<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003731</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Dublin 15</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:cnm2ol1.stj@docservice.ie">cnm2ol1.stj@docservice.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd.</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mary O'Toole</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Michael Keating</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>16</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>6</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: 05 August 2014 10:00 06 August 2014 10:00
To: 05 August 2014 18:30 06 August 2014 15:00

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

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<th>Outcome</th>
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<td>02</td>
<td>Communication</td>
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<td>03</td>
<td>Family and personal relationships and links with the community</td>
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<td>04</td>
<td>Admissions and Contract for the Provision of Services</td>
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<td>05</td>
<td>Social Care Needs</td>
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<td>Safe and suitable premises</td>
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<td>General Welfare and Development</td>
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<td>Medication Management</td>
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<td>Records and documentation</td>
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Summary of findings from this inspection
This was an announced inspection and formed part of the assessment of the application for registration by the provider. This was the second inspection of this centre by the Authority. In the first inspection this centre was inspected in conjunction with another centre on campus as the provider had identified both centres as one. However, during the registration process the provider had since taken the decision to register both centres separately.

The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives
and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purposes of application to register were found to be satisfactory. The nominated person on behalf of the provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre’s for Persons (Children and Adults) with Disabilities Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.

A number of relatives’ questionnaires were received by the Authority prior to and during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, relatives were very complimentary on the manner in which staff delivered care to their relative.

Evidence of good practice was found across all outcomes with 10 out of 18 outcomes inspected against deemed to be in substantial compliance with the Regulations. Outcomes judged to be fully complaint included health and safety, healthcare needs and medication management. Three outcomes were judged to be in major non compliance, which related to inadequate staffing resources at specific times, use of resources and lack of social activity. Four additional outcomes were judged to be in moderate non compliance, relating to suitability of the premises, governance and management, the admissions policy and some inaccuracies in documentation. A minor non compliance was found in relation to residents' rights, dignity and consultation.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority’s Standards.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Generally it was found that residents' were consulted with and participate in decisions about their care and running of the centre. Efforts were made to promote the rights of residents and there were ongoing efforts to improve the complaints process and seek the opinions of residents in relation to their satisfaction with the quality of the service provided. Resident's privacy and dignity was protected and promoted in practice, staff knew each of the residents well and understood their needs and preferences. A need to enhance the privacy and dignity of two residents was identified as there was a distance of only one meter separating their beds.

The person in charge agreed that one section of the dormitory was quite tight for space and that this had this impacted upon the dignity of two residents whose beds were placed close together. On the day of the inspection, the person in charge identified ways in which to alleviate this problem and provide additional space to each resident, by moving wardrobes. The inspector agreed that this would help address this issue.

The provider had developed a number of policies to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. These policies and guidelines also provided transparency in relation to the charges applied to each resident, including their long stay charge as well as any additional costs. These charges were also detailed within each resident's contract for the provision of services. The policies also allowed for a charge to be applied to meet staff costs while out of the centre supporting a resident, such as going for a meal or a coffee. However, the person in charge informed the inspector that staff rarely ever charged residents for these expenses and there was no evidence within individuals' financial records that they had been.
Records were kept of how much savings each individual had, which was held in a central organisational account. All residents had a financial capacity assessment completed, and this had determined that they did not have the ability to manage their own finances and required support to do so. Records were also kept of any additional expenditure for residents. The inspector reviewed a number of these and noted transactions were being signed by two staff members and checked by the person in charge (PIC). The person in charge also checked to ensure that individuals' monies were only used to benefit that person and not used for any group purchases.

The centre had a complaints procedure that met all of the requirements of the Regulations. There was a complaints log, however no complaints had been identified. A staff nurse was identified as the complaints officer and she had held one-to-one meetings with each resident monthly which were recorded for the last three months. This was in order to try to identify concerns and promote people's right to have greater choice in their contributions to their daily lifestyle. All residents had complex and differing communication requirements and this level of support was required to support decision making in this regard.

