

**Health Information and Quality Authority
Regulation Directorate**

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



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|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Centre name: | A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd. |
| Centre ID: | ORG-0011625 |
| Centre county: | Dublin 15 |
| Email address: | james.kelly@docservice.ie |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | Daughters of Charity Disability Support Services Ltd. |
| Provider Nominee: | Mary O'Toole |
| Person in charge: | James Kelly |
| Lead inspector: | Michael Keating |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 16 |
| Number of vacancies on the date of inspection: | 0 |

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 25 June 2014 10:00 To: 25 June 2014 18:30

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

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|----------------------------------------------------------------------------|
| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| Outcome 10. General Welfare and Development |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for registration by the provider. The inspection took place over one day and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The nominated person on behalf of the

provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.

A number of relatives' questionnaires were received by the Authority prior to and during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, relatives were very complimentary on the manner in which staff delivered care to their relative commenting on how co-operative staff were with families and how communication with family was constantly maintained.

Overall, while evidence of good practice was found across all outcomes a major non compliance was identified within Outcome 1; specifically in relation to the practice of staff checking on residents every half hour throughout the night. This practice was not assessed as being necessary and was deemed to be impinging upon the privacy and rights of residents. Eight outcomes were deemed to be moderately non compliant including the areas of communication supports for residents, community access, social care needs, suitability of the premises and staff supports. Nine outcomes were found to be in full compliance with the Regulations. These outcomes included the areas of health and safety, governance and management and contracts of care.

On the day of inspection the inspector found that the issues raised during a previous inspection by the Authority in March 2014 in relation to the suitability of the premises to meet the needs of residents remained unchanged. However, the provider gave verbal assurances regarding the complete redesign and development of the centre. The plans were discussed in detail with the inspector during the course of the inspection, and it was confirmed that the work would begin in mid September 2014.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspector found that the provider had not taken adequate steps to ensure residents' rights, dignity and consultation were upheld. There were also improvements required in the management of residents' finances.

While in general, there was a commitment by the provider, person in charge and staff to promoting the rights of residents, night time supervision practises were impinging on the privacy and dignity of all residents. Residents' were being checked on every 30 minutes during the night without any assessment of need in this regard. A body of evidence was actually in place to suggest that this practice was not required within all of the personal plans reviewed by the inspector. For example sleep charts had been used to identify individual sleeping patterns and the inspector reviewed six months of these charts. The charts reviewed indicated that residents were sleeping uninterrupted for on average eight hours per night. Staff spoken to who had worked nights regularly, could not identify the last time there were needed by residents during the night. The person in charge when spoken to agreed that this was not required for all residents, and also identified specific bungalows within the centre whose residence he felt did not require this level of supervision.

The organisations chief accountant had developed and reviewed policies to provide guidance to the provider, person in charge and staff on the care of residents' property and finances, as required by the Regulations. Two policies the Patients Private Property Account Policy (PPPA) and the long Stay Charges Policy had been reviewed during May 2014 and recently reissued to guide practise in the area of financial management.

The person in charge was also provided with a monthly balance of all residents' finances, providing information on the amount they had in savings and expenditure over the previous month. Staff were aware of residents finances and tried to keep residents informed in relation to how their income was spent. Residents finance records also identified how much they were paying for their long stay charges.

However, the policies referred to did not provide sufficient protection of residents' finances, and there was a lack of transparency in relation to the use of residents' monies. Residents paid a weekly amount from their disability allowance to the everyday costs of running the service. The weekly amount was set out within the long stay charges policy and was also referred to within the individuals' contracts of care. The remainder was used as 'disposable income' to fund their activities and meet additional day to day expenses.

In addition, residents were contributing a fixed sum per month as 'accessories money'

which was used to pay for household items such as kettles, toasters, televisions and curtains. These examples were provided by the person in charge. This 'accessories payment' was recorded within the individuals' personal records and if not needed for household expenditure would be used by the resident. There was also a policy in place to guide all staff and persons in charge in relation to this practice called the 'procedure for managing service users' monies (10th June 2013). This policy instructed staff to request a specified sum per resident each month and that the 'accessories requisition sheet should be used for any items required for each house e.g. household items, small items of equipment, accessories, bed clothes, general items etc'. The information contained in this policy directly contradicted the guidance within the PPPA Policy which stated that the long stay charge provided for a certain standard of basic equipment, furnishings or personal supports.

