

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003951
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd.
<b>Provider Nominee:</b>	Breda Noonan
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
11 August 2015 10:00	11 August 2015 17:30
12 August 2015 09:00	12 August 2015 14:30

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

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 report sets out the findings of an announced inspection of Group H St. Anne's Residential Services following an application by the provider to register the centre.

This was the third inspection of this centre by the Health Information and Quality (The Authority). The first inspection took place on 27 January 2015 and was a triggered unannounced inspection in response to unsolicited information and a previous notification received by the Authority. The second inspection took place on 8 May 2015 and was a follow-up inspection in relation to the progress made by the provider to address failings identified during the first inspection.

The centre can accommodate six residents, all of whom may display behaviours that challenge. Inspectors met with residents, staff members, the person in charge, the house manager and the provider nominee. Inspectors observed practices and reviewed documentation such as communication books, training records, personal plans, risk assessments, health plans and documentation pertaining to restrictive practices, medication management and behaviours that challenge. Inspectors observed staff interactions with residents.

Since the first inspection, improvements had been made and sustained in a range of areas, which were having demonstrable positive effect on the quality of life of residents. For example, behaviour support plans had been revised and developed to support residents to manage behaviours that may challenge, specialist input had been sought and provided to assess residents' needs where necessary, restrictive practices had been reduced or removed and residents were supported to pursue activities, interests and explore new opportunities.

On the day of inspection, inspectors found that residents appeared happy and content and there was a calm atmosphere in the centre. Staff demonstrated that they knew the residents and their needs well. Staff were observed to support residents to use verbal and non-verbal communication to express their choices, feelings and wishes.

Questionnaires were returned by some relatives that indicated that they were very satisfied with the service being provided to their loved one and that staff were both supportive and understanding of residents' needs.

A new person in charge had also been appointed to the centre and had commenced in her role 10 weeks prior to this inspection. Due to the short time-frame that the person in charge was in the role in this centre, the effectiveness or otherwise of this arrangement has yet to be demonstrated.

However, four outcomes were found to be at the level of major non-compliance.

Outcome 14 pertaining to governance and management of the centre has been increased to the level of major non-compliance at this inspection. There was a clearly defined management structure in place that identified the lines of authority and accountability in the centre. However, significant improvement was required in order to ensure that both the provider nominee and the person in charge were facilitated to fulfil their responsibilities in relation to ensuring that the service provided was safe, consistent and effectively monitored. In particular, the person in charge had not been made aware of a previous complaint made by a nurse working in the centre in November 2013 in relation to poor practices in the centre nor had she been made aware of an anonymous complaint made in December 2014 in relation to allegations of abuse in the centre. The provider nominee had not seen or received a copy of an independent report completed into an investigation into the aforementioned complaint in July 2014 nor had she seen or received the preliminary screening report completed into the allegations of abuse dated 5 February 2015. Inspectors found that this failing was at the level of major non-compliance.

Outcome 10 pertaining to the notification of incidents to the Authority has been increased to the level of major non-compliance at this inspection. It was found that not all incidents have been notified to the Chief Inspector, as required. This was also a finding on the first inspection of this centre.

Outcome 6 pertaining to the provision of safe and suitable premises remains at the level of major non-compliance at this inspection. It was found that the design and layout of the centre did not meet the needs of residents in terms of accessibility. While interim steps required were on target, this outcome will remain at the level of major non-compliance until the action has been completed.

Outcome 5 pertaining to social care needs remains at the level of major non-compliance and this relates to the finding that the centre was not suitable for the purposes of meeting the needs of each resident due to the number and unsuitable mix of residents in the centre. The provider had not demonstrated that this actions has progressed in a timely manner.

Other improvements were required in areas relating to care planning, the monitoring and documentation of restrictive practices and residents' rights, which will be discussed in the body of this report and included in the action plan at the end of this report

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that residents were consulted about how the centre was planned and run, systems were in place to manage complaints and residents were treated with dignity and respect. Improvements were required in relation to upholding residents' rights.

Where night-time checks were required, written protocols were in place for each resident that specified the supervision requirements and the nature and frequency of the checks required. Care plans had been completed and checks were recorded.

The mix of residents in the centre resulted in environmental restrictions in place for some residents that had an impact on other residents. Inspectors found however that staff endeavoured to minimise this impact on residents; for example, where access to taps had to be restricted, some residents were given keys to the cupboard under the sink so that their fluid intake was not restricted unnecessarily. This will be addressed under Outcome 5: Social Care Needs and in the associated action.

Inspectors found however that where consent was required for medical procedures and residents did not have the capacity to consent for themselves, that consent was sought by family members instead of this being a clinical decision. This is not in accordance with best practice as it relates to obtaining consent for adults with an intellectual disability.

The house manager had explained the process to make a complaint to residents at a residents meeting. An easy-read version of the complaints policy was visibly displayed. Where a resident had a visual impairment; the complaints process had been explained

by their key worker. In a questionnaire completed by a relative, that relative confirmed that any issues they have raised have been dealt with to their satisfaction by the service.

The process for managing residents finances appeared satisfactory. One resident had purchased a car on the understanding that it was solely for their own benefit. There were records available of discussion with or advice given to the resident in relation to these purchases. There was a record of input from the resident's family in relation to the buying of the car. There was a record available of the rationale from the service provider as to the reason why this purchase was made by the resident.

In relation to day to day expenses managed on behalf of residents two signatures by staff members were in place for all credit and debit transactions. The house manager engaged in an audit of residents' finances every two months and all relevant bank statements were kept with expenditure sheets.

**Judgment:**

Non Compliant - Moderate

**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

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

No actions were required from the previous inspection.

**Findings:**

Overall, inspectors found that the communication needs of most but not all residents were being met.

In the sample of care plans reviewed each person had their communication needs identified and what help and support the resident needed to communicate. Throughout the inspection, staff and residents were seen using alternative forms of communication, including lámh communication. This is a manual sign system used by children and adults with intellectual disability and communication needs.