The main part of the centre comprised of a large dormitory style setting where 12 people lived with an additional 2 single rooms at each end of this dormitory. Concerns were expressed during the last inspection in relation to the dignity provided to three residents living in a separate part of the centre known as Sacred Heart. The previous inspection had identified this area as a secluded environment for three residents who lived there at that time. Since then, one resident had moved out, and the remaining two have transitions plans in place to relocate them. Each resident was already spending time in their new location, and there was a plan in place to move them on a permanent basis by January 2015. Within Sacred Heart there was also a large dormitory, which was not in use. However, the inspector viewed this area in consideration with its temporary use in providing respite care to six residents between September 2014 and March 2015. It was noted that there were also two single rooms available to this group, so therefore, four residents would be using the ‘dormitory’. The inspector noted that this would provide suitable temporary accommodation to this group of residents, while their own home was renovated as identified in the statement of purpose. The statement of purpose proposed using this areas for 'specific purpose respite care' until March 2015' upon which the provider would 'submit an application to vary' the number of registered beds in the centre which would mean a reduction in bed capacity from 22 to 14, closing the 'Sacred Heart' part of the centre completely.

Efforts have been made to personalise personal space and rooms, and residents were provided with adequate storage to keep their personal possessions. The inspector viewed lists of residents' possessions in each file, and these were updated regularly to ensure that residents' property was accounted for and to prevent items going missing.

Shower trolleys and chairs were used to assist in the provision of personal care to residents. These were also used to transport some residents to and from the bathroom to minimise the number of transfers and lifts. Dignity was maintained throughout this process and staff were observed bringing residents to and from the bathroom area.
Judgment:  
Non Compliant - Minor

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

Findings:  
The inspector found that the person in charge and staff were responding effectively to the communication support needs of residents. Relevant information was available throughout the centre in accessible formats. For example, pictures of each day's meals were provided and the complaints policy and residents guide was provided in an easy to read format. The person in charge and staff also acknowledged that more was required, as residents' ability to understand easy to read formats was not known. Therefore, they had begun the process of revising care plans to provide these in a more accessible way to individuals. This style referred to as 'communication passports' had been fully completed for two resident, with the key elements of their care plan now provided in photographs, to increase the involvement of them in the process.

The person in charge had arranged regular meetings in the centre as another way of supporting residents to communicate their views. The inspector saw notes of some of these meetings.

Residents had access to a cordless phone as well as access to a number of televisions. One resident was being supported to be more independent in her choice of television viewing in her own room by the provision of an especially adapted remote control. While this had not yet been provided, the referral to and response from the occupational therapist, showed a simple remote control had been ordered to support this resident to change channels herself.

Consistency and continuity of staff was described by the persons in charge as the most essential element in being able to assist residents communicate effectively. This was clearly evidenced by the inspector who witnessed staff pick up on subtle cues from residents' and could clearly understand each resident's method of communication.

Judgment:  
Compliant
**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:**  
The inspector did not have the opportunity to meet with family members during this inspection however, questionnaires reviewed from family members where highly complementary of the service and referred in particular to the approach from and the way in which staff communicate on a regular basis with family.

Care plans read by the inspector provided evidence of significant family input. In addition multi disciplinary support team meetings documented the involvement and inclusion of family members in decisions around behavioural support plans, medication reviews and healthcare needs.

There was an open visiting policy as reflected in the statement of purpose. There was a small private sitting room available for residents to meet family members in private.

**Judgment:**  
Compliant

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

**Findings:**  
There was a centre specific admissions transfer and discharge policy in place and it set out the arrangements for admitting new residents. This was also summarised within the statement of purpose. However, there are tentative plans in place to close the centre and this has been documented as taking place between four and six years. This long term aim was read by the inspector in the providers report on the quality of service provided, and also in an email from the provider nominee to the organisations.
admissions, transfer and discharge (ATD) committee.