In addition to weekly charges already outlined, residents' were also expected to meet staff costs such as meals out while on outings. This was not clearly stated in the contract of care. Some guidance was provided in relation to the suggested costs of coffee or dinner out within Policy, suggesting 'local discretion must play a significant role in determining what is reasonable'. This guidance was quite vague leaving residents prone to varied interpretation of the guidelines. Also, when residents went on holiday trips, staff costs (excluding payroll costs) were charged to residents. Residents or their representatives were not clearly informed of this, or the amounts being included to cover such staff costs.

The provider showed the inspector a copy of a proposal she has worked on with the organisations chief account to try and address some of these already identified issues. This proposal was provided in writing and committed to updating policies to reflect greater transparency in the area of charges to residents in all areas identified within this report. There was also an intention to complete capacity assessments with all residents, to involve them more in financial affairs and try to open personal bank accounts. The inspector judged that implementation of this proposal would significantly improve the system of financial management of resident's monies and provide greater transparency.

A complaints policy was available, with an easy to read version available to residents. A staff member had recently been identified as the complaints officer. No complaints had been recorded at the time of inspection.

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Overall residents were supported to communicate by staff who were well aware of the different communication needs of residents. Residents also had access to a speech and language therapist as required. However, there was limited effort to provide effective and supportive interventions to residents to ensure their communication needs were met. For example, residents' personal plans were only available in typed format and the residents were unable to read.

The inspector reviewed a care plan with one resident who repeatedly told the inspector she 'did not know what was in there as I can't read'. However she was very interested in the information read to her from the folder by the inspector. A communication profile outlining their communication support requirements was in each residents file. One of the profiles read by the inspector identified the need to have an album of photographs showing daily activity to support choice and decision making. However, this associated 'communication action plan' identified that this would be completed by November 2011. This was not completed, as there was no information available as to why it was not done.

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Residents were supported and encouraged to maintain personal relationships with their family members with families actively encouraged to be involved in the lives of resident's. Feedback provided to the inspector from relatives was extremely positive in relation to efforts staff made to include families in the lives of residents both formally through their involvement in the planning process or in issues related to healthcare and informally through on-going phone calls and through visits. There were rarely any restrictions placed upon visits and any such restriction was only imposed if the timing of the visit was deemed to pose a risk. A discreet 'traffic light' signage system operated on the front door of one of the bungalows. A red sign encouraged visitors to call back later if it was posted on the door. Staff reported that it was about two months since the red sign had been used.

Residents were not being supported to develop and maintain links with the wider community. Residents' were highly reliant on organisational supports and activities provided within the campus. The inspector reviewed a log to record 'outside activity' which had been developed since the previous inspection and noted there was disparity in the opportunities for all residents' to access the wider community. One resident had been 'out' 21 times in the previous 2 weeks while others had only been out once. Those who had been outside much less frequently had higher support needs, but still had their wish to be involved in community activities more frequently identified as a goal within their care plans.

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

An admissions and transfer policy which set out the arrangements for admitting new residents and/or transferring residents to other parts of the service had been developed locally by the person in charge in consultation with the provider and was in accordance with the admissions criteria as set out within the statement of purpose.

Residents had all been provided with a 'contract for residential services' as required in the Regulations. This agreement sets out the services provided; however, it also had a addendum which outlined information in relation to the weekly long stay charges and identified the income that remained from their social welfare payment.

Outcome 05: Social Care Needs

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

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Overall it was judged residents' wellbeing and welfare was being maintained by a good standard of care and support. However, there were limited opportunities for residents to engage in meaningful activity and personal plans identify one off activities as personal goals and were not outcome focused.

