 had 14 bathrooms/shower rooms available to residents (some with toilet).
- ▶ With the exception of one bungalow (which has two separate toilets), four bungalows had no separate toilets for residents to use.
- ▶ Laundry facilities were available and apart from one resident, these were used to varying degrees by everyone else.
- ▶ Kitchen/cooking facilities were also available, and in all but one bungalow residents used these facilities.
- ▶ A separate quiet area (apart from bedrooms) was available in two bungalows for residents to access, and one of these was the single occupancy bungalow.
- ▶ Computer access was available for the use of staff in three of the five bungalows. None of the residents had computer access.
- ▶ Residents had access to transport provided by Áras Attracta.

## Profile of staff

### Staff numbers

The staffing information<sup>42</sup> provided to the Review Group indicated that Centre 2 had a staff complement of 93 or 76.65<sup>43</sup> whole-time equivalents (WTEs), including 59 HSE employees (63 per cent) and 34 agency staff (37 per cent) – as of mid-December 2015. The total number of hours for supporting 32 residents<sup>44</sup> is 6,068 hours per fortnight (76.9 WTEs).

The skill mix was calculated as 38 per cent nursing staff, 6.5 per cent social care and 55.5 per cent healthcare assistants. This calculation included three social care workers and two social care leaders allocated to two recently-opened Social Care Model houses. Also included were eight healthcare assistants and one nurse as a specific resource to the centre's Activation Team, as well as three supernumerary WTE nursing management positions, two at CNM2 level and one new position at CNM3 level (the person commenced duty at the end of August 2015). This represents a new management and governance structure for the centre and in general these managers are not involved in frontline support provision.

All staff had up-to-date job descriptions. Because of the considerable daily movement of staff between bungalows in Centre 2, no specific details were provided about the length of time staff had worked in the various bungalows.

Staffing was managed for Centre 2 as a whole, although this is expected to change to bungalow-based rostering. Staff moved frequently between bungalows as required. Rostering was generally based on a fixed line system and shift patterns mainly consisted of 11-hour paid shifts during the day and 11.14-hour paid shifts at night.

None of the staff working in Centre 2 received formal supervision.

A personal laundry service and clerical support were provided. Cleaning services were on a contract basis.

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<sup>42</sup> Owing to data inconsistencies/errors, the staffing information was resubmitted three times by the management team.

<sup>43</sup> These figures do not include any provision for sick leave, training leave, administrative leave and the like.

<sup>44</sup> Although there were only 26 residents in Centre 2 at the time of the assessment (August/September 2015), 32 are provided for in fortnightly hours requirement – this is to allow for the movement of individuals from Centre 3 to Centre 2's Social Care Model houses in mid-November 2015. Short-term respite users are not included in fortnightly support hours requirement.

## Staff qualifications

The qualifications<sup>45</sup> of the nurses in Centre 2 at the time of the assessment are shown in Table 8.7.

**Table 8.7** Nurses' qualifications (Centre 2)

Qualification	Number of nurses
Registered Nurse Intellectual Disability (RNID)	24
Registered General Nurse (RGN)	6
Registered Psychiatric Nurse (RPN)	10
RNID and RGN	1
RGN and RPN	1
RGN and Registered Midwife (RM)	2

Approximately 90 per cent of healthcare assistants have completed or were undertaking a QQI/FETAC level 5 course.

## Training record

Table 8.8 summarises the relevant training provided to staff from 1 January 2014 to 9 October 2015.

**Table 8.8** Training programmes undertaken by HSE and agency staff members in Centre 2

Training programme	Number of staff trained	
	HSE (61 total staff)	Agency (30 total staff)
Adult protection training	51	30
CPI training	24	0
Key worker training	22	0
Studio 3 training	37	18
Trust in care training	23	0

There has been a relatively low focus on key worker and trust in care training and no evidence of any in-service training on values, de-congregation or the rights-based social model of support.

## Handover mechanisms

The Review Group also sought information on the handover mechanisms used between staff when changing shifts or rosters. These were described as a combination of verbal and written communication.<sup>46</sup>

<sup>45</sup> A number had other qualifications including: National Certificate in Business Studies, BA in Health Services Management, Certificate in Healthcare Management, Certificate in Counselling for Nurses, Diploma in Nurse Management, Diploma in Reflexology, Diplomas and Higher Diplomas in Nursing/Nursing Studies/Mental Health Nursing, Certificate in Palliative Care Nursing, Certificate in Supervisory Management and European Computer Driving Licence.

<sup>46</sup> Details given included: daily nursing notes, verbal/written reports, communication book, bungalow day/night reports and diaries, diary for pager/panic alert, drug press keys and documentation folders.

## 8.3 About Centre 3

### Profile of residents

There were 28 residents living in Centre 3: 12 women and 16 men (including one respite user). Their age profile is shown in Table 8.9.

**Table 8.9** Age profile of residents in Centre 3

Age	Number of residents
40 years or under	1
41–59 years	18
60–79 years	9
80 years or over	0

The length of time residents had lived in the bungalow they currently live in was:

- ▶ Less than 6 months: 1
- ▶ Between 6 months and 5 years: 3
- ▶ Over five years: 24

All but two individuals had contact with their families.

Two residents had contact with an advocate.

Residents' degree of disability is shown in Table 8.10.

**Table 8.10** Degree of disability of residents in Centre 3

Degree of disability	Number of residents
Mild	1
Moderate	20
Severe	7
Profound	0

### Physical characteristics and facilities

The 28 residents were accommodated in three bungalows. The centre had 19 single bedrooms, and 5 bedrooms were shared.

#### Facilities

- ▶ There were six bathrooms/shower rooms available to the residents.
- ▶ Centre 3 had two separate toilets for residents to use, a ratio of 14 individuals to each separate toilet. In one of the bungalows there was a separate staff toilet that residents could also access if required.
- ▶ Laundry facilities were available in all three bungalows – in one bungalow these facilities were used by some residents, in another they were used occasionally, and in the third they were not used.

- ▶ Kitchen/cooking facilities were also available but were used only occasionally by some residents.
- ▶ There was no separate quiet area available in any of the bungalows.
- ▶ Computer access was available for the use of staff but generally not for the use of residents, except in one bungalow where they had some limited access.
- ▶ Residents had access to transport provided by Áras Attracta.

## Profile of staff in Centre 3

### Staff numbers

The staffing information<sup>47</sup> provided to the Review Group indicated that Centre 3 had a staff complement of 39 or 33.5<sup>48</sup> whole-time equivalents (WTEs), including 34 HSE employees (87 per cent) and 5 agency staff (13 per cent) – as of mid-December 2015. The total number of hours for supporting 21 residents<sup>49</sup> is 2,107 hours per fortnight (27.5 WTEs).

The skill mix was calculated as 49 per cent nursing staff, 3 per cent social care and 48 per cent healthcare assistants. This calculation included one healthcare assistant allocated as a specific resource to the activation team. It also included one social care worker, 3.5 supernumerary WTE nursing management positions – 2.5 at CNM2 level and one new position at CNM3 level (the person commenced duty at the beginning of November 2015). This represents a new management and governance structure for the centre and in general these managers are not involved in frontline support provision.

All staff had up-to-date job descriptions. Although the staffing in Centre 3 was relatively stable, there was considerable movement of staff between bungalows and on occasions staff were brought in from other centres – for example, to cover for sick leave and roster swaps. No specific details were provided about the length of time staff had worked in the various bungalows in Centre 3.

Staffing was managed for the centre as a whole rather than by each bungalow, although this is expected to change. Rostering was generally based on a fixed line system and shift patterns mainly consisted of 11-hour paid shifts during the day and 11.14-hour paid shifts at night.

Newly appointed team members for the activation programme were not an integral part of staffing arrangements.

None of the staff working in Centre 3 received formal supervision.

A personal laundry service and clerical support were provided. Cleaning services were on a contract basis.

<sup>47</sup> Owing to data inconsistencies/errors, the staffing information was resubmitted three times by the management team.

<sup>48</sup> These figures do not include any provision for sick leave, training leave, administrative leave and the like.

<sup>49</sup> The revised/updated number of residents includes the movement of individuals from Centre 3 to Centre 2's Social Care Model houses in mid-November 2015; it does not include short-term residents/respite users and day attendees in Centre 3's Day Services

## Staff qualifications

The qualifications<sup>50</sup> of the nurses in Centre 3 at the time of the assessment are shown in Table 8.11.

**Table 8.11** Nurses' qualifications (Centre 3)

Qualification	Number of nurses
Registered Nurse Intellectual Disability (RNID)	14
Registered General Nurse (RGN)	4
Registered Psychiatric Nurse (RPN)	2
RNID and RGN	2
RGN and RPN	1

Approximately 99 per cent of healthcare assistants had completed or were undertaking a QQI/FETAC Level 5 course.

## Training record

Table 8.12 summarises the relevant training provided to staff (HSE and agency)<sup>51</sup> from 1 January 2014 to 9 October 2015.

**Table 8.12** Training programmes undertaken by HSE and agency staff members in Centre 3

Training programme	Number of staff trained	
	HSE (36 total staff)	Agency (11 total staff)
Adult protection training	32	11
CPI training	14	0
Key worker training	11	1
Studio 3 training	1	4
Trust in care training	15	0

There has been a relatively low focus on key worker and trust in care training and no evidence of any in-service training on values, de-congregation or the rights-based social model of support.

## Handover mechanisms

The Review Group also sought information on the handover mechanisms used between staff when changing shifts or rosters. These were described as a combination of verbal and written communication.<sup>52</sup>

<sup>50</sup> A number had other qualifications including: Diploma in Management and Industrial Relations, Diploma in First Line Management Supervision, Diploma in Nursing Studies, Diploma in Childcare, Diploma in Reflexology, Certificate in Clinical Teaching, Certificate in Foundations of Assistive Technology, Higher Diploma Gerontological Nursing and European Computer Driving Licence.

<sup>51</sup> Including one staff member on contract from Western Care.

<sup>52</sup> Details given included: in-depth report from day/night activity, nursing progress notes discussed, day/night summary book maintained and discussed, handover of keys/panic alerts and pagers, incident reports/safeguarding information exchanged, bungalow diary/communication book discussed, update on care plans that have been developed/updated and CNM's handover report for the night supervisor and vice versa.



## 8.4 Summary

Most residents in Áras Attracta have contact with their relatives, but relatively few have contact with an advocate.

The laundry, kitchen/cooking facilities were under-utilised in the bungalows and units; residents had poor privacy owing to the limited availability of separate toilets; most have no access to a separate quiet area; they have very limited or no access to computers; and many residents in Centres 1 and 3 share bedrooms. Residents, however, have access to transport provided by Áras Attracta.

Staffing was managed on a centre basis rather than on a bungalow or unit basis and there was considerable movement of staff; staffing information was not clear; activation team members were not integral to the team; agency staff comprised a significant proportion of the workforce in Centres 1 and 2; the skill mix data highlighted a low representation of social care staff by comparison with nursing staff and healthcare assistants; and rostering was generally based on a fixed line system with long shift patterns.

The majority of nurses are RNID qualified; most healthcare assistants have completed a QQI/FETAC level 5 course; staff (including agency staff) have had significant opportunities in adult protection and Studio 3 training (Centre 2) but insufficient training in key working, trust in care, values, de-congregation and the rights-based social model of support. There was no formal supervision for staff in any of the centres.



# 9

## Person-focused assurance part 2: *thematic review*

In Part 2 of the person-focused assurance, the Review Group moved on to explore the organisational and management supports and practices in each bungalow and unit separately, while keeping the residents' perspectives firmly in the foreground.

Our approach was designed to facilitate consideration of care and service practices, and also to provide insights into the culture within the bungalows and units.

The content of this chapter comes from two sources:

- ▶ Information supplied by Áras Attracta management.
- ▶ Observations made by the Assurance Team on site at Áras Attracta.

### 9.1 How residents are kept healthy and safe

#### Safety and protection

In considering how safe and protected residents at Áras Attracta are, the Assurance Team looked at a number of issues, including:

- ▶ Critical incidents and how they are handled.
- ▶ Complaints procedures and how available they are to residents.
- ▶ Residents' level of access to their own money and personal property.
- ▶ How residents with behaviours that challenge are supported.
- ▶ Management of traumatic events.
- ▶ Checking of panic buttons and pagers.
- ▶ Support to residents and staff after a bereavement.
- ▶ Policy, practice and training in relation to safeguarding.
- ▶ Restrictive practices and records.

#### Critical incidents

All accidents and critical incidents are recorded by staff in the unit or bungalow where they occurred in a *Critical Incident and Near Miss Book*. Each incident/accident is given a unique reference number, and is analysed to see how similar incidents could be prevented in the future.

In September 2015, a daily campus-wide incident review group was introduced, and includes the CNM2s and CNM3s from each centre, the Clinical Nurse Specialist, the Person-Centred Planning Coordinator and Studio 3 staff. Any accidents and incidents that occur are reviewed and appropriate action is taken, including (where necessary) notification to HIQA.

## Complaints procedures

Readily accessible complaints procedures are a key component to ensuring the health, safety and protection of residents. The complaints policy and procedures were readily available to staff in Centres 2 and 3, but not in Centre 1.

An 'easy read' version was available to residents in all of the bungalows and units. However, we received no assurance that residents themselves have any access to the complaints procedures or that they have received any training in how to use it.<sup>53</sup>

There was no evidence of the use of suggestion boxes anywhere on the campus for the use of residents or others.

## Personal property and monies

Residents have a right to have their personal property and possessions respected, and as part of the assurance process we looked at arrangements for safe-keeping of their personal property (particularly clothing) and money during the assurance process.

Details of each resident's items of clothing are generally kept in a 'clothing folder'. As residents acquire new items, details of these are added to the folder, and the items are labelled centrally. The property of people who come to Áras Attracta for respite is also logged and their clothes are labelled. Some residents have their own laundry baskets. However, should any item of personal property go missing, there is no practice guideline available and some staff were unsure what to do in such a situation.

The policy in relation to safekeeping residents' money takes a 'one-size-fits-all' approach that does not take account of the capacity of different residents to exercise judgement about money. Each resident has a purse (maximum of €60–€100) that is held securely in each centre, and the nurse manager keeps a money log book for each resident. (In one bungalow, residents are encouraged to become involved in checking their own money log books.)

Residents can also withdraw larger amounts from their accounts. This is paid by way of a cheque payable to the resident that can be encashed at a local bank by a nominated staff member or by a cheque payable to a supplier – for example, a shop where the residents wants to buy something. Receipts are required for all expenditure, and spot checks are carried out by management.

## Behaviours that challenge

Staff say that they know what to do when a resident engages in a behaviour that challenges, and as they get to know the residents better, they come to understand what triggers their behaviour.

Where the staff group changes frequently, however, this is more difficult. Staff have access to a Clinical Nurse Specialist who can be consulted on approaches and techniques to follow in relation to behaviours that challenge. In addition, some staff have been trained in the Studio 3 approach, which is currently being rolled out across the campus.

<sup>53</sup> The importance of adequate complaints processes is highlighted in *The Distant Voice* (Inclusion Ireland, 2015).

## Management of traumatic events

The Assurance Team explored whether staff knew what actions to take in the event of a traumatic event such as cardiac failure, suicide or other such event. We received assurance that all staff know what actions to take.

However, we note that there are no formal guidelines in relation to such events.

## Panic buttons and pagers

On the days of the assurance visits, we checked all the alarm systems and pagers and almost all were found to be in good working order. One bungalow had a pager that had been broken for a week.

The general practice is to check alarm systems and pagers twice a week.

## Support to residents and staff following a bereavement

A sensitive, person-centred, informal approach is taken to death and dying in Áras Attracta, and staff offer support and comfort to residents, relatives and staff as appropriate. A prayer room is available in which deceased residents can be laid out, and in one recent instance, the body of the person was laid out in his own bungalow enabling the other residents to pray for him with his relatives.

In another instance, where a resident had passed away in hospital, the body was returned to Áras Attracta, prayers and a service were held, and residents followed the coffin to the entrance gate to say their final goodbyes as the hearse drove away. Residents and staff are generally involved in funeral rituals, including attendance at removals and funerals. If possible, the family decide on the person's last resting place, which sometimes involves a return to the parish from where they came.

## Safeguarding – policy, practice and training

The national safeguarding policy<sup>54</sup>, launched by the HSE in December 2014, was available in all bungalows and units for staff to access, and in some cases an 'easy read' version of it was available for residents. The picture of the Designated Liaison Officer was widely displayed across the campus. Staff in Áras Attracta have received considerable training in this area (see chapter 8).

However, the Assurance Team notes that residents have not received comprehensive training in relation to safeguarding.<sup>55</sup>

## Restrictive practices and records

Áras Attracta has a restrictive practices<sup>56</sup> policy that is available for staff to consult at bungalow and unit level. Currently, however, the policy is past its revision date. Staff told the Assurance Team that restrictive practices are not generally used at Áras Attracta, with the exception of one bungalow where the kitchen is locked at certain times because one resident is at risk of choking.

<sup>54</sup> HSE Social Care Division, 2014. *Safeguarding vulnerable persons at risk of abuse – national policy and procedures*

<sup>55</sup> Some relevant issues have been discussed by some at 'a Voices and Choices' meeting

<sup>56</sup> Restrictive practices may include, but are not limited to, the use of mechanical restraint, physical restraint, psychotropic medication as restraint and seclusion (MHC, 2009)

The Assurance Team notes that a code is required to access the units in Centre 1. We also note that restrictive practice records are kept at bungalow/unit level and are monitored by the CNM2. In particular, we note that where PRN<sup>57</sup> medication is prescribed by the Mental Health Intellectual Disability Team (MHID) or GP that this is included in the bungalow and medical records.

### Safety and protection: summary of findings

Lack of comprehensive training for residents in the use of the complaints procedure, and no use of suggestion boxes for residents or others.

Lack of practice guidance for staff when items of personal property go missing.

Little exception to the 'one-size-fits-all' approach which is adopted to looking after residents' money, regardless of their capacity.

Although staff know what action to take should a traumatic event occur, there is no policy in place in relation to this.

Sensitivity was shown in the handling of death and dying; however, this is not codified in policy.

Residents have not received comprehensive training in relation to adult protection and safeguarding.

## Health and well-being

In considering how the health and well-being of residents is assured at Áras Attracta, the Assurance Team looked at the following areas:

- ▶ Access of residents to health screening and health services.
- ▶ Access of residents to hospital appointments and mental health services.
- ▶ Residents' spiritual well-being.
- ▶ Residents' opportunities to exercise choice.

## Health screening and health services

Assurance was given in relation to the health screening and services that are available – all residents have a medical card and have:

- ▶ Access to clinics and regular health screening (where consent is given).
- ▶ Influenza immunisation.
- ▶ Annual general and mental health reviews.
- ▶ Annual blood tests carried out by a member of staff who is also a phlebotomist – such familiarity helps to reduce the anxieties of residents.
- ▶ Access to allied health services such as physiotherapy, chiropody/podiatry, dental and optical services – these are arranged as needed by the resident's key worker or GP.

<sup>57</sup> *Pro re nata* – when necessary or as the situation demands.