The current admissions policy and transfer criteria did not refer to the proposed closure of the centre, and subsequent transfer of residents.

Each resident was provided with a contract for the provision of services which detailed the support, care and welfare of each resident and included the details of the services to be provided for that resident and the fees to be charged. Residents’ representatives were also provided with a copy of this contract.

**Judgment:**
Non Compliant - Moderate

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**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:**

In general it was found that there was a low expectation of residents needs in relation to need for social and meaningful activity, and the related 'person centred planning' goals had not been met for many residents.

Each resident had a personal plan and the inspector reviewed seven of these plans. In some cases, the inspector reviewed these care plans with the identified key working staff member, and in other cases, read them alone. Many assessed needs in relation to meeting the social aspect to people's lives were activities that would be deemed as basic rights and expectation for residents. For example, many care plans identified getting a hair cut which was provided on the campus, as a meaningful social activity. Hair cuts were provided on the campus at a cost to residents, but meant residents did not access community services. In addition, six of the seven care plans referred to identified a goal of going 'out for tea' (meaning off campus) once a month. Others referred to going to the onsite canteen or going for a drive once a month. These basis expectations had not been met in many cases. For example, documentation suggested that a number of residents had only left the campus two or three times in 2014. This was confirmed by
staff as well as by the person in charge. This had also been raised as an issue to the provider by the persons in charge in writing 4 weeks prior to the inspection, and was related to a recent reduction in staffing. The impact of these plans on the lives of residents has not been appropriately assessed to ensure that they were meaningful activities impacting positively upon their lives.

**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:**
Many of the actions identified in the previous inspection report had been addressed. Overall the centre was warm, well maintained and efforts had been make to make it homely. The centre is deemed a congregated setting and includes a dormitory style accommodation where 12 residents live. As detailed previously there is a long term plan in place to reduce number and ultimately close the centre. However, the bathroom which provides an accessible Jacuzzi style bath to residents was housed in a room that was not accessible to all residents.

A number of residents relied upon the use of a bathing trolley which was used to transport them to the shower area, and used to shower them while lying in the trolley. The option of a bath was not available to these residents as the entrance to the bathroom was narrow and there was no changing trolley or hoisting facility available within this bathroom.

Additional storage had been provided since the last inspection for shower trolleys and wheelchairs however, storage remained a difficulty where staff had to remove a number of items from the shower room before attending to the personal care needs of residents. Additional efforts to increase storage capacity must be considered to enhance accessibility to all within the area referred to as the 'square' which houses the bathroom, shower room and 'salon'.

There were separate dining areas for dining and relaxation. There was a large sitting room where residents relaxed during the day, watched television, listened to music, or
engaged in table top activity with staff. There was also a separate small sitting room, which provided an alternative relation space to residents. Residents also had unrestricted access to other parts of the campus as well as to outside space, as appropriate to their support needs. These needs were documented within care plans.

There were two sluice rooms in the centre required to meet the needs of residents who used bedside commodes at night time.

**Judgment:**
Non Compliant - Moderate

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

There was a health and safety statement in place which had recently been reviewed and updated by the provider. There was also a detailed risk management policy and associated risk register which provided a 'summary of risk' and well linked to the individual risk assessment contained within care plans.

Accidents, incidents and near misses were being recorded in detail and copies of the reports were submitted to the organisation quality and risk officer for review as well as to the organisations health and safety committee. A member of staff had recently been nominated health and safety officer in the centre and a summary log of incidents relating to health and safety issues was maintained in order to identify issues and trends. For example, there was a 'falls analysis' completed weekly, monthly and quarterly in order to identify any recurring issues in relation to falls management. There was also an emergency plan in place to guide staff in the event of such emergencies as power outages or flooding. An internal hygiene audit was also carried out on behalf of the provider on an annual basis.