There was evidence of review and assessment by speech and language therapists as required. One resident had recently been seen to assess their receptive and expressive language. The recommendations from the speech and language therapist were seen to be implemented. For example following this review there was a communication book in the resident's bedroom with a photograph of each activity or item labelled. There were instructions on how to use the book at the back of the folder so it was used in the same way by each member of staff.

The flooring in one resident's bedroom had also been upgraded to a lighter colour. This

was in response to a recommendation from an occupational therapist to facilitate the resident, who had visual impairment, to distinguish between objects. However, inspectors found that residents' communication needs were not all being met in a timely manner. For example a psychologist review in June 2014 had recommended that one resident have a formal hearing assessment and a visual assessment. These reviews had not yet taken place. The referral for the hearing assessment was sent in April 2015 with an appointment date of August 2015. The referral for the visual assessment was sent in May 2015 after an appointment with an optician. In relation to another resident actions identified by a senior clinical psychologist in a report dated June 2014 relating to communication had not been completed at the time of inspection. The actions related to the development of on-going skill development in the area of communication to support a resident to manage his own behaviours and the development of communication goals. The resident had however recently had a speech and language review which demonstrated that this issue was now being progressed. Other communication tools seen in use by inspectors included a meal planner in the kitchen which had a picture of the meals for each day. A number of policies like the complaints policy and residents guide were in an easy to read format. Each resident had an acute hospital communication booklet which was available in case a resident had to be admitted to hospital. This outlined things that hospital staff needed to know about the resident. The provider nominee outlined that one resident was sampling the use of an iPad at work and it was to be introduced in the house when the resident was more familiar with it. Television was provided in the main living room and there was a stereo system in the dining room.

**Judgment:**

Non Compliant - Moderate

**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

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that positive relationships were supported.

There was a policy on visiting and it was demonstrated that families were welcome and free to visit. A log was maintained of all visitors. There was adequate communal space in the houses to receive visitors with a kitchen/dining rooms and a separate living room.

Family relationships were supported by staff in various ways as applicable to each



individual resident. Residents were supported to visit their family members, to stay overnight or for weekends in their family home and to go out on day visits with family. Residents communicated to inspectors when they were due to go home. Family were invited to attend personal planning review meetings.

The person in charge said that they were working to further develop links with the community. Residents participated in events external to the centre according to their wishes and preferences, such as attending community events, sports matches, eating out and going bowling.

**Judgment:**

Compliant

**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

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

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed a sample of resident contracts of care and found that they had been signed either by the resident or their representative.

The sample contracts seen by the inspectors included: an introduction; personal effects; staffing arrangements; provision for family contact; policies; assessment/care planning; medication management; suggestions; comments/complaints and; insurance.

However, the contracts did not outline the residential charges for accommodation.

The admissions policy did not take account of the need to protect residents from abuse by their peers. This was particularly relevant as there had been six incidents of residents assaulting other residents since January 2015.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that*

*reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**

Effective Services

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

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

**Findings:**

Inspectors found that each resident had a comprehensive assessment of their personal, social and health needs. However, an assessment of each resident's education, training and/or developmental needs had not been completed.

Each resident had a personal plan. Inspectors reviewed a sample of personal plans and found that they were individual, person-centred and met the requirements of the Regulations. There was evidence of family involvement in personal planning and family were invited to attend MDT meetings and meetings pertaining to the review of personal plans. An MDT meeting had been held for each resident since January 2015. Goals had been set for residents and these reflected the wishes, capabilities and interests of individual residents. Some plans were maintained in a format of the resident's choice, including computerised format and updated by the resident themselves. Further improvement was required in relation to the setting of residents' goals in order to demonstrate how such goals contributed to residents' quality of life and what supports were required to achieve these goals.

A clinical nurse manager (CNM3) had provided support to the staff team in relation to reviewing the opportunities available to residents to pursue activities, interests and new opportunities. Improvements since the previous inspection had been maintained and further developed. Each resident had a detailed activity programme, tailored to their individual needs, capabilities and wishes. Activity schedules included activities external to the centre such as visiting a park, going for walks, participating in dance class or music session. Activity schedules considered individual resident's needs and choices to participate in activities in smaller groups and in individualised activities where applicable. The house manager said that the residents continued to enjoy such activities, outings and trying new experiences. Outings included trips to Japanese gardens, the Bora bog and the Titanic docks in Belfast. Within the centre residents participated in activities and interests such as listening to music and working in the garden. Life skills necessary to increasing independence such as cooking, ironing and hand washing were also supported and facilitated.

The provider nominee was taking steps to address the finding from the previous inspections that the centre was not suitable for the purposes of meeting the needs of each resident due to the number and unsuitable mix of residents in the centre and in some cases, the design and layout of the centre. This continued to have an impact on residents in terms of not meeting individual resident's needs for quiet time and space

and as previously discussed, the right to live with the least possible environmental restrictions. In addition, the environment was not designed or laid out to meet the needs of residents with a visual impairment.

A review group had been set up within the required timeframe to review the most suitable accommodation for the residents in the centre. This outcome will remain at the level of major non-compliance until the action has been completed.

**Judgment:**

Non Compliant - Major

**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

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

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

**Findings:**

While some parts of the premises had been upgraded since the last inspection there were still issues relating to limited accessibility for some residents and also the upgrading of the kitchen.

It had been found in previous inspections by the Authority that for two residents, the design and layout reduced their capacity to exercise personal independence. An occupational therapist had undertaken a review of the suitability of the premises for these residents in May 2015. A copy of this report and its recommendations were not made available to inspectors. Since the last inspection grab rails were now in place to assist one resident who was visually impaired to access the bathroom. However, due to the design and layout of the centre these two residents were still limited in terms of accessing all areas.

The house was a large two-storey building. On the ground floor was a large sitting room with couches and television. There was a dining room with tables, chairs and a sofa. There was a kitchen area, adjacent to which was one resident's bedroom and a bathroom. There was second resident's bedroom downstairs also and this bedroom was ensuite with shower, toilet and wash hand basin. Upstairs there were four resident bedrooms and a shower/bathroom.