GP clinics are held twice a week – at lunchtime on Mondays and Wednesdays. A first-come-first-served queuing system is used – so, if time runs out, there is the risk that the last people to join the queue will not be seen by the GP on that day. They may then have to wait until the next scheduled clinic, unless their condition is sufficiently urgent to require a GP home-visit. There is a protocol to guide staff on calling a GP for home-visits to residents outside clinic times.

## **Hospital appointments and mental health services**

Áras Attracta management gave assurance that residents are supported to avail of hospital and health-related appointments, as required; and non-attendance only occurs if the resident is feeling unwell or chooses not to attend. Transport is arranged and such appointments are prioritised over other activities.

Staff indicated that mental health services are readily accessible and appointments are available within a reasonable timescale. A member of the MHID team will visit a bungalow or unit if necessary, and staff report that a consultative approach is taken by this team. Changes in behaviour, appetite, sleep patterns and mood are fully discussed by the MHID team member with the bungalow/unit staff member who knows the person well.

## **Spiritual well-being**

All current residents in Áras Attracta are Roman Catholic, and Mass is said weekly in the gym hall on Wednesdays. On Sundays, some residents go to Mass in a local church if transport can be arranged, while others watch Mass on television. Although it was possible to access pastoral support at bungalow/unit level in the past, staff indicated that there are now few visits from clergy outside the weekly Mass.

Staff in one bungalow noted that saying prayers is a source of great comfort to residents, and prayer is honoured and incorporated into the daily life of the bungalow.

## **Opportunities to exercise choice and make decisions that impact on daily life**

The extent to which residents have autonomy or personal choice relating to their daily lives varies from one bungalow or unit to the next. In one centre, for example, residents had choice about where to sit, but have little choice about personalising their living space, or selecting their bed covers, or other aspects of their life. This was particularly noticeable where some rooms were shared by four people, with panels used as dividers between the beds.

A greater degree of choice existed in other centres and bungalows where some residents visit relatives, go shopping to the local supermarket and go to the pub. Staff also maintained that residents could choose their clothing, their food and meal-times, whether to shower or bath, and so on. However it was accepted that choice can also be limited by circumstances – for example, bus trips might not be available where staff are unable to or not permitted to drive, or where trips have to be curtailed because of staffing patterns.

### Health and well-being: summary of findings

GP services are delivered twice a week on a first-come-first-served basis; so, depending on demand, some residents might have to wait till the next week.

Not many residents go to Mass on Sundays in local churches – instead they watch it on television in the bungalows or units. This represents a lost opportunity for community integration.

There is considerable variations between bungalows and units in the extent to which residents can exercise choice in their daily lives.

Choice of outings such as bus trips can be limited because some staff are unable or not permitted to drive. Such trips can also be curtailed by staffing patterns.

## 9.2 How residents spend their day and learn new skills

### Lifelong learning

In reviewing what lifelong learning opportunities are available to residents, the Assurance Team looked at the following areas:

- ▶ Each individual resident’s programme of activities and the extent to which they are followed.
- ▶ Encouragement of residents to participate in learning activities and interests.
- ▶ Are residents helped to maximise their life skills and social skills?

### Does each resident have an individual programme of meaningful activities?

To a varying degree, there are programmes of activities for residents in bungalows and units across the whole campus. In some instances programmes have been recently enhanced by the involvement of an occupational therapist and an Activation Team who have developed an ‘Occupational and Social Well-being Assessment and Planning Folder’ for some residents. The resident’s level of participation, interaction, orientation and enjoyment of an activity is assessed on a scale of 0–3 and recorded in this folder. The use of these folders provides useful assurance that residents’ programmes are being followed.

Across the campus, it appears that there are a number of variables determining whether a resident participates in a programme of meaningful activities – these include staff availability, staff patterns, the exercise of choice by the resident who may opt in or out of an activity, and whether a resident has a personal support (some do).

The Assurance Team acknowledges that improvements have been made recently in relation to the availability of meaningful activities for residents, but believe that there is scope for greater enhancement and personalisation in this regard. Closer attention could be paid to residents’ individual interests and preferences, and the degree to which the activities are meaningful for each individual.



## Are residents encouraged to participate in accredited learning programmes and hobbies and interests?

Opportunities to participate in accredited learning programmes and hobbies and interests ranged from none at all in some bungalows and units, to quite a few in others. The variation across the campus was substantial.

In relation to accredited learning, a very small number of residents have already attended some Education Training Board (ETB) courses and one resident has achieved a FETAC award and has the personal goal of going to college. Nine other residents have very recently embarked on a tailored course run by the local ETB, organised in conjunction with a volunteer who, during the course of its development, consulted with staff on what topics and interests might be included.

In relation to hobbies and interests, again this ranged from little or no encouragement in some bungalows and units (where staff stated that ‘there was little interest from residents’), to some encouragement in others. Residents in some of the bungalows have been involved in such activities as Tidy Towns, gardening and maintenance, and producing goods to sell at a farmers’ market. Also, some residents have been encouraged to join the local library.

While these developments are welcome, it is felt that opportunities both in relation to accredited learning and hobbies and interests could be greatly enhanced across all bungalows and units throughout the campus.

## Maximisation of life skills and social skills

The degree to which residents are encouraged or enabled to maximise their life skills and their social skills again varies from ‘none’ to ‘some’ across the campus. In almost all of the bungalows and units, laundry and meals are provided on-site or in the canteen, and cleaning staff undertake most of the cleaning duties.

In one or two instances, staff maintained that they encourage and assist residents to develop their potential in relation to personal care, shopping, gardening, laundry (to a degree), and going to the cinema, but these were the exceptions. There was an acknowledgement among some staff that a lot more could be done to facilitate the development of residents’ life skills and social skills, and they were open to considering ways of doing this.

### Lifelong learning: summary of findings

There is considerable variation in the availability of meaningful activities for residents. There have been recent improvements, but there is still scope for greater enhancement and personalisation.

Opportunities to participate in accredited learning programmes and hobbies and interests ranged from none at all in some bungalows and units, to quite a few in others.

In relation to hobbies and interests, there was little or no encouragement in some bungalows and units, and some encouragement in others.

## Enabling and sustaining independence

In considering the extent to which residents are enabled to be as independent as possible, the Assurance Team looked at the following areas:

- ▶ How involved are residents as a group in determining their day-to-day lives?
- ▶ How available to residents is information regarding their rights and entitlements?
- ▶ What arrangements are in place in relation to residents' informed consent?
- ▶ What supports are available to families to maintain contact with residents?

## Involvement of residents as a group in day-to-day decisions about their lives

The involvement of residents in group discussions on matters of interest or concern to them again ranged from 'none' to 'some' across the campus. In one instance, a group discussion had taken place, was minuted with identified actions and solutions which were agreed in relation to a particular problem, but a long period had elapsed since this meeting and not all of the issues had been resolved. There has been no skill-based training for either residents or staff to encourage this kind of participation.

An example of good practice was described in another bungalow where a staff member had facilitated a group discussion among residents about possible outings, and how they would like to celebrate their birthdays. The result was both pleasing and unexpected, with the suggestion of a visit to a bog which one resident used to visit with his family as a child, an overnight stay at the coast, and baking cakes for the birthday celebrations. All of the suggestions had been implemented subsequently but this member of staff had not been affirmed for her good practice, nor did she have the opportunity to share the learning and her skills with her colleagues.

## Availability of information regarding rights and entitlements

Information regarding rights was available to residents in an accessible form, and this information was also displayed on an 'Our Rights' poster, that was displayed in communal areas around the campus.

No information regarding entitlements to benefits and services was observed in most bungalows and units. In one bungalow, however, information regarding rights and entitlements was available for residents, but this information had originated in Scotland and had little relevance to the residents of Áras Attracta.

## Arrangements for enabling informed consent<sup>58</sup>

During the visits to the bungalows and units, the Assurance Team were advised that informal arrangements are in place to enable residents to give their informed consent to particular interventions relating to their health or well-being, and that if they withhold consent, that this too is honoured. Staff will involve relatives and advocates as required wherever it is felt that consent is an issue.

<sup>58</sup> For more information on consent, see the HSE's National Consent Policy webpage: <[http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National\\_Consent\\_Policy/](http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/)>

The Assurance Team notes that there are no procedures or practice guidelines in place in relation to enabling residents to give informed consent, except in relation to photographs and finances.

## Supports to families and friends to maintain ongoing contact with residents

Meaningful contact between residents and their families and friends is recognised as a very important element in residents’ well-being, and this is an area that the Assurance Team explored with staff in the bungalows and units. Staff maintained that, in general, positive contact is established with families, and most residents have family contact, although minimal in some instances. Staff maintained that they actively support such contact, and encourage families to attend reviews, to visit residents in the centres, and to attend Mass if they so wish. Families and friends can use the canteen in Áras Attracta, and refreshments are usually offered to visitors arriving in the bungalows and units.

One centre has a sitting room that can be used for residents to share private time with their friends and family. There is very limited or no private space available in other centres, and the only option for privacy is the resident’s bedroom, and not all residents have their own bedrooms. Staff maintain that they do try to facilitate privacy, but this can be very difficult.

One resident has Facebook contact with family, and in some instances residents have their own phones. In one bungalow where no internet connection was available, a staff member facilitated Skype contact for a resident whose family lives abroad, using their own phone.

### Enabling and sustaining independence: summary of findings

The involvement of residents in group discussions on matters of interest or concern to them ranged from ‘none’ to ‘some’ across the campus. There has been no skill-based training for either residents or staff to encourage this kind of participation.

No information regarding entitlements to benefits and services was observed in most bungalows and units.

There are no practice guidelines in place in relation to enabling residents to give informed consent.

Residents have not received awareness training on the roles of the key worker or link worker – what they should expect of them or what role they play.

Although staff encourage family contact, with few exceptions there is little or no private space for visits other than residents’ own bedrooms. Internet access is not available in all bungalows/units for residents to communicate with relatives – for example, via Skype, Facebook, or other means.

## 9.3 What residents need from the people who support them

### Staff needs

In looking at the contribution that well-trained staff members make to ensuring that residents get the support they need, the Assurance Team looked at the training and learning opportunities that are made available to staff at Áras Attracta, including:

- ▶ What induction arrangements are in place for new staff?
- ▶ How accessible policies and procedures are for staff?
- ▶ What structured training opportunities are available for staff?
- ▶ Do staff have access to up-to-date literature in the field?

### Induction arrangements

For new staff arriving in Áras Attracta, organisational induction is carried out approximately twice a year and this is made available to new HSE staff.<sup>59</sup> However, there can be a long gap between a person starting and receiving induction – in one case the gap was nine months.

The topics covered in the organisational induction programme include an overview of the HSE, local management structures and services, infection prevention and control, employment policies and procedures, dignity at work, and the like. However, the Assurance Team could see no evidence in the programme documentation of any general information about intellectual disability services, values, ethos or person-centredness, dignity and respect, or staff support and supervision.

Apart from organisational induction, new staff members (HSE and agency) also receive local induction from the CNM2 in the first day or two of arrival.

Local induction includes areas such as access and introduction to service guidelines, policies and procedures, health and safety, and so on. It does not include key principles of service delivery such as values, person-centredness, dignity, respect and choice, although the Assurance Team were advised that these would be included in future.

There is a sign-off process by which new staff members indicate that they have read and understood policies, but this is in place only for some policies and not for others, and is not codified.

Staff believed that protected time is needed for familiarisation with policies and procedures, as it is difficult to find time during a busy day-shift to do this.

<sup>59</sup> It is noted that a recruitment embargo has been in place in the HSE for some time, so this induction programmed is newly re-instigated.

## Accessibility of policies and procedures

In relation to accessibility of policies and procedures, the Assurance Team were advised that these are available in each bungalow and unit both in hard copy and electronic form. However, when we reviewed the hard copy folder of policies, we found some issues that needed attention: in particular, the indexing system was confusing (with two sets of policies numbered 1–10), and a number of policies were past their revision date (particularly those relating to the roll-out of the Studio 3 training). In relation to the accessibility of the electronic versions, we noted that not all bungalows had computers, and in those that had, not all computers were working.

## Structured training

Áras Attracta has invested heavily in training over the last number of years, and structured training opportunities are offered both to healthcare assistants and to nurses (see chapter 8 for details of training taken up in Centres 1, 2 and 3). The Assurance Team also notes that:

- ▶ Training is mandatory in the following:
  - Safeguarding
  - Studio 3
  - Moving and handling
  - Fire prevention
  - Communicating with an individual with an intellectual disability
  - Person-centred planning
  - Key worker training
  - Trust in care
  - Social care model of care training
  - Children First training.
- ▶ Studio 3 training in handling behaviours that challenge is currently being made available across the campus.
- ▶ Speech and language therapists are introducing two courses for staff across the centres – these courses will be mandatory.<sup>60</sup>

It was not clear to the Assurance Team what training is made available to other support staff members such as the cleaning, catering or laundry staff.

## Access to relevant literature

One of the features of staff development is access to literature regarding practices in other organisations and information about new developments in the wider disability sector. The Assurance Team found little or no evidence that such material was available for staff to access in the bungalows and units. It was suggested that such material had been more readily available in the past when Áras Attracta hosted student placements, but this appears to be no longer the case.

<sup>60</sup>These courses are: *Supporting the communication needs of adults with intellectual disabilities* and *Supporting people with eating, drinking and swallowing difficulties*.

### Staff needs: summary of findings

The HSE organisational induction does not deal with intellectual disability services, values, ethos or person-centredness, dignity and respect, or staff support and supervision. In its timing it does not always match the arrival of new staff.

The local induction programme did not include key principles of service delivery such as values, person-centredness, dignity, respect and choice.

A number of policies are past their revision date; others are difficult to access (for various reasons).

Staff are not afforded dedicated time to familiarise themselves with policies, and there is no codified sign-off for staff to indicate that they have familiarised themselves with or understood policies.

There has been substantial investment in training for nurses and healthcare assistants in Áras Attracta, particularly in areas such as safeguarding and Studio 3 approaches.

There was little or no literature pertaining to developments in the wider intellectual disability sector available in the bungalows and units for the use or benefit of staff.

### Leadership and direction

In looking at the contribution that strong management and leadership can make to ensuring that residents get the support they need, the Assurance Team explored the following areas:

- ▶ Management statements of purpose and function.
- ▶ Staff meetings: opportunities for staff to raise issues of concern.
- ▶ Support and supervision for staff.

### Statements of purpose and function

Each of the three centres has its own clearly written individualised Statement of Purpose and Function which covers:

- ▶ Its philosophy of care and support.
- ▶ Its overarching aims, mission and ethos.
- ▶ Details of staff.
- ▶ Statement of lines of accountability for professional and operational issues, for reporting processes, and so on – in some instances, this information was displayed on a noticeboard for staff to consult.

It is understood that these statements were compiled by senior nursing staff and nurse educators, but did not include the perspectives of residents or team members. None of the statements is dated, but that for Centre 3 has a review date of February 2016.

Although each bungalow and unit has its own unique character, none had developed their own statement of purpose and objectives.

## Staff meetings

Centre-based meetings are held for staff at weekends on a monthly basis in Centres 2 and 3, but less often in Centre 1. These have a set agenda and cover essential issues such as safeguarding, fire safety and so on; but staff also have the opportunity (where time permits) to raise items of interest or concern.

These staff meetings are convened by the CNM2 on duty, who in turn ensures that staff who could not attend are provided with the minutes.

At the time of the Assurance review, however, opportunities did not arise in staff meetings for staff to discuss bungalow issues, to share good practice, or to expand their learning.

## Staff support and supervision

At the time of the Assurance review, there were no arrangements in place for staff support, supervision, or documented performance review or appraisal. We understand that there are plans to address this matter.

We noted, however, that new HSE staff members are interviewed twice during their probation period. In the absence of any performance feedback system for staff, there is therefore no formal mechanism in place to communicate formally to them that they are valued or respected, or that they have 'done a good job', although this may sometimes happen informally.

### Leadership and direction: summary of findings

Each centre has a published Statement of Purpose and Objectives, but individual bungalows and units do not, even though they have their own unique character.

Two of the centres hold monthly meetings where staff can raise matters of interest and concern. No such meetings are held at bungalow or unit level.

There are as yet no arrangements in place for staff support, supervision, or documented performance review – this is being addressed.

There is no mechanism in place to communicate and demonstrate to staff that they are valued or respected, or that they have 'done a good job'.

## Records and communication

In looking at the contribution that good records and communication can make to ensuring that residents get the support they need, the Assurance Team looked at the following areas:

- ▶ Residents' care plans.
- ▶ Communications between staff members.
- ▶ Confidentiality of communications between staff members.
- ▶ Availability of staff rosters.
- ▶ Visits by multi-disciplinary team members and others.

## Residents' care plans

Each resident has both an individual care plan (My Plan) and a person-centred plan, and some residents also have a behavioural support plan. The My Plan document contains a considerable amount of detailed information, and in some instances has 'been consigned to the drawer' and is not actively referenced by staff. The person-centred plan is intended to describe a resident's goals and aspirations, but some staff queried whether or not the stated goals were truly the resident's own.

For some residents with communications difficulties, the Speech and Language Therapy Department has recently introduced a 'communications passport' that explains a person's style of communication. It is hoped that this will eventually be in place for all those who need one.

Staff complete a substantial number of forms of various kinds in relation to residents, including daily flow charts (a detailed written account of four time periods), activities folders, nursing notes and medical files. These all amount to a considerable volume of paper work. Some staff highlighted that the challenge is to move to a social care model with less documentation.

## Communications between staff

Assurances were given that at shift change-over all relevant information is passed on by each member of the outgoing staff to the designated accountable staff member of the incoming team. The accountable staff member records the information in writing.

## Confidentiality

Staff maintain that they always try to ensure that confidential information is exchanged between team members in private, although this is difficult in bungalows where there is no designated space available for this and interruptions can occur. Some staff use initials rather than names to try to preserve confidentiality when exchanging information of a personal nature. In other instances, staff have access to an office, and sensitive information is exchanged once residents are in bed.

## Staff rosters

A list of the staff who are on duty for each shift is kept in a central location at centre level. At the time of the Assurance review, there was a considerable degree of movement of staff between bungalows (owing to sick leave, swaps, and other absences) and it was observed that the lists of staff on the information boards were inaccurate in many cases.

## Keeping a record of visitors

Staff indicated to the Assurance Team that all visitors to bungalows and units (including members of multi-disciplinary teams) are expected to communicate with an appropriate member of the team on duty and to sign the Visitor's Book on arrival and on departure.



This, however, does not happen in every case, and could lead to important safeguarding issues, for both residents and visitors. In the event that an allegation of abuse is made, it is important to be able to establish whether or not an alleged perpetrator was present at the time and date indicated by the person making the allegation – this might not be possible if the record of arrivals and departures is incomplete.

## Key workers

All residents in Áras Attracta have been assigned a key worker<sup>61</sup> and most (not including respite residents) also have a link worker.<sup>62</sup> Most key workers have two residents assigned to them. Lists of key workers and link workers were available to the Assurance Team in the bungalows and units.