Each resident had a personal plan and the inspector reviewed seven of these plans. One plan was reviewed with a resident while three others were reviewed with staff. There was evidence that residents had been involved in their plans. However, improvement was required to ensure that goals identified considered how they would impact upon the lives of residents. Goals read by the inspector were either task orientated or everyday activities which everyone should expect to have within their lives. For examples, goals identified included shopping once a month, meal 'out' once a month, swimming once a week, talking to a relative once a week on the phone and a holiday. These goals were described as 'residents' dreams and wishes for the year ahead' within their care plans. There was no evidence of outcomes to promote independence, living skills or personal development. In addition there was no record if these goals had been achieved or how often residents' had availed of them.

The person in charge was aware of these non compliances. He had written a letter to the provider two months previously which was read by the inspector. This highlighted that due to reduced staffing, residents were not able to be provided with the social supports as identified above and that staff were only able to meet the basic needs of residents. This staffing shortage had only been addressed in the days prior to inspection, with two staff nurses having commenced employment. The inspector formed a view that while this may help to address to lack of opportunity for residents to engage in meaningful activity, evidence on inspection demonstrated that staff required guidance and training in the person centred planning process.

Residents were observed on the day of inspection participating in campus and community based activities including swimming, music therapy trips to the day activation unit. One lady also had her own multi-sensory room, with dimmed lighting and plenty of personal space which she required. Many residents had also availed of recent holidays to different parts of the country which was recorded as a big success for all concerned.

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The centre consists of three separate single story bungalows providing full time residential care and distinct models of service to groups of residents.

Each of the bungalows was similar in design and layout, with some specific distinctions to meet individual support requirements of residents. For example, one lady has her own quiet room, which was adapted from a bedroom for her use. Numbers of residents in each house varied in order to meet the assessed needs of distinct groups within each bungalow. One bungalow is home to four residents' and there were six residents living in each of the other bungalows. There was one twin room in each of the bungalows, with the rest of the residents accommodated in single rooms. Many issues in relation to the suitability of the premises and relating to the fact that they were built and designed more than 30 years ago were raised during the previous inspection by the Authority in March 2014. Some improvement was identified in relation to the overall aesthetics of the premises, including some areas freshly painted areas, soft furnishings and new curtains which have added an element of comfort to the premises.

During this inspection the inspector met with the head of buildings and maintenance to review the plans for the complete renovation of the centre. Architect drawings had been submitted to the relevant authorities seeking the fire safety certificate as well as the disability access certificate. During this meeting it was confirmed that the development would commence in September 2014, upgrading one bungalow at a time in order to minimise the impact upon residents. It is planned the three bungalows would be completed within roughly 18 weeks. Residents were consulted on the design and had made many requests during the design phase. For example, residents' had requested a automated front entrance to each of the bungalows which has been factored into the design.

All of the non compliance identified within the previous report were catered for within this design. The design had considered the ageing profile of residents and considered

potential future requirements. For example, ceiling track hoists will be provided and assistive technologies including photo-cell activation of lighting and internet accessibility will be provided to meet the requirements of residents.

The inspector judged that upon completion of this project, the residents will be provided with a safe and comfortable environment, purpose built to meet their specific requirements.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

Overall it was found that the health and safety of residents, visitors and staff was promoted and protected. There were arrangements in place to manage risk and adequate precautions against the risk of fire.

There was a health and safety statement in place which had recently been reviewed and updated by the provider. There was also a detailed risk management policy and associated risk register identifying environmental and individual risk for residents. Individual risk assessments were also being used to promote the independence of residents and allow them pursue activities of choice such as leaving the centre unaccompanied by staff, assisting with cooking and in areas of personal care.

Accidents, incidents and near misses were being recorded in detail and copies of the reports were submitted to the organisation quality and safety officer for review as well as to the organisation's health and safety committee. A member of staff had recently been nominated health and safety officer in the centre and had begun the process of using a health and safety incident measurement tool to allow her complete monthly audits which were then presented to the health and safety committee. There was also an emergency plan in place to guide staff in the event of such emergencies as power outages or flooding.

Records reviewed by the inspector indicated that fire safety training had been provided to all staff since the last inspection in March 2014. In addition, further fire prevention and safety measures had been implemented such as putting fire doors in place, installing emergency lighting and signage and identifying a more suitable assembly point outside the premises.