Records reviewed by the inspector indicated that fire safety training had been provided to all staff since the last inspection in March 2014. There was a comprehensive fire evacuation plan in place and staff were knowledgeable in relation to this. The evacuation plan was posted clearly at all main exits. There were regular fire drills and staff were able to tell the inspector about what they would do if the fire alarm went off.
The records of the fire drills were detailed and included learning outcomes. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergency lighting.

Magnetic door closers had been identified as being required from a health and safety and fire evacuation perspective. This was being done to prevent internal doors from being held open with door wedges and to ensure doors were kept closed in case of fire. While this promotes best practice in relation to fire safety it also promotes independent access throughout the centre for residents who have mobility issues.

There were infection control measures in place to manage any outbreak of infection. There was also an industrial washing machine which had a sluice cycle on it. Alginate bags were used to launder soiled clothes and linen. Sluice facilities were available in two locations within the centre. Incontinence waste was collected three times a week by an external waste disposal contractor to minimise any infection control issues.

There was an emergency evacuation plan in place to guide staff in the event of such emergencies as power outages or flooding. An emergency pack was also available with blankets, torches; high visibility jackets and rain wear should it be required.

**Judgment:**
Compliant

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### 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

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

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

**Findings:**

Generally, there were arrangements in place to safeguard residents and protect them from the risk of abuse. There was a policy in place which had been reviewed and updated in May 2014 which provided guidance to staff on how to manage and report any concerns in relation to the protection of vulnerable adults. Staff spoken with were competent in their knowledge regarding reporting mechanisms within the centre and in how they would deal with any incidence of abuse. All staff had completed training in the area of adult protection. In addition, a plan was in place to provide a three hour information training session on the revised policy to staff who had completed
safeguarding training prior to the implementation of the new policy.

A restraint free environment was promoted within the centre. Any possible restrictions had been recorded and risk assessed and the use of any interventions to reduce likelihood of injury to any resident had been reviewed and reduced. For example, the use of lap straps and padded bed rails had been risk assessed and protocols were in place in care plans regarding the use of slings and hoists and bed transfers. All restrictive practices identified had been identified to the Authority through the notifications process. All practices had also been reviewed by a multi disciplinary support team, considering any alternative approaches and identifying how these practices enabled residents to be protected or to be transferred safely throughout the centre. Risk assessments included the rationale behind the use of the restrictions identified, such as increased absconding activity identified the need to use fobbed locks on some doors for one resident in one part of the centre. This restriction was also identified as temporary and there was a plan in place to remove this restriction completely.

Intimate care plans were implemented for each resident and had been reviewed in June 2014. However, they did not identify individual choices, abilities and needs in each area identified in relation to intimate and personal care. For example, sections 2 and 3 referred to the resident's physical abilities and communication needs in relation to personal care. These referred to general physical ability (i.e. use of stairs, use of transport etc) and general communication (i.e. non verbal) rather that identifying individual need in these areas relating to supporting personal care. This non compliance in actioned under Outcome 18: Records and Documentation.

Positive behaviour support plans were in place for those who required it. These plans used a traffic light system to indicate the supports required for residents. ‘Red' identified a crisis situation with interventions used such as pro re nata (PRN) or as required medication. Efforts had also been made to remove the need for PRN medication for one resident whose behaviour had been more settled and as a result his PRN had been withdrawn five months previously. There was no record of physical restraint within any care plans and the person in charge confirmed that this was not used.

**Judgment:**
Compliant

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**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):**
No actions were required from the previous inspection.
Findings:
The staff were maintaining detailed records of all accidents and incidents in the centre. These were reviewed by the person in charge and health and safety committee. All incidents had also been submitted to the Authority as required by the Regulations. Quarterly reports had also been submitted as requested and copies of all notifications were maintained by the provider.

The quarterly returns of restrictive practices (NF15) were reviewed by the inspector and person in charge during the inspection process.