Key workers and link workers are centre-based, rather than in a particular bungalow or unit. With the frequent movement of staff within the centres, however, key workers may not have the opportunity to work frequently with their assigned residents.

The Assurance Team became aware of one situation where the key worker had not worked with their assigned resident for four months. In another instance, a key worker was specifically rostered to the bungalow where the assigned resident lived, so that she could become familiar with the resident's circumstances in advance of an upcoming review. It was pointed out by one staff member that frequent movement of staff militates against the development of quality relationships between residents and their key workers, and also affects the quality of the review assessments. The Assurance Team understands that this issue is to be addressed by the newly-appointed centre managers.

## Availability of contact details of the multi-disciplinary team and senior management

Staff confirmed to the Assurance Team that the names and contact details of members of the senior management team and those on the medical staff rota are available in the bungalows and units.

By contrast, contact details for the currently on-duty Senior Nurse Manager was not available at bungalow or unit level – especially out of hours or at weekends. However, staff generally know who is on duty at any time because of established work patterns in Nursing Administration.

There was no written procedure for contacting on-call senior nursing management posted on the noticeboards or near the telephones.

<sup>61</sup> The key worker is the member of the staff in the residential centre who carries particular responsibility for the person with a disability, liaises directly with him/ her, coordinates health and social services, and acts as a resource person (HIQA 2013, p110).

<sup>62</sup> A link worker is the person who act as the key worker in the absence of the key worker. Typically the link worker will be a key worker to another service user. The link worker must be a nurse where the key worker is not a nurse. This will enable important correspondence to be transcribed in the resident's My Plan' folder – typically, this is done by a qualified nurse in Áras Attracta.

## Records and communications: summary of findings

Staff spend a considerable amount of time on paperwork, which reduces the time they can spend supporting residents.

There was a lot of movement of staff between bungalows, for various reasons; and the lists of staff on information/notice boards were not accurate.

Each bungalow and unit has a Visitors' Book, but it is not always signed by those arriving and leaving – this could lead to important safeguarding issues, for both residents and visitors.

All residents have a key worker, and most have a link worker. However, the frequent movement of staff between bungalows militates against the development of quality relationships, and also affects the quality of review assessments.

## Working in partnership

The Assurance Team established that, in general, the written aims and objectives of Áras Attracta are not circulated or made known to other services such as HSE Community Care, voluntary sector organisations, or education providers – although individuals from these services may have some knowledge arising from their involvement with particular residents.

In looking at the contribution that working in partnership with other bodies can make to ensuring that residents get the support they need, the Assurance Team also considered the following areas:

- ▶ The level of involvement of residents with community groups.
- ▶ The extent to which residents use advocacy services.
- ▶ Contacts between Áras Attracta and other professionals and other intellectual disability services.

## Involvement with community groups

There were variations in the level of contact residents have with community groups, ranging from almost none to limited interaction.

Residents in one of the centres appeared to have some community opportunities: one resident is involved in the local Tidy Towns initiative, some residents attend Mass locally, and others occasionally attend a music session in a local pub. However, the degree of community integration is minimal.

## Advocacy services

The National Advocacy Service provides a service to some residents in Áras Attracta, and is involved with a small number of residents who are wards of court. The service is currently restricted by its level of resources, and it was highlighted by some staff that an expansion of the service would be beneficial to residents.

A small number of residents attend the meetings of an Advocacy Group in Roscommon.

## Work with other professionals and with intellectual disability services

There are some limited and informal contacts between staff of Áras Attracta and other disability services such as Western Care and the Brothers of Charity. These contacts generally centre on individuals. However, some organisational assistance was provided by psychologists from Western Care to residents and staff around the time of the airing of the RTE programme. However, there is no formal structure to facilitate organisational links between Áras Attracta and the wider intellectual disability sector.

### Working in partnership: summary of findings

The written aims and objectives of Áras Attracta are not circulated to other key services locally or regionally.

The degree of community integration of residents is minimal.

An expansion of the involvement of the National Advocacy Service would be beneficial to residents.

There is no formal structure to facilitate organisational links between Áras Attracta with the wider intellectual disability sector.





# E

## IN CONCLUSION

**Chapter 10: Where we go from here** describes how our engagement with residents, their relatives and staff members and our management review persuaded us that there is a compelling case for change.

We set out our recommendations for action under three strands: for Áras Attracta, for the HSE and for the management of all congregated settings.



# 10

## Where we go from here

### 10.1 A compelling case for change

In the course of its work, it has become increasingly clear to the Review Group that there is a compelling case for change in the way service is delivered at Áras Attracta. Change is also required at a national (HSE) level and across the disability sector, particularly in light of national policy on the move to non-congregated settings.

At an early stage it was identified that every person living in Áras Attracta should have their needs assessed and their support requirements identified. This work, commissioned by the HSE and undertaken by the American Association on Intellectual and Developmental Disabilities (AAIDD) in late autumn 2015, has now been completed. The residents who are ready to move now to a non-institutional setting in the community must be supported to do so without delay. At the same time the Review Group is cognisant that the quality of life must be enhanced for those who remain in Áras Attracta until they too can move.

#### The learning

The Review Group wanted, above all, to focus on the perspective of people living in Áras Attracta, and to come to an understanding of what daily life is like for them. It was found that they were mostly positive about living in Áras Attracta, they felt supported by staff and most of them had some contact with their families but would like more activities, and to get out more often. The things that mattered most were to feel safe, be respected, have privacy and meet their friends.

However, these relatively positive accounts must be placed in the context that Áras Attracta is the world that they know. As such their expectations, hopes and aspirations are very much limited by the horizons of that world – a congregated setting.

The *day in the life* narratives present a picture of life in Áras Attracta that is characterised by inactivity, lack of stimulation, and dependency on the support of staff for many of the things that most people take for granted. Residents have little opportunity to realise their potential to live the rich and satisfying lives that they have a right to aspire to.

The quality of life survey results are also of real concern. The average number of personal outcomes scored as *fully present* for the sample of people in Áras Attracta was very low and compared poorly with the National Survey findings, which was conducted in 2007.

The engagement with relatives highlights that many have confidence in the services in Áras Attracta. Notwithstanding this, other relatives share common concerns with regard to the level and quality of day-to-day activities, the overall management of the service, a culture that does not encourage people to speak out, poor communications, and lack of involvement in personal planning for their family members. Relatives made a number of eminently sensible recommendations to address their concerns.

The events in Bungalow 3 and the attendant publicity have had a profound effect on staff. They were shocked, horrified and embarrassed about what happened, and many also felt hurt, angry and ashamed. Overall, staff were highly critical of many aspects of the service, some of which were historical and others related to more recent developments. Their criticism focused on the lack of leadership, poor management oversight and visibility, poor training opportunities in the past, and overcrowding in the bungalows with an unsuitable mix of residents. Staff felt these issues contributed to the events in Bungalow 3. Despite morale being low, a sense of hope and optimism about the future was also expressed and a number of practical and policy issues were suggested to ensure that residents are safe and protected, and realise their full potential.

The management review involved the completion of questionnaires by both senior management for the organisation and management at bungalow and unit level in the three centres. The purpose of this was to establish how many of the recommendations of the various inspections and reviews had been implemented to date. The management review also incorporated a person-focused assurance review to capture information on the organisation, management and day-to-day supports and practices at Áras Attracta.

The management review was undertaken against a backdrop of a senior management team in a state of flux over the past year, with many changes in personnel and new senior appointments. With regard to the senior management questionnaire, the overall findings indicated that the majority of the partially implemented recommendations have a completion date in 2016, and six have a longer time-scale. Most progress has been made in the areas of *meeting health and well-being needs* and *ensuring residents are safe and protected*; however most attention is required in the areas of *enabling and sustaining independence, meeting staff needs* and *leadership and direction*. At centre level, the overall findings indicated that most attention is required in the areas of *enabling and sustaining independence, meeting health and well-being needs, and ensuring the safety and protection of residents*.

The person-focused assurance findings highlighted that there was no training for residents on keeping safe and in the use of the complaints procedure. There is a 'one-size-fits-all' approach towards looking after their personal money, regardless of individual capacity. There are lost opportunities for community integration. There are considerable variations in residents' freedom to exercise choice in their daily lives; lack of privacy and personal space; and the current GP services are on a first-come-first-served basis. With regard to how residents spend their day and learn new skills there is considerable variation in the level of activities people are involved in and how meaningful these are for each person.



Residents in Áras Attracta need staff to implement personal plans through the key worker system and for staff to be well trained, knowledgeable and formally supervised. They also need a regular team of familiar staff; up-to-date policies; access to an advocate when needed; and for staff to facilitate contact with family and friends.

## 10.2 Recommendations

The Review Group was asked to identify gaps and make recommendations for further improvements in Áras Attracta and to ensure that any learning from its work is reflected and promoted throughout the wider intellectual disability sector. For these reasons there are a number of strands to our recommendations:

- ▶ Three overarching recommendations relating directly to service delivery at Áras Attracta.
- ▶ Thirteen actions for the HSE to improve the quality of lives of people with intellectual disabilities, and to ensure national policy is fully implemented.
- ▶ An action plan for the managers of all congregated settings, as they move people to the community, in compliance with *Time to Move on from Congregated Settings* (HSE, 2011).

In arriving at its recommendations, the Review Group felt it important to propose actions that are feasible and meaningful, and that can have direct and beneficial impact on the lives of people.

### Recommendations for Áras Attracta

The three overarching recommendations for Áras Attracta are:

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#### 1. **A move to a rights-based social model of service delivery.**

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The current model of service delivery at Áras Attracta is one that promotes dependence over independence; it does not equip people to make decisions about their own lives, nor does it take account of individuals' talents or potential. It fails to respect the dignity and rights of individuals. These are all characteristics of an institutionalised congregated setting. By contrast, a rights-based social model of service delivery would:

- ▶ Positively affirm the rights of those with a disability.
- ▶ Look at disability as a functional limitation or loss of opportunities to take part in the normal life of a community in the same way as everyone else.

The practical implications of following such a model in Áras Attracta would require:

- ▶ A much greater emphasis on person-centred practices at all levels of service.
  - ▶ Actively involving each resident in developing services around his or her particular needs, circumstances and personal preferences.
  - ▶ Changes in working practices and management structures.
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## **2. The voices of residents need to be facilitated, listened to, and promoted.**

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Some people with an intellectual disability have considerable communications difficulties and cannot speak for themselves; others have become accustomed or resigned to a pattern of life and cannot envisage an alternative; others still have become institutionalised and are not equipped to make even simple decisions about their lives. In certain circumstances there is a requirement to infer their needs from observation, from conversation with their family members, and from the opinion of key workers and other staff in relation to their will and preference. Initiatives that might make it easier to listen to residents and to act upon their will and preferences include:

- ▶ Promotion and extension of the residents forums that have emerged in some bungalows.
- ▶ Greater attention to the expressed and inferred preferences of individual residents.
- ▶ Extension of the role of the key worker to include a remit to actively give effect to residents' preferences.
- ▶ Appointment of a community liaison officer to identify organisations, groups, sports clubs or individuals in the community with whom particular residents might share mutual interests, skills or activities.
- ▶ Ensuring that residents know their rights, have access to advocacy services and know how to make a complaint if necessary.

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## **3. Strengthening and enhancing the leadership and management.**

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The patterns of support for residents in Áras Attracta and professional thinking and practices of management and staff have not kept up with national and international developments. The service has become isolated and marginalised resulting in a situation where there is no clear vision for the service and residents' futures; inadequate engagement with the community; and significant isolation from other services. In order to address these shortcomings, the leadership and management need to:

- ▶ Adopt current national policies and good practice.
  - ▶ Articulate a clear vision and develop a strategic plan for Áras Attracta and communicate it widely to residents, relatives, staff and relevant others.
  - ▶ Ensure that all staff have a clear understanding of their role and of the efforts required to achieve this vision.
  - ▶ Ensure that residents are represented on the governance structure for the oversight of the campus.
  - ▶ Implement a leadership development programme.
  - ▶ Facilitate organisational links with partners in the sector.
  - ▶ Develop a communications strategy for all key stakeholders.
  - ▶ Ensure that statements of purpose reflect the characteristics of each centre.
  - ▶ Improve staff morale by promoting the culture of a 'learning organisation'.
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The Review Group believes that the three overarching recommendations outlined above should guide management at Áras Attracta in addressing the following deficits, which were identified in the course of our work.

Deficits in Áras Attracta	
Residents	<ul style="list-style-type: none"> <li>▶ Absence of full life and meaningful relationships</li> <li>▶ A culture of dependency and lack of empowerment</li> <li>▶ Inadequate protection</li> <li>▶ Insufficient opportunities to take risks</li> <li>▶ Insufficient access to advocates</li> </ul>
Relatives	<ul style="list-style-type: none"> <li>▶ Ineffective engagement in person-centred planning</li> <li>▶ Untimely and insensitive communication with relatives</li> <li>▶ Lack of opportunities to be informed about changes</li> <li>▶ Poor consultation around decisions</li> <li>▶ Inadequate consultation</li> </ul>
Staff	<ul style="list-style-type: none"> <li>▶ Absence of a strong person-centred focus</li> <li>▶ Low expectation of residents' potential and capacity for risk-taking</li> <li>▶ Inflexible staffing arrangements and frequent staff movement</li> <li>▶ Low staff morale</li> </ul>
Management	<ul style="list-style-type: none"> <li>▶ No clear vision for Áras Attracta</li> <li>▶ Lack of strong leadership and direction</li> <li>▶ Poor communications</li> <li>▶ Ineffective use of staff resources</li> <li>▶ Lack of support, supervision and performance management of staff</li> <li>▶ Lack of implementation of national policy</li> <li>▶ Weak accountability and governance systems</li> </ul>
Environment	<ul style="list-style-type: none"> <li>▶ Unexplored community housing options</li> <li>▶ Poor engagement with the local community and community organisations, and underuse of transport facilities</li> <li>▶ Dearth of employment and educational opportunities</li> </ul>
Policy	<ul style="list-style-type: none"> <li>▶ Lack of awareness training for the residents and their relatives in how to use complaints and protection policies effectively</li> <li>▶ Lack of staff access to and familiarity with organisational policies</li> <li>▶ Inadequate compliance with national disability policy</li> </ul>

## Recommended actions for the HSE

The Review Group recommends that the following actions be taken by the HSE. These actions are in line with the HSE's *Corporate Plan 2015–2017* (HSE, 2015).

- 1** Create, implement and roll out a National Protection Awareness Programme for people with intellectual disability, and include people with intellectual disability in its design.
- 2** Make certain that structures and accountability mechanisms ensure that national policy is fully implemented at local level.
- 3** Implement a rolling programme of assessments of individual needs in all congregated settings.
- 4** Ring-fence resources to support people to move out of congregated settings, ensuring that the funding follows the individuals, and that personalised budgets are an option.<sup>64</sup>
- 5** Accelerate the process of supporting people to move into community living, avoiding transitional arrangements.
- 6** Place failing services into 'Special Measures'.<sup>65</sup>
- 7** In the review of *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures*, ensure that guidance is included for the development of local adult protection and welfare procedures.<sup>66</sup>
- 8** Develop a mechanism for promoting good practice throughout the intellectual disability sector.
- 9** Promote voluntary advocacy services and initiatives under the aegis of the National Advocacy Service.
- 10** Ensure that HSE disability managers engage with people with intellectual disabilities and their representatives.
- 11** Develop a bespoke leadership development and management of change programme for managers of all congregated settings.
- 12** Ensure the entitlement of people with disabilities living in designated centres to access all housing supports.
- 13** Conduct a review of the foregoing actions, and provide a progress report on the recommendations and deficits in *Áras Attracta*, to be reported back to the Minister with responsibility for Disability Services within 12 months.

<sup>64</sup> Personalised budgets or individualised budgets are designed for one person at a time based on a whole life personal plan that focuses on what matters to the person. People should be able to take their budget in a number of ways – as a direct payment, as a notional budget, or as a budget managed by a third party.

<sup>65</sup> Different models of special measures can be adopted, but would include the external appointment of an interim 'improvement team' which would oversee an 'improvement' action plan

<sup>66</sup> A similar model to the one used in Appendix 8 of *Children First* could be considered (Department of Children and Youth Affairs, 2011).

## Recommended action plan for congregated settings

An action plan directed to all congregated settings is outlined below. This identifies the steps that need to be taken to support a rights-based social model of service delivery, and a move away from life in congregated settings for approximately 2,800 people with an intellectual disability who continue to live in such settings. Many of these actions are also applicable to Áras Attracta.

- 1** In line with national policy, everyone living in a congregated setting will be given the opportunity to live in the community.
- 2** Transitional monies will be provided to enable this to happen. Transitional monies are additional funding for a 12–18 month period to cover the additional costs of transition.
- 3** The move to a community setting will be individually planned, using an extensive person-centred planning (PCP) process, based on the person’s will and preference, and in partnership with their family.
- 4** The supports that each person needs to live successfully in the community will be carefully assessed using the Supports Intensity Scale (SIS) or similar assessment tool. This then is the level of support that will be provided on an ongoing basis to each person.
- 5** The transition to community living will be completed over a five-year period. In year one, 15 per cent will move to a community setting; in year two, a further 20 per cent will move to community settings. Further targets will be set for the remaining three years in the light of that experience.
- 6** The HSE or voluntary body will determine appropriate alternative use for the campus as the site is vacated. Where land or property is sold, the monies realised will assist with transitional costs.
- 7** All staff currently employed will continue to work for the service provider; staff who do not wish to work in the new community settings will be offered employment in other facilities and services.

## 10.3 The challenge of moving to community living

Moving from a congregated setting to a community setting is a major challenge for any service provider and will require a simple, clear and explicit vision that describes what the new reality will look like. It will also require strong leadership and total commitment from all senior management to help realise this vision – there can be no ‘sitting on the fence’ by senior management. The challenge is to create a new kind of service that is tailored to each person’s needs and priorities.

The management should engage with all stakeholders to articulate this vision for the future, and the values that will underpin the new service. The values should reflect a commitment to support a meaningful life, community participation, individual empowerment and respect for human rights.

The transition to community life will entail a fundamental change in culture, from learned dependence to personal choice and calculated risk-taking; from staff controlling people’s lives to workers supporting individuals to live the life of their choosing; from people having limited options to having the same options as others living in that community, this includes healthcare needs being accessed through primary care centres and community services. Such a fundamental change will involve:

- ▶ A steep learning curve for senior management (this will involve opportunities to visit de-congregated sites, to meet with the leaders of successful transition to community settings, and to learn about the management of organisational change).
- ▶ Sharing the learning with all levels of the organisation and with people supported and their families.
- ▶ Identifying leaders at all levels in the organisation who are ready, willing and able to lead the change.
- ▶ Constant communication with all stakeholders (newsletters, websites, Facebook, Twitter, meetings, and so on).
- ▶ Formalised arrangements for regular consultation with the people supported and their families, with staff, and with funders.
- ▶ Fostering the independent voice of the people supported by the service, through self-advocacy training, speak-up groups, house forums, and so on.
- ▶ Supporting those individuals who already want to move to a community setting, through the process of transition into the community.
- ▶ Sharing the successes as they occur with all stakeholders, and learning from the challenges that arise.
- ▶ Ensuring that large-scale institutionalised living is not replaced with small-scale institutionalised living.