There were regular fire drills and both staff and residents were able to tell the inspector about what they would do if the fire alarm went off. The records of the fire drills were detailed and included learning outcomes. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergency lighting. Fire evacuation plans were posted clearly at all main exits.

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Generally, there were arrangements in place to safeguard residents and protect them from the risk of abuse. There was a policy in place which had been reviewed and updated in May 2014 which provided guidance to staff on how to manage and report any concerns in relation to the protection of vulnerable adults. Staff spoken with were competent in their knowledge regarding reporting mechanisms within the centre and in how they would deal with any incidence of abuse. However, not all staff had completed training in the area of adult protection. Training records indicated that five staff were due to complete this training during July and August 2014 however, for other staff who have not had training as far back as 2003 there was no plan in place to provide revised and updated training for this group. This non compliance is actioned under Outcome 17: Workforce.

The residents appeared to be very comfortable and relaxed in the company of staff and residents who could communicate verbally expressed they felt safe and well cared for.

A restraint free environment was promoted within the centre. Any possible restrictions had been recorded and risk assessed and the use of any interventions to reduce likelihood of injury to any resident had been reviewed and reduced. For example, one of the bungalows had padding on many of the walls to minimise the impact of self-injurious behaviour. While documentation reflecting a need for this previously, this padding had been removed from most areas within the house, including the communal areas, as it was no longer required. Recorded restrictions included the use of bed rails and lap belts. Bed rails were used for one lady and this practice had been subjected to rigorous review

in recent months. This included the referral of the practice to a multidisciplinary support team. The resident concerned represented herself at this review and requested that she kept her bed rails to enable her to move herself around the bed.

Positive behaviour support plans were in place for those who required it. These plans used a traffic light system to indicate the supports required for residents. 'Red' identifies a crisis situation with interventions used such as pro re nata (PRN) or as required medication. However, upon review of care plans and medication administration sheets for two residents there was no record of PRN medication being used since 2011. These care plans also provided progress reports as well as review by a psychologist every three months. These records indicated that staff had considered removing the need for chemical restraint completely from the support plans, but this was considered unwise by the psychologist. There was no record of physical restraint within any care plans and the person in charge confirmed that this was not used.

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The staff were maintaining detailed records of all accidents and incidents in the centre. These were reviewed by the person in charge and health and safety committee. All incidents had also been submitted to the Authority as required by the Regulations. Quarterly reports had also been submitted as requested and copies of all notifications were maintained within the centre.

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Limited evidence that residents had opportunities for new experiences and social participation was available. Limited community access has already been detailed as a feature of Outcomes 3 and 5 within this report.

Evidence within plans and within written communications between the person in charge and the nominee provider had suggested that due to a recent shortage in staffing, residents were not being supported to access the community and carry out their chosen activities as identified within their person centred plans. This staffing shortage had been addressed in recent days however, there was no plan in place to develop residents' opportunities for new experiences and to enhance their social participation. Considering the profile of residents, opportunities for education or employment was not considered a priority for residents and for this reason, emphasis was placed upon community and social participation as well as maintaining and enhancing daily living skills. These plans were not being developed or provided for many residents. Some residents were leaving the centre infrequently, sometimes just once a month. Activation or day services were provided on the campus for some residents. Overall though, institutional care practices of centralised catering, centralised laundry facilities and campus based activity has reduced opportunities for residents to be involved everyday living tasks and to gain new social experiences.

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that residents were supported to access health care services relevant to their needs. A general practitioner (GP) was available to visit the centre on a daily basis and visited one resident during the inspection to review a resident. There was evidence of access to specialist and allied health care services to meet the diverse needs of residents such as psychology, speech and language, dietician, ophthalmology, dentistry, chiropody and occupational therapy.

Health care plans and associated medical files detailed specific health issues and related support requirements. Some of the residents had epilepsy and the inspector reviewed the file for one of these residents. The file contained records of reviews by medical specialists and a specific epilepsy response plan had been developed based upon the advice of medical specialists.