On previous inspections it was found that the kitchen units were dated and parts of the

worktop was damaged. On this inspection the person in charge outlined plans to update the kitchen units but the units and worktop were still in the same condition as previously. While the building was generally clean it was again observed that some parts that were difficult to reach or access needed closer attention and in particular an area behind the sink in the kitchen; gaps between the cooker and kitchen units on both sides.

Since the last inspection the flooring had been replaced and upgraded in many parts of the house including the dining room, kitchen and laundry area. The bathrooms areas had also been upgraded since the last inspection and were now clean.

There was a large garden to the rear of the house. However, the accessibility to the garden was limited due to the poor condition of the patio area; there were uneven paving stones that needed replacement and some pipe work was visible in parts of the footpath.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective Services

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

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

**Findings:**

Improvements were required in relation to how hazards were being assessed and also in relation to some fire safety arrangements.

Since the last inspection there was now a centre procedure on risk management. This local procedure included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. It also included how hazards were identified and the method by which incidents were reviewed.

Inspectors found that the system in place for the assessment, monitoring and management of risk still required improvement. There were examples of risk assessments not being reviewed within the specified timeframe. In addition some nursing risk assessments were being completed using inappropriate assessment methodology. For example, a clinical risk assessment for falls identified a resident as being 'fully mobile' when he had been assessed by a physiotherapist and an occupational therapist as requiring the assistance of two people when mobilising. In addition, the clinical risk assessment tool being used has not been validated for use on a younger person in an intellectual disability setting.

Inspectors reviewed the incident reporting records from January 2015 to 11 August

2015 and saw records for 40 incidents including:

- 9 medication management errors
- 8 incidents where a resident received medication to manage an episode of agitation
- 6 incidents of residents grabbing the hair or pulling other residents
- 6 incidents of residents biting/scratching staff

There was evidence that incidents were being followed up appropriately. The person in charge had undertaken a review of all incidents in the house every three months. All incidents were being recorded on a risk management database.

At the previous two inspections, inspectors found that the evacuation plan for one resident was not sufficient. On this inspection it was found that a fire risk assessment had been completed which outlined in detail the controls in place to manage this hazard. This included new instructions for staff to assist the resident. An occupational therapist had reviewed the fire evacuation arrangements for this resident in June but the report was not yet available. Staff were to update the evacuation plan once received from the occupational therapist.

There was an emergency policy which outlined the arrangements in response to emergency situations. Fire evacuation maps were available and on display. There were monthly fire evacuation drills being undertaken involving the residents and records indicated that all residents were cooperative with the drills.

The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of servicing of fire alarm system and alarm panel in July 2015; fire extinguisher servicing and inspection in November 2014 and; servicing of emergency lighting in July 2015. However, the doors throughout the premises were not fire doors and could not be guaranteed to restrict the spread of fire and smoke in the event of a fire emergency.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

Measures were in place to protect residents being harmed or suffering abuse. Improvements were required to the monitoring and review of restrictive practices.

All staff had up-to-date training in relation to the protection of vulnerable adults. All staff, bar one new staff member, had received training in relation to supporting residents who may display behaviours that challenge and the use of any approved interventions, including breakaway techniques. Training was scheduled for this new staff member.

Each resident had an up-to-date behaviour support plan. The inspector reviewed a sample of the behaviour support plans and found that they demonstrated a positive approach to behaviours that challenge and included positive supports such as the use of distraction, relaxation activities and techniques and the verbal tone required. Interventions were clearly outlined. Protocols were in place for the use of any PRN medication. Each behaviour support plan was signed and dated by staff. However, inspectors found that a physical lift had been used on 26.6.2015 which did not form part of the behaviour support plan and had not been reviewed by the team following the incident.

There was evidence that some restrictive practices had been reviewed and reduced or removed since the previous inspections. However, improvements were required as not all restrictive practices were managed in line with national policy. A restrictive practice (a wrist transmitter worn to alert staff when a resident is attempting to climb the stairs) was in place that had not been considered by the organisation's restrictive practice committee in a timely manner. While there was a clear rationale for the practice and it had been recommended for use by an appropriate professional, it had been in place for at least 8 months and had yet to be considered and approved by the restrictive practice committee.

In addition, the review of a number of existing restrictive practices for other residents was outside of their 12-month review date.

Improvement was required to the management of some physical restraints, specifically physical holds to take bloods. This practice had been approved by the organisation's restrictive practice committee with a clear rationale provided and a written description of the approved hold. However, the description was in the form of a letter to the resident's parents as opposed to written guidance for staff. In addition, the restrictive practice committee had requested that any such holds be recorded so that the effectiveness of the procedure used could be reviewed at the next restrictive practice committee meeting. This action had not been completed.

While the mix of residents in the centre remained unsuitable, the person in charge and house manager described the positive effect that changes in relation to how 1:1 supports were being used had had in terms of managing peer-to-peer injury or harm. In addition, staffing levels were being maintained and the house manager explained that this allowed staff the freedom to bring residents out if they wished to do so, which in turn had a positive effect on behaviours. Inspectors spoke with staff members who said that the application of the behaviour support plans in practice had made a positive

difference to how they support residents to manage their own behaviours. The house manager and person in charge said that the range of improvements in the centre had resulted in a cumulative positive effect that had been sustained since the previous inspection and that it was now a "calmer" house. Over the course of the 2-day inspection, the inspectors found that residents appeared happy and content.

The house manager confirmed that there had not been any incidents of peer to peer abuse in the centre since the previous inspection. However and as outlined in Outcome 7, there had been a number incidents of aggression by one resident against other residents (these were not targeted at any individual resident).

All incidents of behaviours that challenge were clearly documented and recorded. Tracking charts to record and track antecedents, behaviours and consequences were maintained following incidents as required.

**Judgment:**

Non Compliant - Moderate

**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

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

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

**Findings:**

The person in charge is required to notify the Chief Inspector within three working days of all serious adverse incidents. This includes any serious injury to a resident which requires immediate medical or hospital treatment. Inspectors saw records that indicated one resident had two separate falls. Following each fall he had been seen by a doctor or referred to an out-of-hours service. However, these incidents were not reported to the Authority as required by the Regulations.