## What will determine the success of community settings

The success of the move from the congregated setting to a community setting will be determined by a number of factors:

- ▶ The involvement of the person in all aspects of the move, including deciding where they will live, and who they will share their home with.
- ▶ The commitment of all staff and management in each setting to prepare people for the transition to community living. This preparation will focus on empowering each person to make everyday choices, to speak up for themselves, and to express preferences.
- ▶ The HSE's engagement with housing bodies (local authorities, NAMA, voluntary housing associations) and landlords and developers, to ensure a variety of housing options for people in suitable community locations.
- ▶ In identifying suitable locations, the focus will be on local facilities (closeness to shops, churches, GPs, education, sports and leisure facilities, active community groups, opportunities for part-time employment, closeness to family members, access to public transport, friendly neighbours, and so on) and personal choice.
- ▶ Engagement with education providers to explore, facilitate and promote learning opportunities.
- ▶ Focus on preparing the local community for the transition.
- ▶ As far as practical, the person will choose their own support staff.
- ▶ A transition team will have responsibility for coordinating the transition from living in the congregated setting to living in the person's chosen community location.

## 10.4 Áras Attracta: a bleak picture...

There was widespread institutional conditioning and control of residents in Áras Attracta resulting in limitations in their rights, choices and freedom. Institutional conditioning occurs when people living and supported in institutions react, behave and conform to established rituals and rigid routines, which are generally imposed for the ease of managing the service and convenience of management and staff. The outcomes for people living in such organisations include loss of independence, limited options and poor control over their lives.

The lack of a stimulating environment and fulfilling activities; residents spending long hours confined to their bungalows and units and without any valuable contact with the outside world; a world where the human dignity, privacy and rights of residents were not always respected or catered for; a model of service that is not organised to meet the needs, wishes and aspirations of residents and is structured to suit staffing constraints – these are all factors that paint a bleak picture of life for residents in Áras Attracta and are the complete opposite of a person-centred and person-focused service.

Overcrowding and lack of privacy were significant issues. Some residents had their own bedrooms, while there were as many as four sharing others. Creating a homely feeling in these circumstances is difficult to achieve. Some residents had personal items (photos, furnishings, and so on) in their rooms, but others were living in dull or bleak surroundings with their beds separated by dividers and curtains. Few had a key to their own room.

There are few links with the local community and community organisations and many examples of missed opportunities in this respect – one resident was observed knitting in the day services centre while there is a thriving knitting club in the town. Mass is celebrated every week in Áras Attracta, but few residents attended the local church. There is a GAA pitch across from the main entrance to the campus yet residents who follow GAA do not attend matches.

### ... with some rays of hope for the future

In the course of our work we were encouraged to observe much patient, kind and sensitive support being shown by staff to residents, and it was clear that there are strong bonds of affection and dedication between staff and many residents.

In some bungalows, there were the beginnings of residents' forums that might give residents a say in what happens in their home, but we know that this voice needs greater support.

There are also some beginnings of engagement with the local community – one resident was involved in the local Tidy Towns initiative, some had joined the local library, and a small number were taking part in a programme run by the Education and Training Board. This was a recent initiative.

The HSE has prioritised Aras Attracta as one of the services which will see an accelerated implementation of the 'Transforming Lives' programme including implementation of the *Time to move on from congregated settings report*. This is a fundamental change in the way in which services and supports for people with disabilities are currently provided which will empower them to live independent lives, provide them with greater independence in accessing the services they choose, and enhance their ability to tailor the supports required to meet their needs and plan their lives.

To support implementation of the change programme the HSE has secured substantial revenue and capital funding. Details of these funding streams are set out in the **HSE response to recommendations** (p.187ff).

Two 'Social Care Model' houses opened on site in Áras Attracta in November 2015. Four residents live in each house and take part in everyday situations at home and in the community with support – for example, preparing their own meals, getting a key to their own front door, going out to the cinema, bowling or to the hairdressers, and so on.

All residents have had individualised assessments which indicate, that with planning and the appropriate supports, they can all transition to community living. 27 residents will move to live in the community in Phase 1 commencing in 2016.



## In conclusion

The findings from our work reflect failures at all levels in the system and change to date at Áras Attracta has been driven mainly by compliance issues. The recommendations and actions outlined in this report, however, require deep transformational change.

To achieve this, the capacity for change needs to be strengthened and the pace of change accelerated so that residents who are ready to move now to a non-institutional setting in the community are supported to do so without delay. At the same time during the transition period, the Review Group is cognisant that the quality of life and the service model must be enhanced for those who remain in Áras Attracta until they too can move.

While progress has been made over the last year, the bigger structural changes outlined above have yet to be addressed.

The HSE has developed a roadmap that sets out the vision for the future service model at Áras Attracta and a timeline for its implementation. This will be used in a comprehensive consultation and engagement process with residents, their families, staff, unions and other stakeholders before the final action plan for Áras Attracta is agreed.

Now is the time to face up to the deficits and failures, to listen to what residents and their families have said, to implement the findings and recommendations in this report and to concentrate all efforts on what matters most – a better future.





F

# APPENDICES

**A1: Terms of reference**

**A2: Bibliography**

**A3: Acronymns**



# A1

## Terms of reference

### Terms of Reference for the Review and Assurance that the Standards of Care meet the needs of the Service Users in the Áras Attracta Service, Swinford, Co. Mayo

#### Introduction and Background

Over the past 12 months concerns have been highlighted to the HSE in relation to the services being provided to residents in Áras Attracta Centre, Swinford, Co. Mayo. Significant work has been initiated arising from inspection reports from HIQA, HSE Audits, an extensive programme of training and additional staffing resources.

The Terms of Reference for a Review of Services at Áras Attracta Service, Swinford, Co. Mayo are set out below following allegations of serious mistreatment of residents reported to the HSE on Tuesday 25th November 2014. The Review will provide assurance that the Standards of Care meet the needs of the Service Users. This Review is commissioned by the National Director, Social Care Division.

#### Purpose

The purpose of this review is to:

- ▶ Review the programme of work already underway at the centre on foot of reports from HIQA, HSE Audits and reports to establish their effectiveness, identify any gaps and make recommendations for further improvements.
- ▶ Identify any immediate concerns and advise on the care and safety of the residents to the Commissioner.
- ▶ Identify any key causal factors that may have occurred.
- ▶ Identify any contributory factors that caused the key causal factors.
- ▶ Recommend actions that will address the contributory factors so that the risk of future harm arising from these factors is eliminated or if this is not possible, then reduced as far as is reasonably practicable.
- ▶ Ensure that any learning from the assurance group is reflected and promoted throughout the system

## Scope of the Review

The scope of the review should examine:

- ▶ All relevant reports including the HIQA reports and the HSE Audit report and other relevant reports as deemed appropriate by the Review Team.
- ▶ Any relevant materials to ascertain what measures have been taken to improve the standards of care.
- ▶ Evidence to support these changes and ensure they are embedded in the day-to-day practice and in the culture of the organisation.
- ▶ Submissions made from the wider Disability Community.
- ▶ Relevant National and International Research.
- ▶ Any further actions deemed necessary.

The Review Group will engage with Service Users (supported by Advocate/Family Member as appropriate) and interview staff as the Review Team consider necessary. Arising from the review process the review team will make recommendations in respect of each unit/bungalow in Áras Attracta, in relation to specific service improvements required.

## The Review Group Members

- ▶ Dr Kevin McCoy (Chair)
- ▶ Ms Deirdre Carroll
- ▶ Dr Bob McCormack
- ▶ Ms Ann Judge

Through the Chairperson, the review Group will:

- ▶ Be afforded the assistance of all relevant staff and other relevant personnel within the Service.
- ▶ Have access to all relevant files and records (subject to any necessary consent/data protection requirements including court applications, where necessary).
- ▶ Should immediate safety concerns to other residents be identified, the Chair of the Review Team will convey the details of these to the Commissioner immediately so that any required actions will be taken in a timely manner.
- ▶ Should the review team require further external independent input, the Chair of the review team will discuss and agree this with the Commissioner.

## Review method

The review will follow the HSE Guidance for Systems Analysis Investigation of Incidents and Complaints (QPSD November 2012), the Safety Incident Management Policy (QPSD May 2014) and will be cognisant of the recently launched National Policy and Procedure for Safeguarding Vulnerable Persons at Risk of Abuse (December 2014) and recognising the rights of all involved to privacy and confidentiality; dignity and respect; due process; and natural and constitutional justice.

The review will commence with immediate effect and will be conducted in the shortest timeframe necessary to achieve the purpose of the review. Interim reports will be produced and submitted to the National Summits in 2015

Following completion of the review, an anonymised draft report will be prepared by the review team outlining the chronology, findings and recommendations. All who participated in the review will have an opportunity to give their input into the extracts from the report relevant to them to ensure that they are factually accurate and fair from their perspective. The anonymised Report maybe published and maybe subject to a freedom of information request.

## Recommendations and Implementation

The report, when finalised, will be presented to the Commissioner of the review. Implementation of the recommendations will be undertaken by local Managers and will be the subject of monitoring until finalised. Local Managers will provide assurance to the National Director and to his Team that the recommendations have been implemented and the monitoring of this will be provided by the Lead for Quality & Safety – Social Care Division.

## Communication Strategy for the Review

A named individual will be appointed for the purpose of communicating information pertaining to the review to the families / relevant stakeholders and staff members effected by and or involved in the incident.

## Reference

- ▶ Guideline for Systems Analysis Investigation of Incidents and Complaints (HSE 2012)
- ▶ Safety Incident Management Policy (HSE May 2014)

Commissioner, National Director HSE Social Care Division

7 January 2015





# Bibliography

- Commission on the Status of People with Disabilities, 1996. *A strategy for equality*. Dublin: Commission on the Status of People with Disabilities.
- Costello, L. and Cox, W., 2013. *Living in the community: services and supports for people with disabilities*. Dublin: Disability Federation of Ireland.
- Council on Quality and Leadership, 2005. *Personal Outcome Measures – Measuring Personal Quality of Life*. Towson, MA: CQL. < [www.c-q-l.org](http://www.c-q-l.org)>
- Department of An Taoiseach, 2006. *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015*. Dublin: Stationery Office.
- Department of Environment, Community and Local Government, 2011. *National housing strategy for people with a disability 2011–2016*. Available at: <<http://www.environ.ie/en/Publications/DevelopmentandHousing/Housing/FileDownload,28016,en.pdf>>
- Department of Health, 2012. *Value for money and policy review of disability services in Ireland*. Dublin: Dept. of Health. Available at: <[http://health.gov.ie/wp-content/uploads/2014/03/VFM\\_Disability\\_Services\\_Programme\\_2012.pdf](http://health.gov.ie/wp-content/uploads/2014/03/VFM_Disability_Services_Programme_2012.pdf)>
- Gardner J., Nudler S. and Chapman, M., 1997. Personal outcomes as measures of quality. *Mental Retardation*, 35, 295–305.
- Gardner, J.F. and Carran, D.T., 2005. Attainment of personal outcomes by people with developmental disabilities. *Mental Retardation*, 43, 157–174.
- Government of Ireland, *Education Act 1998*. Dublin: Stationery Office.
- Government of Ireland, *Health Act 2004*. Dublin: Stationery Office.
- Government of Ireland, *Citizens Information Act 2007*. Dublin: Stationery Office.
- Government of Ireland, *Disability Act 2005*. Dublin: Stationery Office.
- Government of Ireland, *Education for Persons with Special Needs Act 2004*. Dublin: Stationery Office.
- Government of Ireland, *Health Act 2007*. Dublin: Stationery Office.
- Government of Ireland, 2013. *Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013*. Statutory Instrument 367/2013 Dublin: Stationery Office.
- Health Information and Quality Authority, 2013. *National standards for residential services for children and adults with disabilities*. Dublin: HIQA. Available at: <<https://www.hiqa.ie/publications/national-standards-residential-services-children-and-adults-disabilities>>

- Health Service Executive, 2011. *Time to move on from congregated settings: a strategy for community inclusion*. Dublin: Health Service Executive. Available at: < <http://www.hse.ie/timetomoveon/>>
- Health Service Executive, 2012. *New directions: review of HSE day services and implementation plan 2012–2016 – personal support service for adults with disabilities*. Available at: <<http://www.hse.ie/eng/services/publications/Disability/newdirections2012.pdf>>
- Health Service Executive, 2014. *Safeguarding vulnerable persons at risk of abuse – national policy and procedures*. Available at: <<http://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>>
- Health Service Executive, 2015a. *Building a high quality health service for a healthier Ireland – Health Service Executive corporate plan 2015–2017*. Available at: <<http://www.hse.ie/eng/services/publications/corporate/corporateplan15-17.pdf>>
- Health Service Executive, 2015b. *National Service Plan 2015*. Available at: <<http://www.hse.ie/eng/services/publications/corporate/sp2015.pdf>>
- Houses of the Oireachtas, 16 July 2015. Written Answer 537 [to question 29994/15]. Available at: <<http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2015071600083#WRFF00100>>
- Inclusion Ireland, 2015. *The distant voice: A working paper on the first 50 HIQA inspections of residential services for people with disabilities*. Available at: < <http://www.inclusionireland.ie/sites/default/files/attach/article/1215/hiqafinal.pdf>>
- McCormack, B., 2004. Trends in the development of Irish disability services. In Walsh, P.N. and Gash, H. eds., 2004. *Lives and times: practice, policy and people with disabilities*. Bray, Co. Wicklow: Rathdown Press.
- McCormack, B. and Farrell, M., 2007. *The quality of life of people with disabilities in Ireland in 2007: results of a national survey*. Dublin: Outcomes Network of Ireland and Delivering Outcomes to People Project.
- McCormack, B. and Farrell, M., 2009. Translating quality of life into service action: use of personal outcome measures in the Republic of Ireland. *British Journal of Learning Disabilities*, 37, 300–307.
- McCormack, B. and Farrell, M., 2010. Using POMs to get a better quality of life: The Outcomes Network of Ireland Survey. *Frontline*, 78, 24–26.
- Review Group on Health and Personal Social Services for People with Physical and Sensory Disabilities, 1996. *Towards an independent future*. Dublin: Stationery Office.
- Schalock, R, Gardner, J. and Bradley, V., 2007. *Quality of life for people with intellectual and other developmental disabilities: applications across individuals, organizations, communities, and systems*. Washington, DC: American Association on Intellectual and Developmental Disabilities.

# A3

## Acronyms

HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICT	Information and Communications Technology
IMPACT	Irish Municipal Public and Civil Trade union
ISBAR	Identify, Situation, Background, Assessment, and Recommendation
ISO	International Organization for Standardization
LÁMH	Means 'hand' in Irish - and in this context it refers to a manual sign system
MAPA	Managing Actual and Potential Aggression
MHID	Mental Health Intellectual Disability
NAS	National Advocacy Service
PC	Personal Computer
PCP	Person Centred Plan
PECS	Picture Exchange Communication System
PEEPS	Personal Emergency Evacuation Plans
PNA	The Psychiatric Nurses Association of Ireland
POMs	Personal Outcomes Measures
PRN	Pro re nata – when necessary , or as the situation demands
QQI	Quality and Qualifications Ireland
RCN	Registered Children's Nurse
RGN	Registered General Nurse
RM	Registered Midwife
RNID	Registered Nurse Intellectual Disability
RPN	Registered Psychiatric Nurse
SAM	Safe Administration of Medication
SIPTU	Services Industrial Professional and Technical Union
SIS-A™	Supports Intensity Scale - Adults
SMS	Short Message Service

TEACCH	Treatment and Education of Autistic and Communication related handicapped Children
TEEU	Technical, Engineering and Electrical Union
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WTE	Whole Time Equivalent

# HSE Response to Recommendations

## Summary

The Health Service Executive (HSE) welcomes the findings of the McCoy Assurance Review and wishes to thank Dr McCoy and his team, Ms Deirdre Carroll, Dr Bob McCormack, Ms Ann Judge and all who have had input into this report. The involvement of residents and family members of Áras Attracta, staff, management, people with disabilities across the country, partners within the disability sector and external parties sees a comprehensive report that provides recommendations and actions for Áras Attracta, the HSE and the wider disability sector.

The HSE's response to the report's recommendations and actions outlines progress on service improvements that have taken place to date at Áras Attracta. It also outlines improvements in safeguarding and disability services nationwide as key initiatives were progressed by the HSE's Social Care Division and Community Healthcare Organisations (CHOs) parallel with Dr McCoy's Assurance Review. Our ongoing focus is to implement the changes required at Áras Attracta to ensure the safety and wellbeing of all residents and to ensure that they, and their families, are consulted with, and involved in, the transition to a community based model of living and support. By the end of 2015, as referenced in the report, more than 60% of all the recommendations in the reviews conducted since 2014 had been implemented, and further progress is being made during 2016. Significant further improvements are under way in Áras Attracta in line with its agreed vision, which is:

### ***Vision for Áras Attracta***

***“To 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”***

In working towards this vision, while at the same time ensuring ongoing service improvements, the approach to reforming services has been adopted as follows:

#### **▶ Transition to community living**

Accelerate the transition to a person centred, community based model of support in line with the policy “Time to Move on from Congregated Settings” (HSE 2011) and the wider disability reform programme, ‘Transforming Lives’, which is the programme to implement recommendations of the Value for Money and Policy Review (VFM) of Disability Services (Department of Health, 2012).

#### **▶ Improve current services**

Improve current services, safeguarding, and compliance with HIQA residential standards for disability services (2013) through the implementation of the new National Policy on Safeguarding and the ‘Six Step’ change programme for Social Care services.

### ► **Developing a *Roadmap* for services at Áras Attracta**

In line with this approach to service improvement and reform and the initial consultation with residents, their families and staff at Áras Attracta, the HSE has developed a *Roadmap* that sets out the vision for the future service model at Áras Attracta and a timeline for its implementation. This is informed by the McCoy Assurance Review.

This response from the HSE encompasses much of what is outlined in the *Roadmap* which will be used in a comprehensive consultation and engagement process with residents, their families, staff, unions and other stakeholders before the final action plan for Áras Attracta is agreed. The action plan, once implemented, will enable residents to transition to community living and live meaningful lives of their choice with the appropriate supports.

The individual needs assessments of all residents in Áras Attracta which were completed by December 2015, will inform individual care plans for residents. Implementation will be on a phased basis with 27 residents to transition in Phase I, commencing in 2016. Phase II, commencing in 2017, will see a further 26 residents transition. In accordance with their individual needs assessments, these residents will require significant additional support and time to progress to community living. Phase III will involve a comprehensive programme of communication and engagement with 37 residents and their families about choices and options for their future. Phase III residents have significant complex needs, ageing or medical conditions and will require additional transitional planning and time to ensure that the most appropriate supports and service are provided for them in accordance with their individual needs assessments. Planning has already commenced for this third phase.