Judgment:
Compliant

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:
The inspector found that residents had limited opportunity for new experience as identified previously within this report. However all of the residents had access to an day activation centre, that was accessed by residents for on average between one and two hours per day. Some residents had also been assisted to access community activities by staff from the activation centre. Services provided to residents in this way included music therapy, art, massage, reflexology, spirituality, advocacy group, and walks.

Considering the age profile and level of disability of residents these activities were deemed to be important to them, rather than focusing upon educational, training or employment opportunities. However, a critical component of this outcome reflects the need to ensure residents are engaged in social activities internal and external to the centre. Residents were not involved in external social activity.

Judgment:
Non Compliant - Major
Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that residents were supported to access health care services relevant to their needs. The inspector reviewed the health care plans and medical folders for a number of residents and found that they had access to significant multi-disciplinary supports including a general practitioner (GP) who visited on a daily basis. Other clinical supports included dietician and nutritional input, speech and language, dentistry, occupational therapy, psychiatry, psychology, clinical behavioural specialists and dementia care specialists. An outreach service was also provided from an acute hospital for epilepsy management.

All residents' care plans had long and short term nursing goals identified. Emerging needs were documented considering specific health care issues such as epilepsy, diabetic care, hypertension and preventing the recurrence of oedema. Personal care plans also had a section at the end summarising outpatient and consultant visits for each resident, detailing the details of the consultation and were then used to update health care plans as necessary.

Residents' dietary and nutritional needs, as well as food preferences were also detailed in their health care plans. These were used to inform the catering staff of dietary and menu requirements. Residents were provided with modified consistency diets and some residents required the assistance of staff to eat their meals. Staff were observed providing this support in a discreet and sensitive manner, engaging with the resident at all times. Residents were also encouraged to feed themselves, and specialist plates, cups and cutlery were provided through consultation with an occupational therapist to assist residents in this regard. Residents' food was fortified through the use of added butter or cream and supplements were also prescribed as required to assist residents' maintain weight. Weight loss charts were used to monitor the weight of all residents and residents were regularly reviewed by a dietician. Weight loss plans documented the need to weigh some residents on a weekly or monthly basis. Care plans stated that nutritional screening and weight recording charts were being used for all residents to monitor weight. However, assessment scores which would dictate any interventions necessary were not actually being calculated for any residents, including for one person identified as having unintended weight loss. While the person in charge suggested the dietician may be calculating and recording the assessment scores for residents, these records were not available in their care plans or medical record folders. This non compliance is actioned under Outcome 18 Records and Documentation.
Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall the inspector found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by qualified nursing staff.

The receipt of medication was being recorded and medication was being stored in a locked trolley in the staff office. The prescribing and administration of all medication was in compliance with the Regulations and in line with best practice guidelines. A pharmacist was available on site to provide guidance as required and also to audit medication. All unused medication was returned to this pharmacist in a prompt fashion, with a duplicate book used for this purpose. Drug errors were recorded and reported using the organisation accidents and incident sheets and reporting mechanism. A monthly 'MPARS' audit was carried out by the person in charge to assess the effectiveness of the MPARS system which is the system for prescribing and administering of medication.

Medication administration was observed and was found to be in line with best practice. Staff were also found to be knowledgeable with regards to residents specification medication requirements such as the need to crush medication, which was also documented on administration sheets.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There was a written statement of purpose that accurately described the service provided in the centre. It also included all of the information as required in Schedule 1 of the Regulations. The statement of purpose had also been made available to residents and their representatives.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Overall it was found that the management structure of the centre had impacted upon the ability of the person in charge to carry out some of their responsibilities autonomously. For example, the night supervising manager had the responsibility of signing off on night staff annual leave requests. This had impacted significantly on care provision at times, as day staff had to cover these shifts. As the person in charge and night manager had responsibility of arranging annual leave for day and night staff respectively, there was no attempt to coordinate annual leave across the staff team to minimise the impact on residents of a number of staff being on leave at the same time. Additionally, the persons in charge were not aware that the whole time equivalent (WTE) staffing allocation included cover for the number of hours to meet annual leave allocations within the centre. The inspector spoke with the director of human resources during this inspection to confirm this was included in the WTE. This was clarified as being the case and stated she had ensured nominee providers were aware of this. It appeared that this had not been communicated to persons in charge.