The person in charge is also required to provide a written report every three months in relation to any occasion on which a restrictive procedure was used. The person in charge had not included all restrictions, for example, a wrist alarm which one resident had in place.

**Judgment:**

Non Compliant - Major

**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

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

No actions were required from the previous inspection.

**Findings:**

All residents received a day service either external to the centre or an individualised service from the centre, as appropriate. However, the day service provided did not meet the needs of all residents. This was confirmed in case review meeting minutes dated 28 April 2015 for one resident. Also, while actions arising from the case review meeting had named responsible persons, there were no timeframes specified for completion of necessary actions. In addition, it was not demonstrated what progress, if any, had been made to progress and resolve this issue since the case review meeting (16 weeks prior to the date of inspection).

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Residents had access to a range of medical, nursing and allied health care services to meet their healthcare needs. However, improvements were required to care planning and clinical risk assessment. In addition, inspectors found that recommendations arising from reviews and assessments by allied health professionals were not being completed in a timely manner.

There was evidence of regular reviews of residents' health by their general practitioner (GP). As their health needs required residents were referred by their GP to consultant specialists in the acute hospital setting. There was evidence of good access to specialist care in psychiatry. In one resident's healthcare records the general practitioner and the



consultant specialists were updating the psychiatry team in relation to the resident's investigations and tests.

However, the care plans in the centre for residents required further improvement. In the medical reports for one resident, there was reference to an x-ray investigation scheduled for February 2015. It wasn't clear from the care plan if this x-ray had taken place or not. There was an appointment card for an x-ray scheduled for September 2015 but it wasn't clear if this was the first x-ray or a follow-up of the original. Another resident was on the waiting list for a consultant specialist review but there didn't appear to be any care plan in place in relation to this identified healthcare need.

Inspectors found that there had been lengthy and unexplained delays in receiving reports following assessments by healthcare professionals. Such reports contained key recommendations and actions to be completed to meet residents' needs. For example, a psychology assessment was completed for one resident in June 2014 and the report was received in the centre on 14 April 2015 (10 months later). Consequently, inspectors found that there had been delays in scheduling a vision assessment and a formal hearing assessment for this resident, as recommended by the psychologist.

The person in charge had developed a tool for end of life care planning. This had been approved by the Irish Hospice Foundation to use its end of life symbol. The person in charge outlined that this was the first step to developing comprehensive end of life care plans.

There was evidence that residents' nutritional needs were met. Healthy eating plans and had been developed where required and were being adhered to. Input from allied health professionals was sought where necessary, including from speech and language therapy in relation to swallowing. A clinical nurse specialist had reviewed and provided input into residents' meals and meal planning. Residents with specific dietary requirements were being monitored and reviewed as required. Staff were familiar with any specific dietary guidance or requirements.

Weekly menus were in use. The fridge and cupboards were well stocked with a range of fresh foods. Residents' independence when eating or drinking was maximised and where residents' required support, this was offered discreetly and only where necessary.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

On the previous two inspections, it was found that the centre's method of the transcription of medication was not as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. It had also been found that one resident's care plan identified that oxygen therapy was to be administered if necessary but staff had not received training on this.

On this inspection, medication prescription records contained the signature of the nurse who transcribed the record. However, additional controls, such as an independent verification, were not always implemented to safeguard this practice. In relation to the oxygen therapy, staff had still not received this training but inspectors were informed that it was scheduled for August 2015. This is discussed further in Outcome 17 in relation to training.

Medication was dispensed from the pharmacy in a monitored dosage system which packaged the medication for each resident for the correct time each day.

Residents had medication care plans which identified specific issues like reviewing of the levels of medication in a person's blood or checking blood glucose levels for residents with diabetes.

A photograph of the resident was used to identify residents who were unable to verbally confirm their identity. However, inspectors saw that the photos were not recent and therefore there was a risk of medicines being administered to another resident due to mistaken identity.

There had been nine recorded medication errors since January 2015. Five incidents related to drugs not being given; two related to residents' medication being left in day service; one incident related to medication being given but not recorded in the administration record; and one related to a label on the prescribed medication. All errors had been followed up with the doctor as required. St Anne's service also had a medication management nurse who reviewed all medication errors as they happened and had also completed an annual audit of medications. All actions identified in the medication audit in 2014 had been completed.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The Statement of Purpose contained most but not all of the information required by Schedule 1 of the Health Act 2007. Improvements were required in order to accurately describe: the specific care needs that the designated centre is intended to meet; the person in charge; the criteria used for admission to the designated centre, including the centre's policy and procedures (if any) for emergency admissions and; the facilities for day care.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

There was a clearly defined management structure in place that identified the lines of authority and accountability in the centre. However, significant improvement was required in order to facilitate the provider nominee and the person in charge to fulfil their responsibilities in relation to ensuring that the service provided was safe, consistent and effectively monitored. Inspectors found that this failing was at the level of major non-compliance.

The centre is run by the Daughters of Charity Disability Support Services Limited. The Service Manager is the nominee appointed to act on behalf of the provider in all interactions with the Authority.

The provider nominee is dual qualified in general and intellectual disability nursing and has extensive experience in service provision to persons with an intellectual disability.

The person in charge is a clinical nurse manager (CNM2) and is qualified in intellectual disability nursing and had relevant previous experience at CNM1 (clinical nurse manager) level supporting residents with behaviours that may challenge. The post of the person in charge was full-time. The person in charge had commenced in that role 10

weeks prior to the inspection date. She was the person in charge of three designated centres, comprising four high support houses in total. Due to the short time-frame that the person in charge was in the role in this centre, the effectiveness or otherwise of this arrangement has yet to be demonstrated.

The house manager was identified as a person participating in the management of the centre. The house manager is a qualified nurse in intellectual disability nursing with experience in supporting residents who display behaviours that challenge.

The person in charge reports directly to the CNM3, who in turn reports to the provider nominee. The person in charge is supported in her role by a house manager, who is a CNM1 and works full-time in the centre. Care staff report to the person in charge.