All residents had their meals within the centre. Residents were supported in their choice of meal with the use of a pictorial menu. Food was delivered from a centralised kitchen within the campus in sealed containers. Residents were offered a choice of meal and staff assisted residents to make a choice, or used their knowledge of the residents' likes and dislikes to choose if for them. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. Dinner was found to be a relaxing and sociable experience with staff providing support to residents as required in a sensitive and appropriate manner.

Outcome 12. Medication Management

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

Theme:

Health and Development

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Overall it was judged that each resident was protected by the centre's policies and procedures for medication management. All prescribing and administration practices were in line with best practice guidelines and legislation and systems were in place for reviewing and monitoring safe medication practices. All staff who administer medication were registered nurses who must follow Bord Altranais agus Cnáimhseachais na hÉireann safe medication practices.

All residents had a capacity review test completed annually within their care plans to assess their ability and level of involvement in the administration of their medication. All residents were assessed as requiring a high level of support and this review provided valuable information for staff on residents' preferred method of taking medication and the personal support and encouragement required.

The inspector found that each resident's medication was reviewed regularly by the medical team and records demonstrated reduction in medication levels in line with changing needs of residents. Staff were clear on what each medication had been prescribed for. Guidance was also available to all staff from a nurse manager at all times, as well as from an on-site pharmacist. All medication was appropriately stored and

regularly audited. Unused or out of date medication was returned promptly to the on site pharmacist.

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

The statement of purpose contained most of the information required by the Regulations and accurately described the service provided in the centre. However, the statement of purpose contained personal information on each of the residents which was described as a 'directory of residents'. The directory of residents must be contained as a separate document as described within (article 19) the Regulations. In addition, more detail was required in relation to the admission criteria for the centre.

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector was satisfied that there were effective robust management systems in place to meet the needs of residents. The quality of care and experience of the residents

was being monitored on an ongoing basis and these reviews were judged to be providing safe, quality care services. The person in charge had identified an issue relating to a reduction in staffing levels which had impacted upon the quality of service provision to the residents. This concern had been communicated in writing to the provider and this reduction in staffing levels had been reversed. This demonstrated that the person in charge was directly involved in the strategic and operational management of the centre and had the authority to implement significant change and meet his obligation under legislation.

The provider has established a clear management structure and the roles of all managers and staff were clearly set out and understood. The structures included supports for the person in charge to assist him in delivering a good quality service. These supports included regular meetings with the provider and CNM3 linked with the centre.

The inspector found that the person in charge as well as the deputising person in charge had sufficient experience in supervision and management of the delivery of a designated centre of this type and size. Furthermore, throughout the inspection the person in charge was knowledgeable about the requirements of the Regulations and Standards and had clear knowledge about the support needs and personal plans of each resident. There had been a six monthly review of the quality and safety of the service carried out by a person participating in management on behalf of the provider. This identified areas for improvement and actioned how they would be addressed. A copy of this review was made available to the inspector.

Staff informed the inspector that regular staff meetings were held, and records of recent staff meetings were read by the inspector. These provided staff with an opportunity to discuss areas of interest or concern in relation to the daily operation of the centre and also to advocate formal on behalf of their key clients.

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The inspector found that satisfactory arrangements were in place though the availability of another experienced clinical nurse manager to deputise in the absences of the person

in charge. There were additional deputising arrangement in place and when neither person in charge was on duty a staff nurse was identified on the roster as being the lead on that shift.

The person in charge had not been absent for a prolonged period since commencement and there was no requirement to notify the Authority of any such absence. The provider was aware of the requirement to notify the Authority the event of any prolonged absence of the person in charge for more than 28 days.

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Efforts had been made by the provider to link the assessments of residents needs to the staffing requirements for the centre. However, the outcome of this staffing audit had not been made available to the person in charge at the time of inspection. Evidence was provided elsewhere within this report identifying lack of adequate resources to meet the assessed needs of residents, specifically within Outcomes 3, 5 and 17. Although these staffing hours have been increased in recent days, plans and activity log for residents has not yet recorded any increased activity for residents.

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with adults with disabilities.