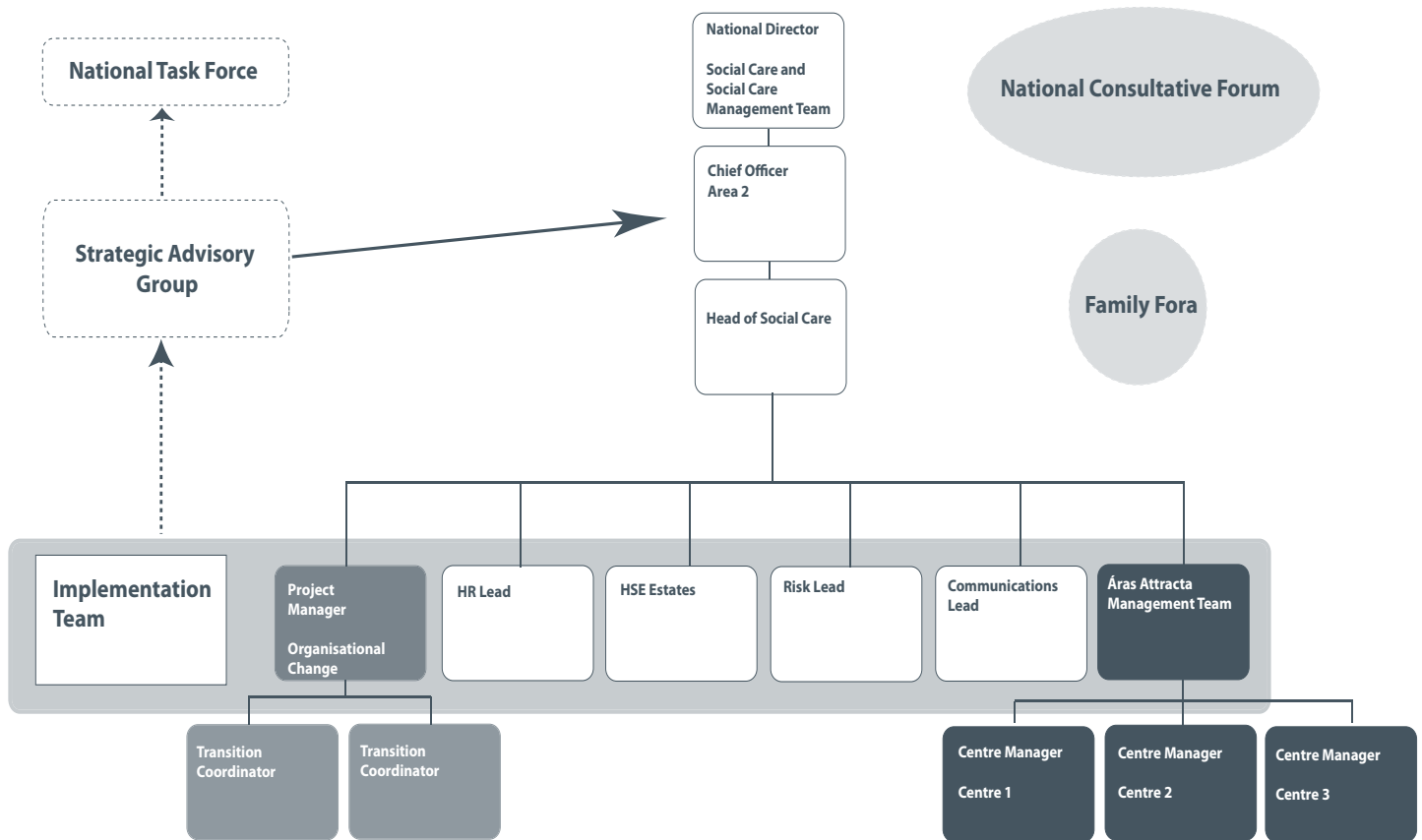
### **Enabling the change programme at Áras Attracta**

#### ***Governance:***

A comprehensive new governance structure, with strengthened leadership and management capabilities has been put in place to oversee the effective implementation of the change programme. The Implementation Team comprises of:

- The *Director of Services* and the team responsible for day to day management of the service,
- A dedicated *Project Manager*, with significant experience in quality improvement and enabling transition of people from congregated to community settings in Ireland and internationally,
- HR, Risk Management, HSE Estates and Communications capacity are enabling the change programme.

Work streams have been established to deliver key elements of the change. Residents, family members, staff from all grades and professions and representatives from voluntary partners within local disability services are included in the work streams.



**Figure 1:** New governance structure at Áras Attracta

The dedicated change management resource consists of a Project Manager with significant experience in quality improvement and enabling transition of people from congregated to community settings in both Ireland and internationally. The Project Manager is supported in her role by two transition coordinators who have completed significant training in the area of Social Role Valorisation. The Project Manager is directly responsible for engaging with all stakeholders, including estates, housing associations, other service providers and other state bodies in order to progress transition to community living.

**Strategic Advisory Group:**

In 2015, the McCoy Review Group recommended, and the HSE accepted, the requirement for a Strategic Advisory Group to support the implementation of the change programme. This group consists of a small senior group of experts to advise and support the Chief Officer and the Implementation Team on the change programme as it progresses.

We are confident that the changes being made in Áras Attracta to improve services and safeguarding will ensure an improved quality of life for all concerned through the creation of a community model of living and supporting residents to choose where they live, how they live and who they live with. Significantly, and for the first time, dedicated capital resources through the Capital Programme, and transitional funding by the Service Reform Fund, have been made available in 2016 to support implementation.

## **Key improvements and progress to date can be summarised as follows:**

### **Transition to Community Living in Áras Attracta**

#### **Building a Community Model of Support**

- Individual needs assessments have been completed for all residents to identify their future support requirements to live a successful life in the community.
- Enhanced independence and community integration for those living at Áras Attracta e.g. supported employment for residents, residents joining local GAA club, participating in cookery classes in the local community, transferring to community based GP services etc.
- Two “Social Care Model” houses opened on site in November 2015 with four residents in each taking part in an everyday normal life situation and integrated into the local community.
- Detailed implementation planning is under way to support residents to transition to community living on a phased basis.
- €20m national investment by Government in 2016: Áras Attracta has been prioritised for funding to purchase or build suitable accommodation locally in line with people’s preferences.
- Transitional Service Reform Fund 2016 (partnership between HSE Social Care and Mental Health Divisions, Genio, Atlantic Philanthropies and Department of Health): Áras Attracta has been prioritised for funding.

### **Improving Services Today in Áras Attracta**

#### **Enhancements in safeguarding at Áras Attracta**

- All staff have undergone safeguarding training.
- Resident specific safeguarding education programme has been developed.
- A permanent senior social worker has been appointed.
- Safeguarding Governance Group has been established with Dr Andrew McDonnell (Studio 3) as Chair.
- Studio 3 approach to support people in challenging situations has been introduced.
- An enhanced incident management structure is in place with daily monitoring of incidents, regular review and analysis and monthly review by an oversight committee which has external representation.
- A robust complaints management structure is now in place.
- National support is provided by the HSE’s Quality Improvement Enablement Programme.

#### **Training and new approaches at Áras Attracta**

- 34% of staff have completed key worker training.
- Studio 3 have provided staff training to support people in challenging situations, and in providing advice and support to frontline staff. Their approach uses a low key non-confrontational approach to manage behaviours that challenge.
- The three designated centres in Áras Attracta have core teams of staff and key workers working consistently with residents in place, resulting in enhanced relationships between staff and residents.



- Three staff have commenced Social Role Valorisation training, provided by Genio.
- Social care model information sessions are being provided by the Centre for Nurses and Midwifery Education.
- Following training of some staff, measurement of residents' quality of life has commenced using the Person Outcomes Measures Tool.
- Formal support and supervision for all staff will commence shortly.

### **Promotion of residents' voices and improved communication with families**

- Time and attention is now given to obtaining the expressed and inferred preferences of residents by including them in determining their futures through 'Discovery' work, advocacy and ongoing consultation with residents and their families.
- The Áras Attracta communication policy has been reviewed and a user friendly template has been devised for residents meetings, which are held monthly.
- A number of residents are involved in the "Voices and Choices" group, which meets weekly.
- Weekly house meetings take place in the new social care model houses opened on site.
- A user friendly pictorial guide has been developed to support residents in making a complaint.
- An information session on self advocacy has been provided to residents who are supported to access advocacy services. A number of residents are now engaging with the Independent Advocacy Service/National Advocacy Service.
- A Family Forum was developed in collaboration with Inclusion Ireland (September 2015).
- Nominations have been sought from residents and family members to participate in the project team work streams, tasked with delivering the change programme at Áras Attracta.

### **Governance and performance management at Áras Attracta**

- Áras Attracta was reorganised into three centres based on residents needs (completed November 2015).
- Following an external recruitment process, a full-time on-site Director of Services has been appointed along with dedicated managers to each of the three designated centres to improve leadership and management of day-to-day services.
- The Director of Services and three centre managers undergo regular performance management.
- Enhanced meeting schedules - all meetings from the "home" meetings to the management steering group meetings are now scheduled.
- Regular unscheduled and scheduled visits to all areas of the campus take place by the Chief Officer for CHO 2, the Director of Services and the three Centre Managers.
- Enhanced staff accountability is now in place including implementation of the HSE's Grievance and Disciplinary Procedure when required.

### Investment in staffing at Áras Attracta

An additional investment of €3 million in staffing has resulted in the recruitment of the following staff:

• 23 Social Care Workers	• 5 Psychology Project Workers (Studio 3)
• 3 Social Care Leaders	• 1 Senior Dietician
• 33 additional Healthcare Assistants	• 1 Senior Speech and Language Therapist
• 1 full-time Director of Services	• 1 Occupational Therapist
• 3 new Centre Managers	• 1 Senior Physiotherapist
• 1 Lead Social Worker	• 1:1 or 2:1 staffing supports in place where required

### Improved Compliance with HIQA Residential Standards

A HSE and HIQA information sharing group, which meets bimonthly, was established.

- Joint approach agreed in October '15 between HIQA and the HSE, implemented through a combination of self assessments and ongoing HIQA inspections.
- Improvements to date acknowledged by HIQA who are particularly impressed with the work done on site in the social care houses.
- Enabled by the additional investment in staffing, six additional accommodation units have opened on site since January 2015.

## Introduction

In late 2014, serious allegations of totally unacceptable behaviour and attitudes towards residents in Bungalow 3, Áras Attracta were brought to the attention of the HSE. This information, which emerged as a result of an RTE programme, gave rise to a fundamental review of all aspects of service delivery at Áras Attracta. The HSE has undertaken actions at three levels since late 2014 as follows:

- **Level 1:** Immediate actions in response to issues raised to ensure a safe and caring environment for the residents
  - ▶ A number of staff were immediately “put on leave”
  - ▶ An Garda Síochána investigation was undertaken
  - ▶ An independent HSE review was conducted
  - ▶ Further HIQA inspections were carried out
  - ▶ Additional staff and practice development measures were put in place.
- **Level 2:** A full assurance review of all services at Áras Attracta was commissioned (the McCoy Review).
- **Level 3:** The Six Step Programme was initiated to ensure system wide improvements in quality and safety of all disability residential services.

In this context, the team at Áras Attracta, the Chief Officer and Leadership Team for Community Healthcare Organisation (CHO) 2 are fully engaged with the HSE at a national level in rolling out the Six Step Programme of system wide change in all disability services. A number of the programme’s steps, such as the McCoy Review, are specifically targeted at improvements in Áras Attracta.

The HSE welcomes the opportunity to respond to the recommendations and actions in the McCoy report which are broadly outlined as follows:

1. Three overarching recommendations that relate specifically to Áras Attracta.
2. Thirteen actions for the HSE to improve services nationally.
3. A recommended action plan, with seven actions, for congregated settings and the move towards community living.

Throughout this response, improvements at Áras Attracta and wider service improvements will be linked to the recommendations and actions in the McCoy report.

## HSE response to the recommendations for Áras Attracta

The three recommendations in the McCoy report for Áras Attracta are:

<b>Recommendation 1.</b>	A move to a rights-based social model of service delivery.
<b>Recommendation 2.</b>	The voices of the residents need to be facilitated, listened to, and promoted.
<b>Recommendation 3.</b>	Strengthening and enhancing the leadership and management.

### HSE response to recommendation 1: A move to a rights-based social model of service delivery.

**Transition to a person centred, community based model of support by accelerating the implementation of *Time to Move on from Congregated Settings* (HSE, 2011) and the wider disability reform programme, *Transforming Lives*.**

The reform under way at Áras Attracta is being progressed alongside the ongoing work to improve services and provide a stable, safe environment for all residents. Accelerating the implementation of the ‘*Time to Move on From Congregated Settings*’ (HSE 2011) policy will see the vision for Áras Attracta being progressed in consultation with residents and their families. As detailed in the *Roadmap*, the vision is to develop a community based model of service where residents can be supported to ‘live ordinary lives’ in the community. This vision will require a range of individual supports including in-home supports to enable the person to live independently and safely in their own home and to develop active links and relationships with the services and people in their own locality. A dedicated resource has been appointed to the project team to ensure that due consideration is given to all aspects of community liaison and integration.

Individuals transitioning to community living will live in ordinary neighbourhoods (dispersed housing) with individualised supports (supported living) designed to meet their needs and wishes. Dispersed housing includes apartments and houses scattered throughout residential neighbourhoods. Those moving from Áras Attracta will be provided with advice or decision making support from advocacy services and/or their families to assist them in expressing their preference. This could be to live on their own, share with others who do not have a disability, with others who have a disability (maximum of four people) or, opt for long-term placement with a family. In advance of people moving from a HIQA designated centre to alternative accommodation, the new accommodation may require HIQA registration.

Living arrangements will be similar to the general population where people do as much as they can of their own cooking, cleaning, laundry and the like and are supported to do so as appropriate. They will access primary health care mainstream services for GP, pharmacy, home help and so on and they will have access to specialist services as necessary.

In line with *"New Directions"* (HSE, 2012), the HSE policy on day services, people moving out of Áras Attracta will be supported to access both mainstream and specialist social and occupational activities. This will require participation in bridging programmes, education and training. It will ensure inclusion in the community and independence based again on choice and self determination and it will be achieved at a level and pace individuals are comfortable with. In all of this, residents will be encouraged to shape the services delivered to them through engagement and feedback.

This is the vision for Áras Attracta and while building this community model of living, the HSE is committed to making the service as effective as possible in the interim. We will facilitate choice and self determination for service users in everything we do. It includes providing individual residents and their families with support and information in an understandable and transparent manner to ensure that choice is real. This is aligned to the principle commonly used nowadays of *'nothing about me without me'* and is based on expecting the very best from all stakeholders.

#### ► **Standardised individual supports needs assessments**

It was highlighted by the McCoy Review Group that in order to develop the most appropriate future model of service/community based living; there was a need to establish each person's individual support needs in an unequivocal manner. This had not been done before at Áras Attracta. The Supports Intensity Scale Assessment Adult® (SIS-A®) version 2015 was chosen because it clearly identifies the supports people require to have success in their lives in the community. It looks at each individual and has been successfully used all over the world since 2004. The services of the American Association on Intellectual and Developmental Disabilities (AAIDD) were acquired through a competitive tendering process. The assessment process commenced in October 2015 following an information session with families and staff. Assessments were undertaken in conjunction with the residents, their families, staff members who knew each individual best and through a review of documentation. They were completed on 93 residents by December 2015.

The analysis and findings of the composite SIS-A® report indicate that:

- Everybody currently residing in Áras Attracta can have successful lives in the community with the appropriate supports.
- Some will require significant additional supports in order to be supported to engage in the social care process.
- Some will require less supports than they currently have to progress to a community based service model.
- Extensive preparation time will be required for some.
- There is a significant number who, for example, currently have awake staff at night but only require non-awake staff, or with training eventually no staff at all at night time.

The report clearly outlines the range and level of supports required for each individual to live a successful life in an appropriate community setting and this has informed the individual plan for each person.

► **Transition to a new model of service**

Informed by the results of the individual assessments, and following detailed consultation with residents and their families, it has been agreed that the transition of all individuals at Áras Attracta to community living will be progressed on a phased basis. Table 1 outlines the number of individuals due to transition to community living in each phase of the change programme, along with an indication of their future living arrangements.

<b>Phased transition plan to community living</b>		
<b>Phase</b>	<b>No. of individuals to transition to community living</b>	<b>No. of community houses required</b>
I	27	5
II	26	7
III	37	9

**Table 1:** Phased transition plan to community living for Áras Attracta residents

As already mentioned, the composite SIS-A® report guides the requirements for additional supports to allow all residents to transition to community living, with the provision of appropriate additional supports. For example, it indicates that there are a significant number of people currently living at Áras Attracta who currently have awake staff at night but, following the assessment process, only require non awake staff or, with training, no staff at all at night time.

<b>Suggested Residential Accommodation Type</b>	
Supervised Group-Awake Staff	63
Supported Living Programme	25
Supervised Group Non-Awake Staff	18
Individualised Intensive Support	5
Independent Model	0
High Medical Support Needs	4
High Behavioural Support Needs	13

**Table 2:** Detail of residential support type required to progress the transition of all current residents of Áras Attracta to community living

Recognising that some individuals have more complex needs, the assessment’s Categories of Care provides a framework for the specific staffing needs required i.e. staffing levels required during the day and at night, whether night staff need to be awake or sleeping, whether for example a staff nurse or a social care worker is required. Table 3 summarises the categories of care based on the individual needs assessments completed and helps to inform, based on choice, where people who wish to live together should do so.

<b>Number of Those Assessed (People) with Particular Compatibility Needs</b>	
Quiet	62
Active	55
Age	26
Gender	10
Non-aggressive	58
Tolerant	52
Other	10

**Table 3:** Compatibility needs of people assessed using the SIS-A®.

It must be acknowledged that a number of residents’ families are apprehensive about community living. Hence time will need to be given to support these residents and their families while at the same time considering the best option for the resident in line with their will and preference.

Inclusion Ireland are supporting families through the Áras Attracta Family Forum established in September 2015. In total, 72% of families supported staff and residents through the individual assessment process. On completion, all families were provided with a copy of the completed assessment reports and invited to meet with the service. Meetings and engagement with residents and their families around choices and preferences for their future are ongoing.

**HSE response to recommendation 2: The voices of the residents need to be facilitated, listened to, and promoted.**

**► Promotion of residents voices**

Recognising the need to facilitate and promote the voices of residents and their families, a number of improvements have taken place. The communication policy has been reviewed and now there is a user friendly template for residents meetings, which are held monthly.

A number of residents are involved in a “Voices and Choices” group, which meets weekly. Plans are in development to ensure that all residents are involved in a meaningful way in decisions that affect them. In addition, staff are working with residents to promote their involvement in on site committees and to participate in internal house planning meetings.

As outlined earlier, as the planning for the future of services at Áras Attracta progressed in 2016, residents were invited to join work streams tasked with delivering individual elements of the plan.

▶ **Enhanced advocacy services**

An information session on self advocacy has been provided for residents and day attendees. Information has also been provided on the services at Áras Attracta in an easy read format. In particular, advocacy has been strongly promoted in the new social care houses.

A number of residents are now engaging with the Independent Advocacy Service/National Advocacy Service and Inclusion Ireland are developing a service, based in Sligo, to support enhanced advocacy services. In the event where an issue occurs, and the resident needs independent advice and support, they are referred to an independent advocate through the National Advocacy Service.