However, significant improvement was required in order to facilitate the provider nominee and the person in charge to fulfil their responsibilities in relation to ensuring that the service provided was safe, consistent and effectively monitored.

The person in charge had not been made aware of a previous complaint made by a nurse working in the centre in November 2013 in relation to poor practices in the centre nor had she been made aware of an anonymous complaint made in December 2014 in relation to allegations of abuse in the centre. The provider nominee had not received or seen a copy of an independent report completed into an investigation into the aforementioned complaint in July 2014 nor had she received or seen the preliminary screening report completed into the allegations of abuse dated 5 February 2015.

The person in charge described her introduction into her new role as person in charge. This consisted of an introductory meeting between the person in charge, provider nominee and CNM3 and a briefing by the previous person in charge, each of approximately one hour duration. The person in charge confirmed that she had not received a structured induction into her role as person in charge. In addition, a one-to-one meeting between the provider or provider nominee and person in charge had not taken place since the person in charge commenced in her role. Also, a one-to-one meeting between the CNM3 and person in charge had not taken place since the person in charge commenced in her role. The person in charge outlined priorities that she had identified since she commenced in the role and provided examples of actions that she had completed within the previous 10 weeks. Actions included progressing outstanding MDT referrals, premises upgrades and improvements, review of staffing arrangements, commencement of audits of care plans, further exploration of suitable activities for an individual resident and encouraging social development and friendships for residents.

A number of proposed actions arising from the previous inspection had not been progressed in a timely manner or satisfactorily addressed. In particular, in relation to auditing of care plans (2 of 6 had been audited), addressing outstanding MDT recommendations, reducing the number of residents in the centre and addressing the unsuitable mix of residents in the centre. The arrangements as described and the findings in this report demonstrate that the person in charge had not received an adequate induction necessary to ensure the consistent delivery of care to residents in the centre.

The provider nominee had completed an unannounced visit to the centre within the previous six months. Inspectors reviewed the subsequent report and found that overall, the review considered the quality of care and support provided in the centre. Further improvement was required in relation to the requirement to put a plan in place to address any gaps. For example, previously identified issues relating to accessibility of the centre and the need to reduce the number and review the mix of residents in the centre had not been included.

Improvements were required to the annual review of the quality and safety of care and support in the designated centre as the review did not provide for consultation with residents and their representatives nor had a copy of the review had not been made available to residents and/or their representatives.

A number of audits had been completed as part of monitoring of the service. These included audits relating to infection control, fire safety, health and safety and medication management. Inspectors reviewed a sample of audits and found that they effectively contributed to monitoring of specific areas.

A certificate of planning has not been submitted to the Authority, as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Regular staff meetings took place and inspectors viewed minutes from such meetings. Topics discussed included activities for residents and incidents.

**Judgment:**

Non Compliant - Major

**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

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

No actions were required from the previous inspection.

**Findings:**

Since the previous inspection, there had been no occasion when the person in charge had been absent for a period of 28 days or more. The provider nominee was aware of the requirement to notify the Authority of any such occasions and the arrangements for the management of the designated centre during that absence.

Suitable arrangements were in place in the event of the absence of the person in charge

for 28 days or more with the CNM3 identified to deputise in such an event.

**Judgment:**

Compliant

**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

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

No actions were required from the previous inspection.

**Findings:**

The facilities provided were in line with the Statement of Purpose.

Resources had been allocated to upgrade the premises since the previous inspection, as outlined under Outcome 6. In addition, a new person in charge had been recruited.

As previously discussed under Outcomes 1 and 5; the centre did not meet the needs of all residents in terms of providing a safe and accessible environment. The provider demonstrated that steps had been taken to progress the action plan submitted following the previous inspection. In that action plan, a timescale of 30 October 2015 was provided for completion of a review of the premises and submission of an action plan for completion of all necessary works to the centre. Also, a referral had been sent to the national council for the blind to seek advice in relation to accessibility of the centre. This action was being progressed at the time of inspection.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

A review of staff rosters demonstrated that staffing levels were being maintained at the level required to meet the assessed needs of the residents. The person in charge, house manager and other staff said that the staffing levels were sufficient to allow for residents needs to be met. For example, a staff member explained that staffing levels allowed for staff to support residents pursue activities and interests both within and outside of the centre, in accordance with individual residents' needs and wishes.

While care staff were experienced, a significant number of care staff did not possess a formal qualification in relation to the role of care assistant. The provider nominee explained that staff skill mix within the centre was under review and that care staff were being offered the opportunity to complete a course relevant to the role of a care assistant.

Inspectors spoke with the person in charge and reviewed training records. The majority of staff had received mandatory training in the protection of vulnerable adults, the management of behaviour that challenges, refresher training for the Therapeutic Management of Aggression and Violence (TMAV), training in fire safety, food safety, infection control or manual handling. A staff member who had recently commenced in the centre had received training in the protection of vulnerable adults and fire safety and all other required training had been scheduled within an acceptable timeframe.

Staff had also received support from a CNM3 in order to support residents to avail of meaningful activities. While training in oxygen therapy was outstanding, this was scheduled for completion by the end of this month (August 2015).

Staff files were reviewed in the central office and were found to contain all of the information required under Schedule 2 of the Regulations.

**Judgment:**

Non Compliant - Moderate

**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

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

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

**Findings:**

As was found on the previous inspection, further improvement was required to the streamlining of documentation to ensure ease of retrieval and to ensure that key information would not be missed. For example, 'protocols' were on file for individual residents in relation to their daily routines, the use of physical aids during transport and assistance required in the event of a fire. It was not clear why this information had not been included instead in existing care plans, personal plans, risk assessments and personal evacuation plans, as appropriate. In addition, some protocols were undated.

Not all records relevant to the care that was being delivered to residents in the centre were maintained in the centre. As previously mentioned under Outcome 6: Premises; a record of an occupational therapy assessment that had been completed on the 27/5/2015 (according to the previous action plan) was not available in the centre. In addition, inspectors found that there had been lengthy and unacceptable delays in receiving reports following assessments. Such reports contained key recommendations and actions to be completed to meet residents' needs. For example, a psychology assessment was completed in June 2014 and the report was received in the centre on 14 April 2015 (10 months later). Finally, information pertaining to the review of the residential placement of two residents was not held in the centre.