The provider had undertaken a number of audits and reviews of the quality and safety of the service. There were regular reviews of risk management arrangements and
incidents and accidents. The inspector read a report of an unannounced inspection of the centre carried out on behalf of the provider which is a requirement of the Regulations. This report highlighted progress in relation to the last inspection carried out by the Authority, as well as identifying areas for improvement independently.

A review of polices had also been carried out and a number of policies have now been updated or replaced including the policy of providing intimate care, safeguarding of vulnerable adults and fire protection.

The existing management structure includes supports for the person(s) in charge to assist her to deliver a good quality service. These supports included a service manager, clinical nurse managers and medical specialists. The nominee provider visited the centre regularly and was knowledgeable about the service. The person in charge also met with the nominee provider and others participating in management on a weekly basis, and these meetings were recorded.

Staff spoken expressed some dissatisfaction with the supports they received and the ongoing 'staff shortage' which they felt was not allowing them to meet many of the assessed needs or residents referred to in this report. For example, staff showed the inspector examples of where planned outings for residents had been cancelled on numerous occasions at the last minute due to staff shortages on the day. Staff also stated that there was no formal supervision and that annual performance reviews had not taken place as planned.

The inspector found that the person in charge and the deputising person in charge of the centre were appropriately qualified and had continued their professional development with ongoing training including appropriate management training. They had also exercised their personal and professional responsibility in highlighting many of the concerns raised in this report to the nominee provider by letter, which was referred to within Outcome 5 earlier in this report. It was also acknowledged that the named provider had been on leave for most of the time since the letter was sent.

**Judgment:**
Non Compliant - Moderate

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**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:
The inspector found that adequate arrangements were in place through the appointment of a deputising person in charge (PIC) who was an experienced clinical nurse manager and has a relevant management qualification. This deputising PIC has been operating as the person in charge since May 2014 as the permanent PIC has been on sick leave. This absence of the PIC had been notified to the authority as required within the Regulations.

The PIC currently running the centre was interviewed during the course of the inspection and was found to be suitably experienced and knowledgeable, deemed to be a fit person in charge. The roster also clearly identifies a staff nurse as being in charge on occasions when the PIC(s) were not on duty.

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

Findings:
The inspector found that there were insufficient resources provided to meet the assessed needs of residents' at specific times of the day. There were not sufficient staff on duty between 18:00hrs and 20:00hrs each evening and there was no clear rationale available as to why numbers of staff reduced dramatically at 18:00hrs.

The provider had identified the need for having seven staff on duty from 08:00hrs to 18:00hrs every day. However, this dropped to three staff on duty from the hours of 18:00hrs to 08:00hrs the next day. Six of the day time staff were located in the designated centre, while one was located within 'Sacred Heart'. From 18:00hrs, 2 staff were allocated to the designated centre with 1 allocated to Sacred Heart. In addition, a review of rosters over the month of July 2014 indicated that on no day did they have six staff on duty and that on eight days the day staff ratio actually dropped from five to four.

The provider had completed an assessment of staffing needs in August 2013 and again in 2014, this assessment was measured against the assessed needs of residents. However, the findings provided within these reports did not identify any reason for reduced resources during this identified time. In addition the inspector stayed on the premises until 18:30hrs on day 1 of the inspection to judge the need of residents as the
person in charge had suggested the drop in staffing numbers reflected a quieter time of the day. It was noted that a key difference from about 16:30 hours on, was that all residents were now in the centre as opposed to earlier in the day when most residents spend some time in the activation centre for between one and two hours each. Considering the fact that five residents required the use of a hoist and required two staff to support their personal care, this meant that when a resident required personal care after 18:00hrs (for example to go to bed) both staff on duty would be required to assist in the bathroom area and there was no available staff member to support the rest of the residents across a large centre.