Five staff files were reviewed subsequent to the inspection within the organisation central management offices and were found to contain all of the documentation as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Training records were held both centrally within staff files as well as locally within the centre. Training records provided by the person in charge identified that all staff had completed mandatory training in the areas of fire safety and manual handling. However, not all staff had completed up to date safeguarding of vulnerable adult training and there was no training plan to provide this to all staff who required it. In addition, staff had not completed basic training in food safety.

The inspector reviewed the proposed and actual rosters for the previous month and all staff were identified on the roster. The roster also clearly identified who was in charge at any given time.

Although it was found at the time of inspection that staffing levels were appropriate to meet the needs of residents, the roster identified times when numbers of staff were significantly reduced, as has been detailed elsewhere in this report.

Staff employed in the centre, observed and spoken to during the course of the inspection demonstrate an intimate knowledge of the residents they supported. The model of care delivery provided for distinct and different models of service to meet the care needs of a diverse client group. Therefore, staff were assigned to a specific bungalow within the centre and this model promoted a consistency and continuity of care provision to residents. Relative questionnaires consistently highlighted the quality of staff as the most noteworthy element of service provision. Staff spoke to and about residents with great respect and were very professional at all times in their dealing with the residents.

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

The provider had completed a recent audit and review of all policies and procedures across the broader organisation and had just recently re-issued revised versions of a number of policies including safeguarding of vulnerable adults and the provision of intimate care. Many changes within the centre since the last inspection such as intimate care planning and the reporting procedures relating to abuse were now reflected within these policies. All of the policies and procedures as required by Schedule 5 of the Regulations had been developed.

The residents were also provided with a residents' guide and efforts had begun to provide this in an accessible format. The provider had also developed a directory of residents with all of the information as required within the Regulations.

The inspector was provided with a copy of an insurance certificate which confirmed that there was up to date insurance cover in the centre.

Records were been maintained in a secure and safe manner. Staff records were stored within the organisations head offices which were provided to the inspector by a member of human resource staff. Residents' records were kept in a locked press in the staff office in the centre. All records reviewed were accurate and up to date. Records were made available to the inspector as required during the inspection.

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

| | |
|----------------------------|--------------------------------------------------------------------------------------------------------------------|
| Centre name: | A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd. |
| Centre ID: | ORG-0011625 |
| Date of Inspection: | 25 June 2014 |
| Date of response: | 27 July 2014 |

Requirements

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: DCAD10 Individualised Supports and Care

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

The resident's privacy and dignity were not being respected in relation to the practice of staff entering bedrooms during the night without consent.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Night sleep risk assessments have been completed and medical declaration forms have

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

been signed by GP. Service user's views sought and documented, family members contacted and informed. MDT scheduled for 24/7/2014 occurred. Result: Night time supervision practices have changed for thirteen service users, remaining two service users need to be checked more frequently due to medical needs.

Proposed Timescale: 24/07/2014

Theme: DCAD10 Individualised Supports and Care

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

The inspector found the providers' procedures regarding the management of residents finances did not meet the Regulations.

Action Required:

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

Financial capacity assessments have been carried out for all service users, permission from has been introduced at designated centre level to clarify with service users and families costs occurred for holidays and specialised equipment. The "Guidelines on Staff Managing Service Users Monies" has been reviewed and include the correct long stay charges as per Patient Private Property Policy (DOCS039). Monthly accessories money requisition sheet has been reviewed and is now specific to what is to be purchased with these funds and is only ordered as required. New household accessories money requisition sheet in place with specifics to what is to be purchased with these funds. These funds are also only to be ordered as needed. Both requisition sheets have been implemented in conjunction with Patient Private Property Policy (DOCS039).

Proposed Timescale: 23/07/2014

Outcome 02: Communication

Theme: DCAD10 Individualised Supports and Care

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

Each resident was not supported to communicate as all information pertaining to them was kept in a medium they could not understand. There was inconsistent implementation of communication implementation from personal plans.

Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

Outstanding individual communication passports are completed. Service users, staff and family members are currently working on new service user friendly personal care plans. A new format is being developed that is picture orientated and more functional for service users.