The management of healthcare records required improvement. In some healthcare files reviews by general practitioners were filed in plastic pockets in the healthcare record. This system did not adequately ensure that relevant healthcare information was available to plan care for residents. In addition, appointment cards were filed loosely in the healthcare files. This practice could not ensure that all appointments were to be followed up as required.

In accordance with Schedule 4 of the Regulations pertaining to other records to be kept in the centre, a complete record of all charges to residents and the amounts paid by or in respect of each resident was not maintained in the centre.

The Directory of Residents was maintained in the centre in accordance with the Regulations.

In accordance with Schedule 5 of the Regulations pertaining to policies and procedures, progress had been made since the previous inspection. An infection control procedure had been developed for the centre. The risk management policy had been revised and now met the requirements of the Regulations. A policy in relation to access to education, training and development of residents had been developed. However, this policy did not meet the requirements of the Regulations. For example, it did not consider how residents' education, training and development needs would be assessed nor did it consider how residents' continuity of education, training and employment would be maintained when in transition between services. The complaints policy required review



as it does not demonstrate a risk-based approach to the management of anonymous complaints.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003951
<b>Date of Inspection:</b>	11 August 2015
<b>Date of response:</b>	18 September 2015

### Requirements

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

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

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

**Theme:** Individualised Supports and Care

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

Where consent was required for medical procedures and residents did not have the capacity to consent for themselves, that consent was sought by family members instead of this being a clinical decision.

#### **1. Action Required:**

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

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

The Person in Charge and the House Manager will ensure all residents will consent for their own medical procedures where they have capacity to do so.

Where a medical procedure is required and consent from the service user is not obtainable, consent will be sought with the support of an advocate and the procedure will be carried out based on a medical decision by the General Practitioner.

**Proposed Timescale:** 10/09/2015

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

Residents' communication needs were not all being met in a timely manner.

**2. 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:**

The person in charge will ensure all recommendations relating to communication are implemented appropriately and in a timely manner as per Service Users' plan and a named responsible person identified with a review date documented

**Proposed Timescale:** 10/10/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

Contracts of care did not outline the fees to be charged.

**3. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

The Clinical Nurse Manager 3 with the Person in Charge will ensure that all contracts of care will include fees as per Service Policy and will be signed by Service User/family and placed in their care plan. This will be done immediately.

**Proposed Timescale:** 09/09/2015

**Theme:** Effective Services

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

Admission policies and practices did not take account of the need to protect residents from abuse by their peers.

**4. Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

The Provider Nominee has requested the Assistant C.E.O who is the Chair of the Admission Discharge and Transfer Committee to have protection and welfare of Service Users from peer to peer abuse included in the Service Admission, Discharge and Transfer Policy. The policy is currently being reviewed to include the need to protect residents from abuse by their peers.

**Proposed Timescale:** 30/10/2015

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

The centre was not suitable for the purposes of meeting the needs of each resident due to the number of residents and the unsuitable mix of residents in the centre.

**5. Action Required:**

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

An application for Capital Assistance with the Offaly County Council was successful and a house has been purchased. Alteration works and refurbishment will be completed in this new house by the end of 2015. One service user from Centre H will be given priority to reside in this new accommodation. The needs of the service user with a visual impairment will be prioritised as part of this process.

For the remaining five service users in centre H a full multi disciplinary team review of

each individual will take place, and an integral part of this review will be their present residential placement and recommendations will be made for each individual. The Director of Logistics is reviewing the area 25/09/2015, a time bound costed and funded plan will be submitted to the authority on the 29/09/2015.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

An assessment of each residents' education, training and developmental needs had not been completed.

**6. Action Required:**

Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

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

The person in charge with the residential and day service staff teams and the service users will complete an assessment of each service user's education and training and development needs. This will be an integral part of each person's personal plan.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

Further improvement was required in relation to the setting of residents' goals in order to demonstrate how such goals contributed to residents' quality of life and what supports were required to achieve these goals.

**7. Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The Clinical Nurse Manager 3 and the Person in Charge will work with the House Manager and staff team on Service Users personal plans to ensure the Service Users' goals are person focused, up to date and appropriate to the individual. These goals will have clear time frames with a named responsible person. These goals will be broken down into measurable steps which indicate progress of each goal. The Clinical Nurse Manager 3 and the Person in Charge will carry out six monthly audits of these care plans.

**Proposed Timescale:** 09/10/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Some parts that were difficult to reach or access needed closer attention and in particular an area behind the sink in the kitchen; gaps between the cooker and kitchen units on both sides.

**8. Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

The services of a contract cleaner will be brought in to the centre to complete a deep clean of the are, in particular areas that are difficult to access day top day for the staff. The cleaning logs/schedules will be reviewed by the house manager and person in charge to ensure standards are maintained. The difficult to reach areas will be cleaned by the services of the contract cleaners as required, this will be monitored and organised by the person in charge.

**Proposed Timescale:** 25/09/2015

**Theme:** Effective Services

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

Kitchen units and worktop were damaged.

**9. Action Required:**

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

The provider nominee has arranged that the Director of Logistics with the maintenance manager will review the kitchen in the centre and repair or replacement will be completed.

**Proposed Timescale:** 30/10/2015

**Theme:** Effective Services

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

Due to the design and layout of the centre one resident was particularly limited in terms of accessing all areas.

**10. Action Required:**

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

The needs of this service user will be prioritized for transfer to a new accommodation. In order to make the individual's current living environment more accessible, the Director of Logistics is developing a plan to provide this individual with an en suite facility that is easily accessible, this will be completed 30/11/2015.

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

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

The accessibility to the garden was limited due to the poor condition of the patio area; there were uneven paving stones that needed replacement and some pipe work was visible in parts of the footpath.