▶ **Enhanced independence and community integration for residents**

A number of residents have been assisted to open bank accounts to promote independence. This will assist their understanding of money management and personal ownership. In addition, the practice of utilising medical officers and on site medical clinics has now been altered. In anticipation of moving to the community, all residents are being encouraged to select a GP of their choice in their locality and to use their medical card to access healthcare.

Other changes that have occurred in the service include the catering arrangements. As more people are availing of the opportunity to learn to cook in their homes, there has been a decline in the demand for canteen services. It has been decided to close the canteen at weekends, but pre-orders are accommodated at weekends, if required, to accommodate families and residents wishing to dine together at Áras Attracta.

In addition, the hairdressing service previously provided on site for everybody is no longer available with people accessing the hairdresser of their choice within the community.

▶ **Cultural changes**

A range of steps have been taken to enable and promote positive cultural changes at Áras Attracta including:

- The appointment of a team lead social worker, key workers, core teams of staff and social care workers, in conjunction with the training provided, has changed the culture at Áras Attracta and helped staff to better communicate with and listen to residents. Gradually, people living at Áras Attracta are becoming more vocal, identifying aspects of their lives that they want to change and now feel confident to do so.
- The development of core teams of staff in the houses is endeavouring to ensure that key workers are now working with the residents they are assigned to.
- There is a concerted effort being made to ensure that there are consistent teams of staff.
- The staff training policy has been updated, a training schedule developed, and mandatory and desired training have been identified. The training plan for each house should evolve from the needs of the residents living there.
- Training programmes for residents are also being developed to include: safeguarding, advocacy, social care model, skills building and sex education.

- Time and attention is now given, to obtaining the expressed and inferred preferences of individual people to include them in determining their futures.
- In recognition of the difficulties that some residents have in communicating, the speech and language therapist is working closely with residents, their families and staff members to develop communication passports for all who require them. Non verbal responses to changes in their lives are being elicited.
- Posters for the Confidential Recipient, the complaints procedure, and the Designated Officer are now displayed around the campus.

#### ► **Enhanced communication with family members**

The Family Forum was developed in Áras Attracta following a meeting with Inclusion Ireland in September 2015. In November and December, further Family Forum meetings with the Chief Officer and service management took place. In April 2016, the National Director for Social Care, the HSE Head of Operations and Service Improvement for Disability Services and the Chief Officer for CHO 2 attended the Family Forum meeting.

The Forum has supported the new management structure to get to know families and keep them abreast of changes. Nominations have been sought from families for their involvement in work streams tasked with delivering the change programme in line with the vision for Áras Attracta. To date, five expressions of interest have been received.

Management are also working with families to be responsive to all of their concerns in a timely manner.

#### ► **Development of a communications and engagement strategy**

As outlined previously, a project team is in place to deliver the change programme at Áras Attracta. A Communications Manager has been appointed, and a communications work stream established. A detailed communication and engagement strategy has been developed, which will ensure that the vision for the service is communicated appropriately to all relevant stakeholders. This vision is now being widely communicated at house meetings, staff meetings, team meetings, meetings with the trade unions, and in meetings with the family forum. Through the residents' monthly communication meetings, the transition process is discussed. The project team is working with the residents on an individual basis to establish their choice and preferences in relation to location, and who they wish to share their future home with.

### **Improvements in current services, safeguarding and compliance with HIQA residential standards to date**

Following the revelations of poor practices at Áras Attracta in late 2014, the initial focus was to ensure that residents were safe and that appropriate safeguarding processes were put in place. This has been carried out and the ongoing focus is to change the culture at Áras Attracta and to create a more person centred, individualised model of care, with increased opportunities for community integration. This is being achieved as follows:

#### ► **Improvements in safeguarding**

Management and staff at Áras Attracta are committed to the protection of vulnerable adults and the promotion of best practice in this area



in line with national policy. Áras Attracta has adopted the National Safeguarding Policy in its entirety and has a zero tolerance approach to any types of abuse.

*Safeguarding training:* All staff have undergone safeguarding training. The team lead social worker and five managers have completed the Designated Officer safeguarding training. One member of staff has completed the Train the Trainer programme and provides training to all staff on safeguarding. The social worker and the speech and language therapist are developing a resident specific education programme to empower them to recognise potential safeguarding issues.

*Enabling residents to voice concerns:* In relation to the policies on safeguarding and making a complaint, progress has been made to familiarise residents with how these policies work. The complaints policy has been reviewed and a user friendly pictorial guide has been developed to support residents. This topic is highlighted at residents' communication meetings to ensure familiarity with the process of making a complaint.

*Risk management:* Since September 2015, daily incident review meetings and weekly safeguarding and risk management meetings take place in Áras Attracta. These meetings ensure that staff are supported to report on all forms of abuse and to implement the safeguarding plans that are now in place. The Designated Officer completes unannounced visits and interviews staff on how the safeguarding plan is being implemented. Each resident has a risk register which is made up of individual risk assessments. The aim is to develop a culture of positive risk enabling rather than protective custodial arrangements whereby overprotection is life limiting.

*Agenda item:* Safeguarding of vulnerable adults is now on the agenda for all team meetings in Áras Attracta and an awareness poster campaign has also been undertaken.

*Additional supports:* In 2015, a significant number of additional staffing resources were put in place to support residents to live in independent houses with 1:1 or 2:1 staffing supports where deemed necessary. The opening of the two additional houses (Lough Conn and River Moy) has since reduced the number of residents in other houses.

*Governance:* A more robust safeguarding governance structure has been set up with external HSE representation, independently chaired by Dr Andrew McDonnell (Clinical Psychologist, Studio 3). Dr McDonnell is a Clinical Psychologist who trained in Clinical Psychology at the University of Birmingham. He has consulted in services for people with autism for over 25 years and has been involved in training staff to support people in challenging situations, providing advice and support to frontline practitioners and designing community-based, person-centred supported living options for people with autism.

*Designated Officer:* A permanent senior social worker has been recruited and appointed as the Designated Officer for Áras Attracta. The first action that occurs on the identification of any safeguarding issue is that immediate safeguarding measures are put in place and the Designated Officer notified. A protocol has been put in place to ensure that all appropriate steps are followed on the identification of any unexplained

injury. All investigations into allegations of abuse take place in line with the *Safeguarding Vulnerable Adults at Risk of Abuse Policy* (2014) commencing with a preliminary screen by the Designated Officer following which appropriate action is taken, including the development of a safeguarding plan which is implemented and kept under review. If the allegation is against a member of staff, the Trust in Care process is used.

The social work service at Áras Attracta is supported by a principal social worker in CHO 2 who has completed the National HSE Training for Designated Officers. An oversight committee is in place to review all incidents with the team on a monthly basis. This is attended by the principal social worker, Dr Andrew McDonnell (Studio 3) and an external representative (CEO of a service provider in Northern Ireland) with considerable experience in the area of disability residential services. The analysis of safeguarding issues is facilitated by the use of an audit tool developed by Studio 3 and MITSUITOMO at Lloyds of London.

#### ► **Staff recruitment**

Throughout 2015, a significant recruitment campaign focused on changing the model of service provision at Áras Attracta. This included the recruitment of:

- 23 Social Care Workers
- 3 Social Care Leaders
- 33 additional Healthcare Assistants
- A full-time Director of Services
- 3 new Centre Managers
- A Lead Social Worker
- Psychology input from Dr Andrew McDonnell (Studio 3) supported by 5 Psychology Project Workers
- A Senior Dietician
- A Senior Speech and Language Therapist
- An Occupational Therapist
- A Senior Physiotherapist

Social care workers and social care leaders have not been employed in Áras Attracta in the past and are a new grade of staff to the service. Their appointment has assisted the introduction of the social care model with a number of them having extensive transitional community experience.

#### ► **Key workers**

The key worker policy at Áras Attracta has been updated to include health care assistants and social care workers as well as nurses. Key worker training has been provided to 34% of frontline staff. The three centres in Áras Attracta now have core teams of staff and key workers working directly with residents in place

#### ► **Opening of Lough Conn and River Moy houses – roll out of the social care model**

In November 2015, two houses, namely Lough Conn and River Moy, opened on the campus of Áras Attracta. The proposal to open these houses was explored with a number of individual residents and their families. Currently eight people are successfully living in these two houses (four people

in each). Most would have known each other or lived together at some time in the past and, in some cases, were friends. Previously, all of these residents were living with eight or nine other people, some of whom did not have their own bedroom. Each person in Lough Conn and River Moy is now supported by two teams of staff. Each team consists of health care assistants, social care workers and each house has a social care leader. The importance of positive support, flexibility and teamwork has been emphasised with these teams through the new governance structure and training. Rosters are developed by the social care leader in conjunction with the staff. The roster is flexible and responds to the needs of the people living there. Sleepovers form part of the rosters. Everybody, including the staff, takes part in an everyday normal life situation. Grocery shopping, banking, hairdressing, recycling, cleaning, washing, cooking, and baking are all tasks that take place very successfully as they would in any ordinary home. Weekly house meetings are held with everybody working and living in the houses to identify plans for the week, menus, share good news stories, positive experiences, concerns or complaints. Some residents have their own front door key.

Some individuals are accessing supported employment, training and education opportunities. Everybody is accessing GP and pharmacy services through the medical card system having identified GPs of their choice. Cognisance is being taken of the fact that all of these people lived in an institutional model and are currently in transitions to community living. Already within the current social care houses, the new teams are working creatively and proactively to support progression and integration into the community. They are promoting and fostering reconnections with their families and natural support networks. It is expected that as further discussions take place with each person, and their family, they will, in time, move on to other accommodation of their choosing off campus.

In addition to providing this group of eight people with a service under the social care model on the grounds of Áras Attracta, these new houses clearly demonstrate the model to other residents, family members and staff. It emphasises why the presence of a core team of staff is so essential to the development of the social care model and the importance of the key and link working system. It is planned to further roll out this model in other areas of the service. The number of residents still present in some houses and units will present a challenge to this but as residents transition to community living, the overall number of residents on site will decrease. The roll out of the social care model on site is being overseen by a governance structure that has a very clear vision of the future.

### ► Training

A significant amount of staff training has been provided at Áras Attracta since 2014. Recognising the lack of impact from training provided throughout 2014 in terms of changing the culture and improving the quality of service provided, the focus of training changed following a review in 2015. External support was sought from change management experts, psychologists with experience in managing challenging behaviours, the National Safeguarding Office, Genio and others to improve the training programme at Áras Attracta.

Specific training initiatives to date include:

- Safeguarding:
  - All staff have undergone safeguarding training.
  - The team lead social worker and five managers have completed the Designated Officer safeguarding training.
  - One member of staff has completed the “Train the Trainer” programme and provides training to all staff on safeguarding.
- Key workers: 34% of staff have completed key worker training (no longer just available to nurses).
- Personal Outcome Measures training has been provided to clinical nurse manager 2s and social care leaders. They will roll this out over the coming year throughout the service.
- Safe Administration of Medication training has been provided to non nursing staff. This allows residents greater freedom in social activities where there will be no requirement for nurses to provide medication and it gives us the opportunity to progress the move to a social model of care.
- Studio 3 has been involved in the training of staff to support people in challenging situations, and in providing advice and support to frontline staff. Their approach uses a low key non-confrontational approach to manage behaviours that challenge.
- Social care model: The Centre for Nurses and Midwifery Education, based in Castlebar, has provided introduction to the social care model information sessions (SSDL – Supported Self Directed Living).
- Three staff working in the service have commenced a 15-day social role valorisation programme, provided by Genio nationally. This is well-recognised theory of practice and a validated approach to engaging in person-centred discovery, planning and implementation with people with an intellectual disability. It focuses on normalisation for people with disabilities to live and be recognised as valued members of their communities.

#### ▶ Day services

Day Services provided at Áras Attracta are in transition in line with the policy New Directions (HSE, 2012). Some services are being provided directly to people in their residential accommodation and they are being supported to access the community, use public transport and other mainstream community facilities. In other parts of the service, people are getting more involved in making healthy food choices – for example, participation in “Operation Transformation”, agreeing meal menus, grocery shopping and cooking meals. In addition, they are being assisted with budgeting and money management. Future plans for day services include supporting people to review what they would like to do on a daily basis based on their ability and interests.

### **HSE response to recommendation 3: Strengthening and enhancing the leadership and management.**

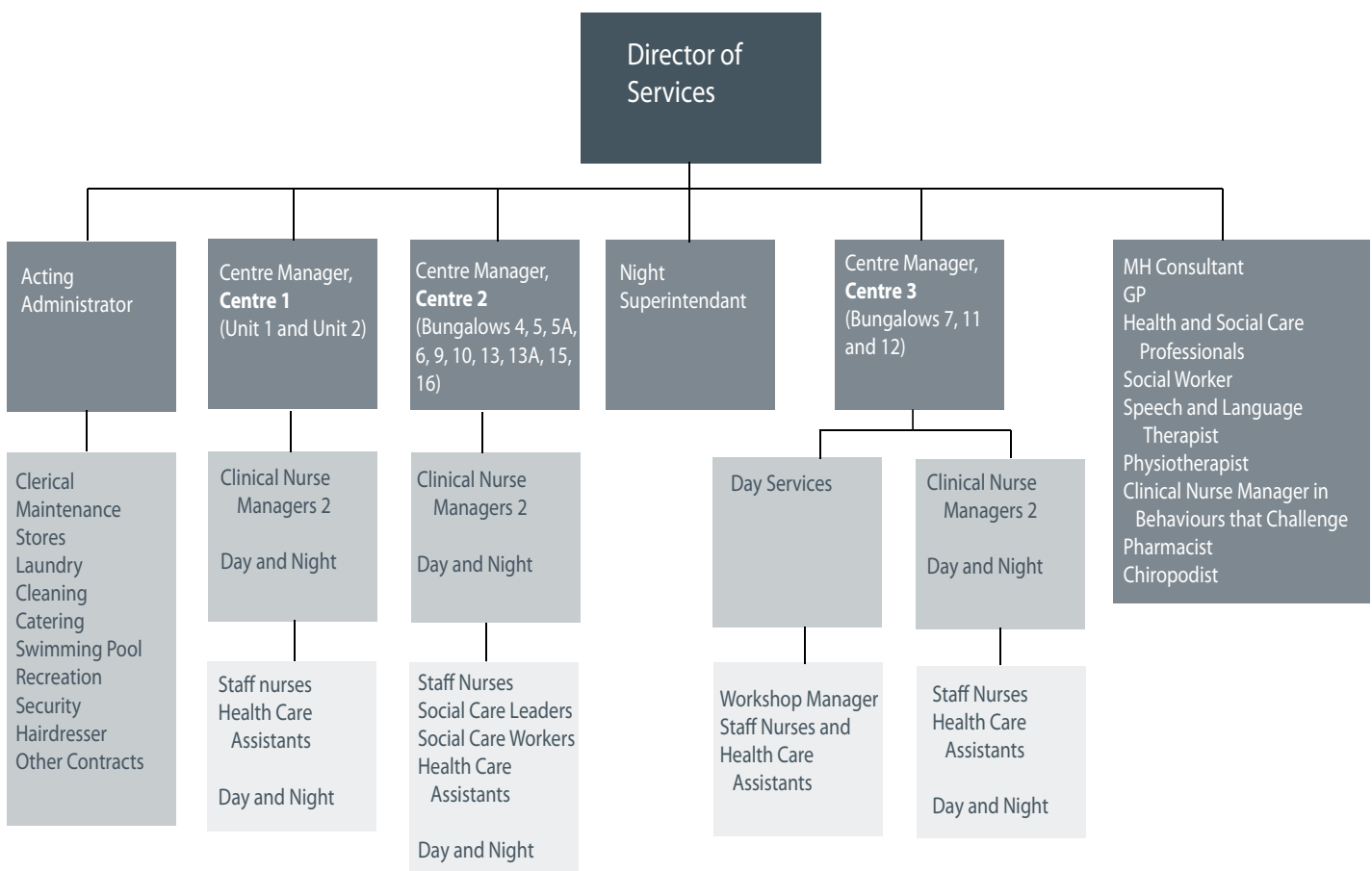
#### **Improvements in leadership and management**

Initiated in July 2015, and completed by November 2015, the first major recommendation emerging from the McCoy Review Group, that the HSE adopted, was the change of governance structures within Áras Attracta.

Prior to July 2015, Áras Attracta was regarded as a single centre and a reorganisation into three designated centres was recommended along with a change in the model of care from a traditional medical model to a rights-based social model of care and support. In line with this, a full-time on-site Director of Services and three centre manager posts were appointed following an external recruitment process to improve leadership and management of day-to-day services. Under the leadership of the new Director, three distinct centres now operate within the campus, headed by a new person in charge responsible in each centre, with one centre each providing:

- services to residents with intellectual disability with complex health needs and high physical dependency
- services to residents with intellectual disability and behaviours that challenge
- support to residents with an intellectual disability and medium levels of dependency

This governance structure brings management closer to the point of service delivery, providing opportunities to concentrate on improving standards of care, and delivering better outcomes for the residents.



**Figure 2:** The new operational management structure at Áras Attracta

► **Management appointments and supports**

In line with the establishment of an integrated CHO for Galway, Mayo and Roscommon (CHO 2), a Chief Officer for the CHO was appointed in September 2015.

The Director of Services for Áras Attracta commenced in April 2015 and took over the role of the provider designate on behalf of the HSE on the 1st of October 2015. Contrary to prior arrangements where the previous Director of Services was based in Áras Attracta only two days per week and also had responsibility for the wider disability sector in Mayo, the Director of Services is now a full-time Áras Attracta appointee, based on site, with no other areas of responsibility. The Director of Services is supported in her role as Provider Nominee by Studio 3 through the current Change Projects monthly meeting. This will expand to include external members to assist in validating the process and to provide a “critical friend approach”. It will include health and social care professionals and nursing staff to ensure the group is fully representative and robust. Audit of practice will form a core element of the agenda.

The appointment of three centre managers/persons in charge has been fundamental to the process of changing the culture. These roles allow for direct management of the three designated centres and strengthen the governance structures within the service. The senior management group of Áras Attracta now consists of the Director of Services and these three centre managers.

As an additional support to the new management structure, the local Centre for Nursing and Midwifery have supported the provision of an experienced team work facilitator for team days. A team day took place for the senior management at Áras Attracta, on the 5th of February 2016, with further team days arranged for each of the 3 centres, attended by the centre managers, clinical nurse manager 2s and two social care leaders. It has been agreed that team days will occur on a three monthly basis. The purpose of the team days is to instil the importance of a functioning team and to ensure clarity about the vision for the future.