Proposed Timescale: 29/08/2014

Outcome 03: Family and personal relationships and links with the community

Theme: DCAD10 Individualised Supports and Care

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

Community access was extremely limited for many residents within the centre.

Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

Following a number of interviews with service users it was identified what community based clubs and activities they would like to attend As a result of this process three ladies have joined knitting clubs in the local area. One service user has opened a Post office account and will collect her money weekly. The process of opening a Post Office account for two other service users is ongoing. Social outings such as shopping, concerts and holidays are ongoing for all service users, a social outing/activity log book has been implemented to ensure equality for service users to access the wider community. These activities will be outcome focused.

Proposed Timescale: 23/07/2014

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents personal plans were not provided in an accessible format.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

Outstanding individual communication passports are completed. Service users, staff and family members are currently working on new service user friendly personal care plans. A new format is being developed that is picture orientated and more functional for

service users.

Proposed Timescale: 29/08/2014

Theme: Effective Services

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

Personal plans were not being reviewed for effectiveness.

Action Required:

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

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

A full audit of care plans is currently being carried out by Person In Charge and the Person Performing In Management. This audit includes person-centred plans, risk assessments and the process of setting outcome based goals. Following this audit, meetings will be held with service users and key workers to discuss the shortcomings identified. A plan will be put in place to improve person centred plans and ensure personal goals are more outcome focused.

Proposed Timescale: 26/09/2014

Theme: Effective Services

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

A comprehensive assessment of personal and social need was not completed for residents.

Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

Gaps identified in care plans will be rectified following the audit by Person In Charge and Person Performing In Management. Care plans will continue to be audited annually or sooner as needed.

Proposed Timescale: 26/09/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The premises required improvement in a number of areas as identified and incorporated in the design of the new premises.

Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

A design group including service users has been established to devise a plan to redevelop four units. The plan includes refurbishment of each unit, including painting and soft furnishings assistive technology and upgrade of bathrooms and shower rooms. This process will be done on a phased basis. The current plans for the redevelopment were presented to the inspector on the 25/6/2014.

Proposed Timescale: 17/12/2014

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Where it had been assessed that training and education opportunities were not a priority for the residents given their age, minimal opportunity had been provided to develop residents everyday living skills and to enjoy new experiences.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Following a number of interviews with service users it was identified what community based clubs and activities they would like to attend As a result of this process three ladies have joined knitting clubs in the local area. One service user has opened a Post Office account and will collect her money weekly. The process of opening Post Office accounts for two other service users is ongoing. Social outings such as shopping, concerts and holidays are ongoing for all service users, a social outing/activity log book has been implemented to ensure equality for service users to access the wider community .A review staffing practices and creative rostering has increased opportunities for service users to access the wider community.

Proposed Timescale: 23/07/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose contained personal information on each of the residents' which should be contained within a separate directory of residents. Adequate information of the admissions criteria was also not available within the statement of purpose.

Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Directory of residents removed from statement of purpose. Specific reference has been made to the admission and discharge policy in the statement of purpose.

Proposed Timescale: 28/06/2014

Outcome 16: Use of Resources

Theme: Use of Resources

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

Sufficient and appropriate resources had not been provided to support residents to achieve the goals contained within their personal plans.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

A review of staffing practices and creative rostering has increased opportunities for service users to access the wider community. Staffing audit has been made available to Person In Charge and will be reviewed on 27/8/2014.

Proposed Timescale: 27/07/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

The outcome of the review of staffing levels was not available and had not been linked to the assessed needs of residents.

Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

Staffing audit has been made available to Person In Charge and will be reviewed on 27/8/2014.

Proposed Timescale: 27/08/2014

Theme: Responsive Workforce

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

Not all staff had been provided with updated mandatory training specifically in the areas of safeguarding of vulnerable adults and food safety and hygiene.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

All staff has completed mandatory training in Safeguarding vulnerable adults. Social work team to provide information sessions on new policy (DOC020). A Refresher Course for the Protection and Welfare of Vulnerable Adults and the Management of Allegations of abuse is now scheduled on 17th September and 8th October 2014.

All staff will receive basic food safety and hygiene by 21/12/14.

Proposed Timescale: 21/12/2014