**11. Action Required:**

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

**Proposed Timescale:**

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

**Theme:** Effective Services

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

The system in place for the assessment, monitoring and management of risk still

required improvement. There were examples of risk assessments not being reviewed within the specified timeframe. Inspectors saw a falls risk assessment for one resident which assessed the resident as fully mobile. However, there was further information from a physiotherapist in the resident's healthcare file which stated that the resident was not fully mobile.

**12. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

The Provider Nominee has requested the Clinical Nurse Manager 3 from another part of the Service with expertise in Risk Assessments to provide input to the Person in Charge and Staff of the Centre on completing risk assessments, ensuring they have a review date with a named responsible person. The service is developing a Falls Risk Assessment, this is being piloted at present, this draft tool will be used in this centre until the finalised document is circulated.

**Proposed Timescale:** 09/10/2015

**Theme:** Effective Services

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

The doors in the centre were not fire doors, as required to contain fire in an area.

**13. Action Required:**

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

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

The Provider Nominee and the Director of Logistics will review all doors in the centre, and ensure changes are made and doors are replaced as necessary to meet the regulations.

**Proposed Timescale:** 09/10/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Not all restrictive practices were managed in line with national policy or best practice. A restrictive practice (a wrist transmitter worn to alert staff when a resident is attempting to climb the stairs) was in place that had not been considered by the organisation's



restrictive practice committee in a timely manner. The review of a number of existing restrictive practices for other residents was outside of their 12-month review date. The documentation for a physical hold to take bloods was not satisfactory.

**14. Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The Provider Nominee with the Clinical Nurse Manager 3 will deliver training to the Person in Charge and House Team on Restrictive Practice Policy. Restrictive Practices that are in place will be reviewed, dated and documented with a named responsible person. Any restrictive practice in place will be team agreed and ensuring that it will be the least restrictive. The Clinical Nurse Manager 3 will carry out quarterly audits and will be an agenda item at staff meetings to provide shared learning.

**Proposed Timescale:** 15/10/2015

**Theme:** Safe Services

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

A physical lift had been used with a resident which did not form part of the behaviour support plan and had not been reviewed by the team following the incident.

**15. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

The person in charge with clinical nurse manager 3 and the multi disciplinary team will review the current behaviour support plan. Supports needed by this service user will be reviewed and included in the behaviour support plan. After exhausting all other less restrictive means, if it is identified and agreed by a team that a physical lift is appropriate and safe for the service user this will form part of behaviour support plan. Training and support around this practice will be provided to the staff team by the Therapeutic management of aggression and violence instructors and the manual handling instructors. This plan will have a review date and a named responsible person to ensure it is adhered to.

**Proposed Timescale:** 10/10/2015

## Outcome 09: Notification of Incidents

**Theme:** Safe Services

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

The quarterly submission did not include all of the incidents that are required to be notified to the Authority. For example, not all incidents of chemical or environmental restraint were included.

**16. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

The Provider Nominee has instructed the Person in Charge that they are responsible for ensuring all restrictive practices are reported to the Authority in the Quarterly Reports, where the person in charge is unsure the nominee provider has advised that they contact the clinical nurse manager or the nominee provider for advice.

**Proposed Timescale:** 02/10/2015

**Theme:** Safe Services

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

31(1)(d) Serious adverse incidents were not being reported to the Authority as required by the regulations.

**17. Action Required:**

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

The Provider Nominee has provided input to the Person in Charge on the Regulations with particular attention given to the importance of all Service Users incidents (if requiring medical attention) are reported to the Authority within 3 working days .

**Proposed Timescale:** 09/09/2015

## 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:**

The day service provided did not meet the needs of all residents.

**18. 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:**

The Person in Charge, with the House Manager and the Day Service Manager and Key Worker, will review the Service Users' Day Programme and its suitability in meeting the Service Users' needs. Alternative day programmes will be developed and supported where required.

The person in charge with the residential and day service staff teams and the service users will complete an assessment of each service user's education and training and development needs. This will be an integral part of each person's personal plan.

**Proposed Timescale:** 10/11/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

The care plans for residents' healthcare needs were not always complete.

**19. Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

The Clinical Nurse Manager 3, with the Person in Charge and the House team will review each service users Care Plans with particular attention to the health care needs to ensure all documentation is up to date with a review date and a named responsible person. Multidisciplinary Team Members will be involved, as necessary. If they are not available from within the Service they will be sourced externally and paid for by the Service. The Service Users will be an integral part of this process.

**Proposed Timescale:** 09/10/2015

**Theme:** Health and Development

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

There had been lengthy and unexplained delays in receiving reports following assessments by healthcare professionals.

**20. Action Required:**

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

The Provider Nominee, with the Human Resource Director, have agreed extra administrative support where time will be allocated to each centre to ensure all reports are typed in a timely fashion and available in each Service User's Care Plan. The recruitment process for the clerical post is in progress.

The nominee provider has informed all persons in charge to ensure that they follow up with clinicians in ensuring receipt of reports following consultations in a timely manner.

**Proposed Timescale:** 30/11/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

Transcribed prescription records were not always accurate.

**21. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The Person in charge, with the Medication Management Co-ordinator, will review the Kardex of the Service Users in the Centre and ensure that all transcriptions are accurate and contain the relevant details as prescribed by the Clinicians. Those will be signed by 2 Nurses at all times as per Service Policy.

**Proposed Timescale:** 10/10/2015

**Theme:** Health and Development

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

Photographs used to identify residents were not recent.

**22. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The Person in Charge with the Medication Co-ordinator have updated Service Users' photographs since the last inspection.

**Proposed Timescale:** 10/09/2015

**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:**

Improvements were required in order to accurately describe: the specific care needs that the designated centre is intended to meet; the person in charge; the criteria used for admission to the designated centre, including the centre's policy and procedures (if any) for emergency admissions and; the facilities for day care.

**23. 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:**

The statement of Purpose for the centre will be revised to include all necessary and relevant information and will be resubmitted to the authority.

**Proposed Timescale:** 18/09/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

A certificate of planning has not been submitted to the Authority, as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**24. Action Required:**

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

The Provider Nominee has liaised with the Director of Logistics; the certificate of planning will be submitted to the authority.