### ► Improvements in incident management

A retrospective review of incidents at Áras Attracta by the Director of Services highlighted that enhanced risk management structures needed to be put in place. Since September 2015, incidents are recorded and monitored through the following processes:

- There is a daily analysis of all incidents, overseen by the Director of Services, Centre Manager, Clinical Nurse Specialist for Behaviours that Challenge, and Designated Person to manage the current incident reporting and response mechanism.
- Analysis includes the monitoring, observation and occurrence of several key components relating to all incidents. This data is utilised and monitored to inform progress related to intervention measures such as the Studio 3 training.
- The Director of Services communicates on a daily basis with each of the centre managers, and visits all areas of each centre on an unscheduled basis three times per week.
- The Director of Services has formal weekly meetings with each centre manager to review and manage the immediate priorities for each of the three centres.
- Each centre manager visits all areas of their centre on an unscheduled basis at least daily and has formal monthly meetings with the managers in their

centres. The agenda for the monthly meetings is action based, and reflective of that used at centre managers meetings with the Director of Services.

- The Director of Services meets with Heads of Discipline (representative of all staff groups) on a monthly basis, with a set agenda.
- The Oversight Committee, with external representation as outlined above, meets monthly to review all incidents.

The Head of Quality and Safety for the Social Care Division is committed to supporting Áras Attracta in reviewing and updating their risk register. A workshop for staff at Áras Attracta to support this process has been provided. There is also a commitment to the strengthening of structures and processes around good governance which are a prerequisite to delivering quality and safety outcomes.

► **Policy and audit development**

A number of policies have been reviewed and updated including the Key Worker Policy, the Intimate Care Policy and the Medication Management Policy. Managers in the different centres are currently working with the staff in their area to ensure that all staff are familiar with these changes. The service has adapted an electronic auditing system which covers all aspects of the 32 HIQA Standards. Managers have been trained in the system and have completed audits in their areas.

► **Improvements in complaints management**

Since the introduction of the HIQA Regulations in November 2013 a focus has been placed on the appropriate management of complaints within Áras Attracta. A robust complaints procedure is now in place. A support person is available to the residents to assist their understanding about how to make a complaint. Complaints are now dealt with as per the Service Complaints Policy (reviewed in March 2015).

► **Staff and union engagement**

Staff morale has been impacted on due to the events and reputational damage at Áras Attracta. In addition, the ongoing change process presents a further challenge. Recognising the need to develop local management further and to instil a culture of ongoing learning and continuous quality improvement, Studio 3 have worked with the service to develop Mindfulness programs for staff and employee support has been available as required. Formal support and supervision will commence shortly for all staff. Training in staff supervision will be provided for managers across all grades, with information sessions also planned for all other staff. The managers will then provide support and supervision on a timed interval basis, e.g. monthly or an appropriate timeline and they will in turn be supervised and supported by their managers. This will enhance quality practices at Áras Attracta. In addition, the service has drafted a Code of Conduct for all staff working at Áras Attracta. The purpose of this is to educate all staff in the expectations of the service in relation to their practice and behaviour when supporting those using the service.

In the context of the above, where staff fail to report or do not follow policy and procedure with regard to the delivery of any aspect of safe care and support, the appropriate disciplinary action will be invoked in line with the HSE's Grievance and Disciplinary Procedure.

There is, however, a significant culture of resistance towards the implementation of change amongst some staff. To date, significant progress has been made in changing the culture as evidenced by a change in the skill mix, a more flexible approach to the delivery of care, rosters and hands on training. In collaboration with staff and unions, management will continue to drive forward the programme of change to implement a safer and more positive environment for residents, supported by the Chief Officer and CHO Leadership Team, the National Disability Office, the Six Step Programme of system-wide reform and an on-site full-time HR manager recently appointed to Áras Attracta.

#### ► Voluntary partners and supporting bodies

Significant benefits can be achieved by partnering with other organisations and voluntary sector providers to maximise the opportunities available and to draw on a wider range of skill sets and experience to achieve the best outcomes for each individual. In Mayo, the service is very fortunate to be surrounded by a number of really good examples of recent successful transition to community living and person centred services. The change programme under way at Áras Attracta is based on a planned collaboration with voluntary and other partners including:

- Residents and family members involved in project work streams
- The Western Care Association
- Cheshire Ireland
- Studio 3
- Genio
- Positive Futures

Genio, one of the partners to the Service Reform Fund is providing support, expertise, assistance and advice to the HSE in implementing the change programme at local, regional and national levels by:

- Working with families to build capacity;
- Building capability at service provider and local level;
- Assisting to build capacity, ensure consistency and embed change.

## HSE response to the recommended actions for HSE

In addition to recommended actions specifically for services at Áras Attracta, the McCoy Review Group identified thirteen actions for the HSE to improve the quality of lives of people with intellectual disabilities and to ensure that national policy is fully implemented.

As well as the significant programme of national work listed heretofore, specific relevant actions under way by the HSE include:

### 1. Create, implement and roll out a National Protection Awareness Programme for people with intellectual disability, and include people with intellectual disability in its design.

**HSE response:** In December, 2014 the Social Care Division launched its national safeguarding policy *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*. This policy supports the Social



Care service’s commitment to promoting the welfare of vulnerable adults and safeguarding vulnerable adults from abuse. The policy applies to all statutory and publicly funded non-statutory service providers within Social Care services and builds on and incorporates previous policies used for Social Care services. The policy outlines the importance of a number of key principles in supporting vulnerable adults to maximise their independence and safeguard them from abuse. These include promotion of human rights, a person-centred approach to care, a support for advocacy, respect for confidentiality, empowerment of individuals, and a collaborative ethos. All of these principles are promoted within a positive culture and each service has publicly declared a ‘No Tolerance’ approach to abuse.

The elements required to support this policy are in place, including specialist training for staff, awareness-raising for frontline staff, the development of safeguarding and protection teams in each of the nine CHOs, the creation of safeguarding and protection committees to be put in place in each CHO during 2016, and the establishment of a National Safeguarding Intersectoral Committee with multi-agency representation and an independent chair. Each safeguarding and protection team is led by a Principal Social Worker and supported by social work team leaders and social workers (representing an additional 23 posts recruited in 2015). Every disability service unit/group home and public residential unit for older persons has identified a designated officer assigned to deal with concerns and allegations of abuse. In relation to training for safeguarding and protection:

- 103 people, from both HSE and voluntary services have now attended an intensive 4 day training programme
- 444 people, from both HSE and voluntary services have now attended a 2 day Designated Officer Training Programme
- 1,186 have attended awareness raising programmes for frontline staff
- 1,023, from both HSE and voluntary services, have attended Management Team Overview training
- 69 people have attended a “Train the Trainer” programme in relation to safeguarding.

In 2016, it is planned that 8,000 staff will complete safeguarding and protection training programmes.

A Practice Handbook is being developed by the National Safeguarding Office as a resource and guide for all professionals and services that have a role in safeguarding vulnerable adults. The Handbook will serve as a guide on areas such as best practice in undertaking assessment, risk analysis and safeguarding planning whilst considering key messages from research. A review of the Safeguarding Policy is currently under way, following which this handbook will be finalised and made available.

The National Intersectoral Safeguarding Team and the National Safeguarding Office rolling out the safeguarding programme will, amongst an extensive programme of work through the local safeguarding committees, create, implement and roll out a National Protection Awareness Programme for people with intellectual disability and include people with intellectual disability in its design. It is intended that the programme will be tailored to meet the needs of individuals with disabilities.

## 2. Make certain that structures and accountability mechanisms ensure that national policy is fully implemented at local level.

**HSE response:** There are very significant structures and accountability mechanisms in place to ensure that national policy is fully implemented at local level including:

- I. The service arrangement governance structure which is a contractual agreement between the HSE and providers is signed annually and monitored regularly. There is an Oversight Community in place including representation from the HSE National Disability Office, the Disability Umbrella Organisations and the Compliance Unit of the HSE. At CHO level, the Chief Officer and the Heads of Service for Social Care (to be appointed in 2016 across the 9 CHOs) have in place a governance structure between service providers and the HSE. This includes an extensive schedule on quality and safeguarding issues that is monitored regularly.
- II. The Chief Officer is responsible for the delivery of all Social Care services in line with National Policy. He/she is accountable to the National Director for Social Care as per the performance agreement in place between each Chief Officer and the National Director, in line with the HSE Accountability Framework.
- III. The HSE Quality Improvement Enablement Programme provides significant support to the disability sector to drive improvement in quality standards.
- IV. The sector continues to work with the regulator (HIQA) to achieve compliance with all residential standards. A process is in place to review compliance with HIQA standards and to develop further training and transfer learning to support the sector to achieve improved compliance with the standards.
- V. The Disability Sector adheres to the National Incident Management System and it's obligations to report critical incidents. This ensures that all incidents are reported, fully investigated and learning disseminated throughout the Disability Sector.
- VI. The HSE policy "Your Service Your Say" is in place to outline procedures for dealing with formal complaints in HSE services and through the service arrangement process is outlined as a requirement for the voluntary services which they must comply with. Each Chief Officer has a named senior responsible person who has taken responsibility for Complaints Management on behalf of the Chief Officer.
- VII. The Confidential Recipient is independent of the HSE and has the authority to examine concerns raised to advise and assist individuals on the best course of action to take to raise matters of concern; assist with the referral and examination of concerns; and ensure that these matters are appropriately addressed by the HSE and its funded agencies.
- VIII. The in depth analysis of services conducted by the HSE Service Improvement Team includes a review of compliance with National Policy.
- IX. Services will adhere to national policies such as "*Time to Move on from Congregated Settings*", "*New Directions*" in terms of service provision. These policies are being implemented through the Transforming Lives programme.

- X. Staff who have a concern are facilitated to make a protected disclosure as per the *Protected Disclosure of Information Policy (2014)* or by good faith reporting.

**3. Implement a rolling programme of assessments of individual needs in all congregated settings.**

**HSE response:** The HSE and the Department of Health have been working with the NDA on the introduction of a standard assessment tool for all service users in Disability Services. In the interim, congregated setting services are being supported to undertake assessment of needs using recognised licensed tools and/or to undertake comprehensive discovery work with individuals that can identify an individual’s will and preference and inform future care supports from a “capability” perspective, rather than a “needs-deficit “ perspective.

Under the Transforming Lives Programme a specific assessment tool is also being developed to assess the outcomes and quality of life of people pre- and post transition to community living.

**4. Ring-fence resources to support people to move out of congregated settings, ensuring that the funding follows the individuals, and that personalised budgets are an option.**

**HSE response:** Following publication of the policy “*Time to Move on from Congregated Settings*” the HSE gave a commitment that funding allocated to congregated settings would be ring-fenced for disability residential services to enable individuals to transition to community living.

The Government’s announcement of a significant capital allocation over the next six years (2016-2021) and a Service Reform Fund, the significant part of which is allocated to disability services, is ring-fenced for supporting people to transition to community living. While the approach is fully committed to individualisation and money following those moving out on an individualised basis, this is not to be confused with direct funding which will take some time to achieve for legal and technical reasons. In keeping with policy and the commitment within the HSE National Service Plan and Social Care Operational Plan 2016, there is an emphasis on delivering a person-centred model of support, which does not require individualised budgets to be fully implemented.

Pilot projects are in place in some area to evaluate the feasibility of individualised budgeting. An evaluation of these projects will be undertaken and the learning disseminated to the system.

**5. Accelerate the process of supporting people to move into community living, avoiding transitional arrangements.**

**HSE response:** The assessment and planning approach defined in ‘Transforming Lives’ is committed to supporting people moving from a congregated setting to access a life in the community in line with their wishes and preferences. Using a process of Discovery (working with the individual to get to know the person, their will and preference, their capabilities and interests) and a model of supported self-directed living, services are working with individuals to ensure that as each person

moves into the community, it is in line with their expressed choices. It is fully acknowledged that the Discovery process is an ongoing process, but for many people it will be enhanced once they move into the community and begin to have wider life experiences, which may lead to further changes for each person. It is our preferred wish to avoid transitional arrangements and the HSE is committed to transitioning individuals from large institutional settings into community living. In some instances, additional supports are required through transitional arrangements to prepare the individuals for transition or in instances where customised housing is awaited.

## 6. Place failing services into ‘Special Measures’

**HSE response:** The HSE has shown capacity to provide for ‘special measures’ where services are failing and to expedite improvements as demonstrated to a significant degree in Áras Attracta and a number of other sites nationally. To date, examples of these “special measures” implemented include:

- Support from the HSE Quality Improvement Enablement Programme
- Secondment and/or reassignment of managers with expertise from other services to lead change and provide oversight
- Use of external experts and consultants for specific work – e.g. Studio 3 for behavioural support, AAIDD for SIS-A® assessments, Genio
- Support the development of project teams and provide dedicated project management resources
- Interventional support by the Head of Quality and Patient Safety for the Social Care Division

## 7. In the review of Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures, ensure that guidance is included for the development of local adult protection and welfare procedures.

**HSE response:** The consistent approach defined in the national policy Safeguarding Vulnerable Persons at Risk of Abuse defines procedure nationally for a comprehensive and structured approach. This policy is applicable both nationally and locally, has been implemented nationwide and is used by all HSE and HSE funded services (or in instances where other policies exist, they must comply with the HSE’s national policy). We would therefore not be advocating local procedures other than complete participation in the process designed.

## 8. Develop a mechanism for promoting good practice throughout the intellectual disability sector.

**HSE response:** The HSE has a number of channels for promoting best practice throughout the disability sector. In developing and implementing each of the current policies, service providers and service users and their families have participated and continue to engage in partnership to ensure achieving the best outcome for individuals is maintained as the focal point to drive good practise. The HSE supports a number of initiatives such as the Next Steps Programme,

an innovative development project delivered by members of the Federation of Voluntary Bodies and a number of partnership projects overseen by Pobal and funded through Dormant Accounts Fund that are promoting innovative practice in the areas of Local Area Coordination and mainstreaming of services for people with Disabilities. As well as supporting these projects, the HSE supports the dissemination of learning to ensure that exemplars of good practice are shared.

Nationally, five summits have been held in the last two years that have focused on improving services to deliver safe and good quality supports to people and moving towards a model of person centredness, where the voice of the person is heard.

The HSE, under the *Transforming Lives* programme, has also held a number of national learning events to promote good practice, by providing case studies and guidance from services that have developed services in line with policy and are leading the way in terms of innovative practice. To date, these events have focused on specific areas such as: the delivery of New Directions models of day supports; the reconfiguration or “debundling” of resources to deliver an individualised community based model of supports; and how providers can support people to access housing solutions in the community. To support this work the HSE is developing benchmarking tools, frameworks, toolkits and guidance documents that support providers in assessing their current practise and guide them towards improving practice in line with policy. Support for the implementation of these tools is provided and there is a commitment to a programme of further learning events and targeted workshops based on the identified need from providers.

Specific training for providers to promote good practise in relation to person centred planning is being supported through the System Reform Fund, and delivered by Genio. There is also an ongoing programme of Quality Improvement engagement across the HSE sites with an audit component to identify deficits in practice and a series of targeted and training modules being provided to address these areas.

### **9. Promote voluntary advocacy services and initiatives under the aegis of the National Advocacy Service.**

**HSE response:** Social Care is completely committed to promoting advocacy services and supporting service users to access advocacy services. Social Care is supporting the emergence of an independent voice for persons with a disability through the use of advocacy groups and residents councils. Working with Inclusion Ireland throughout 2015, the Division have been developing the broader advocacy agenda, being comfortable to openly take on board the voice of the service users and their families.

Currently providers are developing advocacy networks, facilitating self advocacy groups, developing family forums and building individual circles of support around each person, all of which are important components to ensuring that meaningful open communication is happening when individuals are being supported to make choices about their futures. The HSE is supporting a number of these initiatives around family forums that are being delivered by Inclusion Ireland.

## **10. Ensure that HSE disability managers engage with people with intellectual disabilities and their representatives.**

**HSE response:** Disability managers engage with service users and their families as appropriate. The first point of contact in most instances for service users and their families may be different members of the local disability team or the service provider, including Case Managers, Therapy Staff, Key Workers, Residential/Respite Staff. Disability managers have close working relationships with service users and their families and are available on an ongoing basis to engage with service users and their families as and when required.

## **11. Develop a bespoke leadership and management programme for all managers of all congregated settings.**

**HSE response:** Leadership was a theme of two of the recent national disability summits. Dr Eddie Molloy, Director of Advanced Organisation, presented at a national summit in 2015 on leading and managing change. In November 2015, a series of workshops were held with senior managers around the country led by international Consultant for Disability Services Mr. John Armstrong, who then presented at the summit on leading and managing change.

The HSE and the umbrella bodies (funded by the HSE) regularly host events to promote leadership enhancement for positive service development regularly enlisting the support of international champions of change.

As part of Service Reform Fund and working in partnership with Atlantic Philanthropies/Genio and the Department of Health, a change management consultant with expertise in the disability reform sector has delivered a programme called 'Endeavouring Excellence' to train disability services staff to lead out on a major change programme.

## **12. Ensure the entitlement of people with disabilities living in designated centres to access all housing supports.**

**HSE response:** There has been ongoing engagement between the HSE, Department of Health, Department of Environment and Local Community Government and the Housing Agency to ensure that people with disabilities are given access to all housing supports in line with the entitlements of all citizens. There is ongoing engagement at national level and through the local Housing and Disability Steering Groups to drive implementation of the National Housing Strategy for People with Disabilities.

The introduction of Housing Circular 45/2015 provides guidance on accessing housing for people transitioning from congregated settings under the Capital Assistance Scheme (CAS) and removes blockage that centres cannot be "designated centres" under HIQA. This has been further supported by the allocation of dedicated funding of €10m in 2016 for people moving from congregated settings.

Under the Transforming Lives Programme a learning event on the various housing options has been held to support congregated settings providers to identify the processes and mechanisms currently available when supporting individuals to move into the community and to provide guidance on working with individuals to establish will and preference in

terms of where they live, who they live with etc., so that accommodation is seen as building a home and not just acquiring a house.

**13. Conduct a review of the foregoing actions, and provide a progress report on the recommendations and deficits in Áras Attracta, to be reported back to the Minister with responsibility for Disability Services within 12 months.**

**HSE response:** The HSE National Service Plan (2016) and the Social Care Divisional Operational Plan (2016) have in place processes to measure compliance against specific targets in relation to safeguarding and quality and also progress in line with national policies within the disability sector. The National Director of Social Care obtains regular progress reports from the Chief Officer of CHO 2 in relation to progress at Áras Attracta against agreed actions. These reports will form the basis of a report and updates to the Minister with responsibility for disability services.

## HSE response to the recommended actions for congregated settings

A recommended action plan, with seven actions directed to all congregated settings, is outlined in the McCoy report. This identifies the steps that need to be taken to support a rights-based social model of service delivery and a move away from life in congregated settings.

The HSE is committed to these actions as follows:

**1. In line with national policy, everyone living in a congregated setting will be given the opportunity to live in the community.**

**HSE response:** HSE and the Social Care Division are fully committed to the national policy that everyone living in a congregated setting will be given the opportunity to live in the community. This is qualified for individuals with disabilities who are living much longer and where age appropriate group living is a norm in our society. This is further qualified by choice and best interest for those in later life.

**2. Transitional monies will be provided to enable this to happen. Transitional monies are additional funding for a 12–18-month period to cover the additional costs of transition.**

**HSE response:** The HSE Social Care and Mental Health Divisions in partnership with Genio, Atlantic Philanthropies and the Department of Health, have developed the Service Reform Fund (SRF) for three years with 4 key priorities:

- 1) Transition to person-centred models of services and supports
- 2) developing capability
- 3) research and evaluation, and
- 4) developing an advocacy framework.

In 2016 the SRF is specifically targeted at supporting services to transition models of service in keeping with reform policy and current innovative practice. The process of allocating these resources at targeted projects is

currently under way and there is a robust oversight and implementation mechanism in place to ensure that resources are used effectively to bring about real and meaningful transformation in people's lives and that these changes will be sustainable within baseline resource allocations in the long term.

**3. The move to a community setting will be individually planned, using an extensive person centred planning (PCP) process, based on the person's will and preference, and in partnership with their family.**

**HSE response:** In line with the "*Time to Move on from Congregated Settings*" policy, each person transitioning from a large residential setting into the community is supported to do so through a structured process that ensures the persons' will and preference is determined and that decisions are made with them and in partnership with their family and/or advocate as appropriate. The Community Living Transition planning toolkit has been developed to guide providers in this process and ensure that there is meaningful and comprehensive engagement with the person and their family or advocate. Detailed project action plans have been developed by providers and targets set for the number of individuals to transition from large institutional settings in 2016 (as outlined in the Social Care Operational Plan). These project action plans include a clear communication process that identifies all the key stakeholders and draws attention to the need for tailored messages that are delivered in a timely and appropriate manner, whilst ensuring that the voice of the person remains central.

**4. The supports that each person needs to live successfully in the community will be carefully assessed using the Supports Intensity Scale (SIS-A®) or similar assessment tool. This then is the level of support that will be provided on an ongoing basis to each person.**

**HSE response:** Work is currently ongoing across the priority settings identified for accelerated implementation of the "*Time to Move on from Congregated settings*" policy to ensure that the support needs of each person are assessed using a structured and validated assessment tool where necessary and that a process of Discovery is commenced with each person that takes a capacity- based approach (as outlined earlier under recommended actions for the HSE). The use of structured and validated assessment tools across many services is being implemented to effectively guide service providers on the appropriate configuration of supports for people moving into the community. In practice, the tools are not prescriptive in terms of the exact supports required, but they do provide validated information that can be used to inform support structures. As outlined earlier under recommendations for the HSE, the development of a national assessment of needs tool across all disability services is currently being progressed. Once implemented this will provide a robust and consistent mechanism nationally for the allocation of resources to support individuals.

**5. The transition to community living will be completed over a five-year period. In year one, 15 per cent will move to a community setting; in year two, a further 20 per cent will move to community settings. Further targets will be set for the remaining three years in the light of that experience.**



**HSE response:** The HSE is committed to the completion of the transition to community living over a five-year period. It remains our ambition that in year one, 165 people will move to community settings and this will be built upon on an annual basis over the next five years and further targets will be set for the remaining years. These targets will need to take cognisance of the support needs of those still residing in congregated settings, many of whom will have complex medical and age-related care needs that will have transitional and ongoing planning and resourcing implications.

**6. The HSE or voluntary body will determine appropriate alternative use for the campus as the site is vacated. Where land or property is sold, the monies realised will assist with transitional costs.**

**HSE response:** The HSE or voluntary body will determine appropriate alternative uses for vacated congregated settings as they become available. Where land or property is sold, it is intended that the monies realised will be reinvested in the capital programme which supports the move to the community and/or assist with transitional costs. This will be a challenge in some instances as alternative uses for some of these buildings are limited and in some instances the properties are not at the disposal of the HSE.

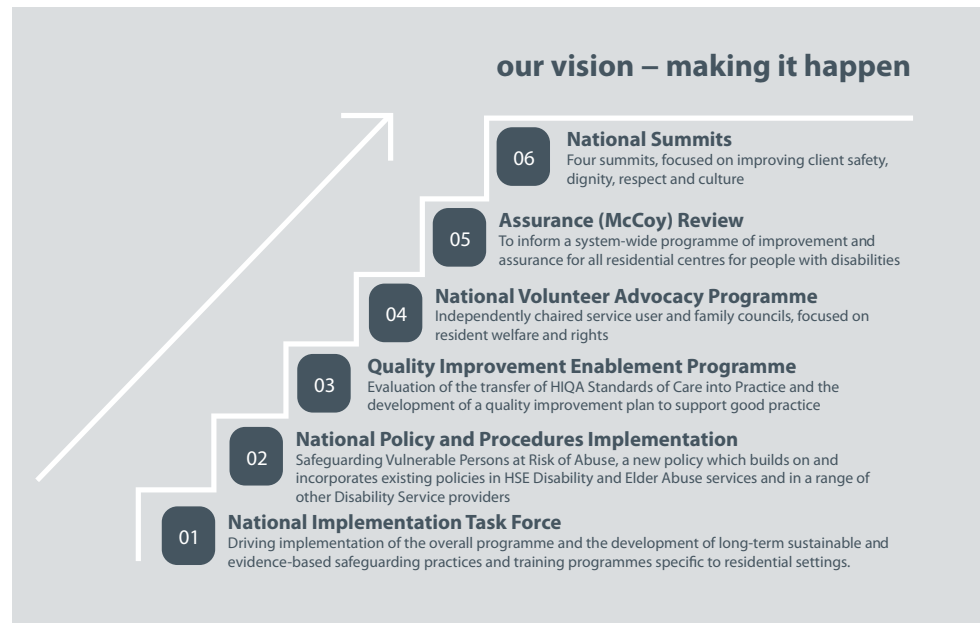
**7. All staff currently employed will continue to work for the service provider; staff who do not wish to work in the new community settings will be offered employment in other facilities and services.**

**HSE response:** In line with public sector pay agreements, all staff currently employed will continue to work for the service; staff who do not wish to work in the new community settings will be offered employment in other facilities or alternative arrangements made.

## Overview of wider disability reform

▶ **The Six Step Change Programme**

In tandem with the work of the McCoy Review Group, a six step system wide programme of measures to enhance quality improvement in disability services was established in December 2014. Led by the National Task Force, the purpose of the six steps is to give direction to local plans and local action, and to ensure quality and safety of all services through empowering and safeguarding vulnerable people. To date, the Six Step Programme has had a significant focus on improving the safety, welfare and quality of life for persons with a disability. Key components of the Six Step Programme are as follows:



**Figure 3:** Six Step Programme for disability services reform

Further details of the Six Step Programme are outlined below, but key highlights to date include:

- Launch of the national safeguarding policy (Dec. 2014) with 103 people now having completed intensive training, 444 completed Designated Officer Training, 1,186 completed awareness raising programmes, 1,023 attended management team overview training and 69 have attended a “Train the Trainer” programme
- The Quality Improvement Enablement Team have now visited all 148 HSE houses/units comprised of 1,054 HIQA registered beds
- Collaboration with Inclusion Ireland to develop advocacy services and family fora/residents councils
- Hundreds of delegates have attended the series of conferences or summits held to capture feedback and provide opportunities for the transfer of learning and to hear of progress on the implementation of the Six Step Programme.

### 1. The National Implementation Task Force

The National Implementation Task Force was established in December 2014 to drive the implementation of the programme for change in disability services and the development of long term sustainable and evidence based safeguarding practices and training programmes specific to residential settings. Taskforce members include senior managers charged with the delivery of disability services nationally, and other senior officials for example An Garda Síochána, advocacy and service user representatives, and representatives from the quality improvement and safeguarding offices. The Task Force is chaired by the National Director of Social Care. A key challenge for the Task Force is to identify how we can build capacity together so that our organisations can respond to what each individual person wants and needs to live the life of his/her choosing.

The work of the Task Force in 2015 was to effect change through the Six Step Programme. This was achieved by focusing on the different components necessary to deliver a value based approach, therefore ensuring that service delivery was person centred. The work in 2015 included capturing

the learning to date from the Áras Attracta review process, the continuous implementation of safeguarding processes and structures, the development of the broader advocacy agenda including the work being carried out in conjunction with Inclusion Ireland, and being comfortable to openly take on board the voice of the service users and their families.

In 2016, the Task Force, through the reform programme, is focusing on changing the culture within disability services and to collectively transfer the vision into a real response and to implement change in a sustainable way to support people to live more independent and ordinary lives. In this way, service user's needs will be met and their choices are listened to.

## 2. National policy and procedures implementation

In addition to detail of the roll out of the national safeguarding policy and development of Safeguarding and Protection Teams at CHO level, a *National Intersectoral Safeguarding Committee* has been established, chaired by Ms Patricia Rickard Clarke – Former Law Reform Commissioner with involvement of the HSE National Lead for Disabilities, National Lead for Older Persons and National Safeguarding Lead. The committee has representation from a number of organisations, both within and external to the HSE, and will give strategic direction on developments to promote the protection of vulnerable adults. A sub group of this intersectoral committee has been established to examine and propose a public awareness campaign for vulnerable adults.

A Safeguarding Reference Group has been established incorporating the HSE, the National Federation of Voluntary Bodies, the Disability Federation of Ireland and the Not-For-Profit Business Association. This Joint Reference Group will support the ongoing implementation of the National Safeguarding policy. The Reference Group has met on three occasions in 2015 and is currently carrying out a checklist audit on implementation of the national policy within HSE funded agencies.

## 3. The Quality Improvement Enablement Programme

A joint initiative was launched between the HSE's Social Care and Quality Improvement Divisions in 2015 to support care improvements in residential services for adults with disabilities. The team have now visited the majority of the 148 houses/units provided by the statutory sector comprised of 1,054 HIQA registered beds throughout the country, and will continue to work with each house/unit in 2016 to improve the quality of disability residential services under these following six key drivers for quality improvement:

- Leading for improvement
- Being person-centred
- Supporting staff to improve
- The delivery of safe, effective, best value care
- Measuring and learning for improvement
- Governing for quality and safety.

A key focus of this Quality Improvement Enablement Programme is to transfer learning in relation to disability residential centres between centres. In so doing, the interdisciplinary quality improvement team will work with service providers on specific areas identified for

improvement including governance, leadership, risk management/risk assessment, policies, procedures, protocols and guidelines, key working and supervision. The Project Team is developing a toolbox to support quality and service improvements, sourcing and assessing models of good practice in areas including: leadership and governance structures to support quality; samples of relevant person-centred documentation; resources for engaging with staff and service users; and guidance on HIQA self-assessment. In particular, the team are working closely with disability residential services which have been identified as priority for quality improvement and where the policy of transition to community living is being accelerated, including Áras Attracta. The work of the McCoy Review Group has provided valuable insight and learning which is transferable to other disability residential services and the Quality Improvement Enablement Programme will provide a mechanism to transfer this learning.

#### **4. The National Volunteer Advocacy Programme**

Social Care services have a particular requirement to develop a culture of openness, transparency and accountability. As part of the Six Steps Programme, working with families and service users, a national Volunteer Advocacy Programme in adult disability residential settings was initiated in 2014, and further developed in 2015 and 2016. To date, a mapping exercise was undertaken to determine existing structures, supports, frameworks, and pathways regarding advocacy for people with disabilities in Ireland. The HSE National Advocacy Department put together a proposal document with a suite of 18 recommendations for future development. The group has been asked to review the document to narrow down the recommendations and also consider the broader issues regarding implementation. To progress the residents council/family fora the HSE asked Inclusion Ireland to develop and support the emergence of an independent voice for persons with a disability and family members who access disability services in a number of residential settings. To deliver on this Inclusion Ireland funded by Social Care are developing Family Fora in a number of these centres. The design, terms of reference, and approach will be determined through local consultation and tailor-made to local need.

Work is underway by Inclusion Ireland to develop self advocacy within the disability sector. Sage has been requested to develop and pilot a volunteer advocacy service for people with disabilities. The National Disability Office has representation on the National Advisory Group for the National Advocacy service (NAS) for people with disabilities and the Citizen Information Board (CIB). NAS and CIB are being advised with regard to the provision of the national advocacy service for people with disabilities in line with CIB legislative requirements and disability policy as set out in the National Disability Strategy.

#### **5. Assurance (McCoy) Review**

A key component of the Six Step Programme is the McCoy Assurance Review, the output of which is contained in this report.

#### **6. National summits**

A series of national summits were held in April, July and November 2015. Building on a December 2014 summit, they were attended by the

Minister with responsibility for Mental Health, Primary Care and Social Care (Disabilities and Older People) Kathleen Lynch and several hundred delegates from statutory and voluntary service providers, service users and family members. The summits provide a forum for people to give feedback as well as hear of progress on the Six Step Programme with themes including:

- Safety, dignity, respect and culture change
- Embedding values in the workplace
- Engaging people to achieve good lives. Essential features of effective and enriching services
- Leadership and change management
- Leadership and cultural change

The November summit provided an opportunity to reflect on service improvement within the service throughout 2015 using what we have learned to make real and tangible changes in the lives of people with a disability. The National summits have provided an important forum to share this learning and most importantly to listen to the voices of people with a disability so that we are focused on their needs and their aspirations for a better life. Another summit is planned for 2016.

The McCoy Review Group provided ongoing progress reports for the National Summits from the group’s engagement with residents, family members, staff and management at Áras Attracta and with the wider disability sector.

► **Appointment of the Confidential Recipient**

In 2015, the Director General of the HSE appointed Leigh Gath, a well known disability advocate as a Confidential Recipient, to whom anyone can make a complaint or raise concerns about the care and treatment of any vulnerable person receiving residential care in HSE or HSE funded residential centres.

The Confidential Recipient is independent of the HSE and has the authority to:

- Advise and assist individuals on the best course of action to take to raise matters of concern
- Assist with the referral and examination of concerns
- Ensure that these matters are appropriately addressed by the HSE and its funded agencies

The Confidential Recipient upon receiving a concern examines the concern and decides whether her office can assist, i.e. whether the concern is related to abuse of vulnerable adult residents of facilities funded or partially funded by the HSE. Where a concern warrants further investigation, the Office of the Confidential Recipient does not investigate complaints, but determines the type of examination required and directs the concern to the appropriate HSE National Director for further action. A report outlining the concern, including any evidence, is prepared by the Confidential Recipient and is referred formally and

in writing to the nominated manager in the office of the appropriate National Director. If requested, the identity of the person who brought the concern may be withheld by the Confidential Recipient. If the Confidential Recipient is of the opinion that the concern is best pursued using another mechanism such as Good Faith Reporting; Protected Disclosure or the HSE Complaints System then the person who referred the concern will be advised of this.

In all cases a concern is not closed until the Confidential Recipient is satisfied that all issues raised have been investigated thoroughly and addressed appropriately.

#### ► **Quality and safety in disability services**

The Head of Quality and Patient Safety (QPS) for the Social Care Division was appointed in late 2014, and a Social Care Division Quality and Safety Committee was established. The office monitors emerging themes from HIQA inspection reports and these are reviewed on a regular basis by the Social Care Management Team, the Social Care Risk Committee and used to review areas of compliance/non-compliance in the monthly performance engagements with the Chief Officer of each CHO. In addition, a bimonthly information sharing forum has been established between the HSE and HIQA.

In line with the Quality Improvement Enablement Programme (QIEP), the Division is ensuring that all providers are working towards improved compliance in 2016. Non-compliance issues are prioritised for support in terms of training, policy development, and support from the Head of QPS for Social Care, and the QIEP. The Head of QPS now visits Áras Attracta regularly to support and guide the development of local QPS structures. Recognising the significant costs involved in improving compliance, significant additional funding has been allocated to the HSE in 2016 for disability residential services.

In relation to Serious Incident Management, all reported Serious Reportable Events and Serious Incidents are reviewed by the Quality and Safety team on a monthly basis. Supported by the Incident Information Management System (IIMS) reports are made available to each CHO, the Social Care Management Team and the Social Care Quality and Safety Committee on Serious Incidents.

Throughout 2016, Quality and Safety Committees and structures will be enhanced and each of the nine CHOs will have a Head of Social Care services appointed. These will provide further accountability and assurance of the quality and safety of disability services provided.

#### ► **Work of the service improvement team for disability service**

A Service Improvement Team was established in 2014 to work with the Disability Sector to review services and support service improvement. This is done by assessing funding provided against activity, outputs, costs, quality and outcomes using existing information and research, working collaboratively and inclusively with the agencies and CHO areas. Performance effectiveness is measured not just in funding or quantum

of service but in quality as well. The aim is to support the delivery of high quality services by sharing best practice service delivery models and by maximising efficiencies and effectiveness within the sector. This leads to enhanced capacity to meet new emerging need, increased need associated with an aging population, meet requirements around quality and safeguarding, and to move to new policy appropriate models of service.

Applying this approach, the service improvement team completed a review of the largest fourteen organisations in the country in 2015 representing circa 50% of the disability budget and are working with the next 45 organisations in 2016 totalling 80% of the available funding.

Specifically on compliance with regulation, the Service Improvement Team review outcomes of HIQA inspections for each service, along with review of standardised systems of accreditation and performance to date, identifying appropriate service improvement initiatives with each organisation and more generic improvements across the Social Care system. On safeguarding, the Service Improvement Team looked at structures in place, appointment of designated officers and incident monitoring and management, reporting compliance, etc. This was triangulated between the agency, the CHO structure and the national quality and safeguarding offices.

**Options available to staff with concerns to raise**

HSE staff with concerns have a number of options available to them including reporting in line with the HSE’s Safety Incident Management Policy (2014); by protected disclosure as per the *Protected Disclosure of Information Policy* (2014); or by good faith reporting. The principles of the *Open Disclosure Policy* (2013) should be part of normal practice and support the function of the Safety Incident Management Team in the context of managing serious incidents and communicating with service users and their families.

## Conclusion

Once again, the HSE would like to thank Dr McCoy and the Review Group members for completing such a comprehensive assurance review. Recommendations and actions in the McCoy report will further inform the system wide programme of improvement and assurance for all residential centres for people with intellectual disabilities which has commenced already. The learning from the McCoy review can be translated into a model of support that enables and supports meaningful lives as chosen by residents, within the resources available, in line with national policies and in an achievable timeframe. It gives us an opportunity to create an innovative model of integrated community support networks that promotes dignity, respect, empowerment, choice and autonomy for the most vulnerable people in our society.

The future plans for the transition of Áras Attracta from institutional to community living will require strong, proactive team work, ongoing communication of the clear vision to all stakeholders about the way forward, a respect for the will and preference of the people currently using the service, and the trust and support of families. This vision is set out in

the *Roadmap*, built around the results of the individual needs assessments of those living at Áras Attracta today, and in line with national policies including *Time to Move on from Congregated Settings* (2011) and *New Directions* (2012). Many other services have developed excellent community based service locally and Áras Attracta looks forward to doing the same.





## Colouring my choice

I ask to choose to have the choice  
to paint with colours of my own voice,  
the turquoise sun I have selected,  
striped stars and spotted plants respected.  
The speed I paint – do not demand  
but with encouraged growth let my palette expand.  
Given the power to hold the brush  
so I may paint my own potential,  
my passion never told to hush,  
my picture exponential.

Unique by design, equal in each degree,  
I ask you not to talk about, but to talk instead with me.  
Dignity deserved, preserve my independence and advocate  
that I may have the right to choose the colours with which I paint.

*Brigid O'Dea*