**Proposed Timescale:** 25/09/2015

**Theme:** Leadership, Governance and Management

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

The annual review of the quality and safety of care and support in the designated centre did not provide for consultation with residents and their representatives.

**25. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

The Nominee Provider will discuss this with the Quality and Safety Officer and will ensure that service users and their families are consulted going forward. The person in charge will also include this audit as an agenda item on the residents meetings in the centre.

**Proposed Timescale:** 18/09/2015

**Theme:** Leadership, Governance and Management

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

A copy of the annual review of the quality and safety of care and support in the designated centre had not been made available to residents (or their representatives, as appropriate).

**26. Action Required:**

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

The person in charge and the house manager will ensure that all residents and their representatives have a copy of the annual review of quality and safety. This will be discussed and its contents explained to the residents at a house meeting in October.

**Proposed Timescale:** 16/10/2015

**Theme:** Leadership, Governance and Management

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

The arrangements as described and the findings in this report demonstrate that the person in charge had not received an adequate induction necessary to ensure the consistent delivery of care to residents in the centre.

**27. Action Required:**

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

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

The Provider Nominee and the Clinical Nurse Manager 3 have met with the Person in Charge. The clinical nurse manager 3 has developed an induction plan and is currently implementing this with the person in charge.

The nominee provider has arranged with the Director of Human Resources that an induction to the service will be delivered, the newly appointed person in charge will be included in this induction programme.

**Proposed Timescale:** 30/10/2015

**Theme:** Leadership, Governance and Management

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

Significant improvement was required in order to facilitate the provider nominee and the person in charge to fulfil their responsibilities in relation to ensuring that the service provided was safe, consistent and effectively monitored, as outlined in the body of this report.

**28. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The Nominee Provider with the Director of Human Resources and the Director of Nursing have reviewed the number of Persons in Charge their expertise and areas of responsibility. Following this review it was agreed to recruit one further Person in Charge with a health care background This will now increase the number of Persons in Charge and will reduce the number of centres for each Person in Charge.

**Proposed Timescale:** 30/10/2015

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

The skill mix of staff required review in order to ensure that it was appropriate to the number and assessed needs of the residents.

**29. 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:**

The Provider Nominee, Director of Human Resources and the Director of Nursing have reviewed the staffing and skill mix within the Centre and where training of staff is required the staff of the Centre will commence Fetac Level 5 in September 2015. The newly appointed person in charge is a registered nurse.

**Proposed Timescale:** 09/09/2015

**Theme:** Responsive Workforce

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

Mandatory and required training, while scheduled, had yet to be completed in relation to oxygen therapy for all staff, and other training was required for a new staff member.

**30. 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:**

The Clinical Nurse Manager 3 and the Medication Management Co-ordinator, with the Person in Charge, have sourced appropriate training in oxygen therapy and staff of the Centre have completed this training on 13/08/2015.

**Proposed Timescale:** 13/08/2015

## Outcome 18: Records and documentation

**Theme:** Use of Information

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



The policy in relation to access to education, training and development of residents did not meet the requirements of the Regulations. For example, it did not consider how residents' education, training and development needs would be assessed nor did it consider how residents' continuity of education, training and employment would be maintained when in transition between services. The complaints policy required review as it does not demonstrate a risk-based approach to the management of anonymous complaints.

**31. Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of 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.

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

The nominee provider will consult with the quality and risk officer regarding the education policy and reviewing same.

The nominee provider has discussed the complaints policy and the management of anonymous complaints. The quality and risk officer will meet again with the national advocacy unit for further advice on the area of a risk based approach to the management of anonymous complaints. The complaints policy will be then revised to reflect this.

**Proposed Timescale:** 30/10/2015

**Theme:** Use of Information

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

The residents' guide did not include the terms and conditions relating to residency.

**32. Action Required:**

Under Regulation 20 (2) (b) you are required to: Ensure that the guide prepared in respect of the designated centre includes the terms and conditions relating to residency.

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

The residents guide will be reviewed and updated by the person in charge and the clinical nurse manager 3, to include all terms and conditions relating to residency.

**Proposed Timescale:** 18/09/2015

**Theme:** Use of Information

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

A complete record of all charges to residents and the amounts paid by or in respect of

each resident was not maintained in the centre.

**33. Action Required:**

Under Regulation 21 (4) you are required to: Retain records set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 4 years from the date of their making.

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

The nominee provider and the Director of finance have delivered training to the Person in Charge and house managers of the centre on the patient private property guidelines. This included training on the maintaining of records of all charges paid by the resident.

**Proposed Timescale:** 10/09/2015

**Theme:** Use of Information

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

Relevant healthcare records were not easily accessible.

**34. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The Clinical Nurse Manager 3, with the Person in Charge, will review the health records of each of the Service Users to ensure they are up to date. Information will be stored in a systematic and legible format. Out of date information will be archived and retrievable as required.

**Proposed Timescale:** 16/10/2015

**Theme:** Use of Information

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

Further improvement was required to the streamlining of documentation to ensure ease of retrieval and to ensure that key information would not be missed. For example, 'protocols' were on file for individual residents in relation to their daily routines, the use of physical aids during transport and assistance required in the event of a fire. It was not clear why this information had not been included instead in existing care plans, personal plans, risk assessments and personal evacuation plans, as appropriate. In addition, some protocols were undated.

Not all records relevant to the care that was being delivered to residents in the centre

were maintained in the centre. A record of an OT assessment that had been completed was not available in the centre. There had been lengthy and unacceptable delays in receiving reports following assessments. Also, documentation pertaining to a review of residents' accommodation was not available in the centre.

**35. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The House manager and the person in charge will review each of the resident's files in the designate centre, ensuring that all relevant information is available and accessible. Information where appropriate will be archived. Where assessments have been completed and reports and recommendations are not available the Person in Charge will contact the clinician/therapist to get same and include it in the service users file. When this review and streamlining of the files is completed an audit of the files will be completed by the clinical nurse manager 3 and actions with responsible persons detailed from the audit.

**Proposed Timescale:** 30/10/2015