The person in charge stated that there were additional supports available in case of emergency and the float staff member provided additional support during the hours of 20:00hrs and 23:00hrs. However, she also stated that this staff member was generally allocated to a different centre, judged to have a higher support need and was rarely available to support residents in this centre.

Overall there was insufficient transparency in the planning and deployment of staffing resources in the centre to demonstrate resources were appropriately managed to meet priority need. This was further evidenced by the fact that there was no knowledge of the assessed staffing whole time equivalent (WTE) as documented under Outcome 14; Governance and Management.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

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

Five staff files were reviewed and were found to contain all of the documentation as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations
Training records were held both centrally within staff files as well as locally within the centre. Training records provided identified that all staff had completed mandatory training in the areas of fire safety, manual handling and safeguarding of vulnerable adults.

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

It was found at the time of inspection that staffing levels were not appropriate to meet the needs of residents at specific times and this non compliance has been actioned under Outcome 16: Use of Resources.

Staff employed in the centre, observed and spoken to during the course of the inspection demonstrated an intimate knowledge of the residents they support. Residents were supported by two key working staff and the staff who were spoken to were familiar with the personal plans and goals set for their key clients.

Judgment:
Compliant

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

Findings:
The provider had completed a recent audit and review of all policies and procedures across the broader organisation and had just recently re-issued revised versions of a number of policies including safeguarding of vulnerable adults the provision of intimate care and fire safety. Many changes within the centre since the last inspection such as intimate care planning and the reporting procedures relating to abuse were now reflected within these policies. All of the policies and procedures as required by Schedule
5 of the Regulations had been developed. Some inaccuracies in relation to documentation were identified within the personal care plans of residents. These related to generic information contained within intimate care plans as highlighted under Outcome 8: Safeguarding and Safety and in relation to the nutritional and weight measurement tool referred to in Outcome 11: Healthcare Needs.

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

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

Records were been maintained in a secure and safe manner. Staff records were stored within the organisations head offices which were provided to the inspector by a member of human resource staff. The human resource department had completed it’s own audit of staff files to ensure compliance with the Regulations. Records were made available to the inspector as required during the inspection.

**Judgment:**
Non Compliant - Moderate

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**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:**

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Centre name: A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID: OSV-0003731
Date of Inspection: 05 August 2014
Date of response: 05 September 2014

Requirements

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The personal space of two residents was compromised by the proximity of their beds to one another.

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

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The furniture from this area was re-located to allow adequate space between both beds.

**Proposed Timescale:** 15/08/2014

**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:**
The current admissions policy and transfer criteria did not refer to the proposed closure of the centre, and subsequent transfer of residents.

**Action Required:**
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
The admissions policy and transfer criteria has changed to reflect the proposed closure of this centre and this is reflected in the statement of purpose

**Proposed Timescale:** 05/09/2014

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no comprehensive assessments of the residents social care needs provided within their care plans.

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

**Please state the actions you have taken or are planning to take:**
Keyworkers to individually meet with all service users monthly and agree to trial new social experiences. This activity sampling will form the basis of a yearly comprehensive assessment for each service user.
Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessed needs of residents contained within person centred care plans were not being met as documented within this outcome.

Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The PIC and PPIM attended a meeting with the Provider Nominee and the HR manager on the 27/08/14. The Whole Time Equivalence was reviewed and a new approved staff compliment agreed.

All PCP goals will be reviewed with the service user with clear outcomes developed based on choice and interests. This information will assist to develop goals. There will be a continuous review of this process.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plans had not been reviewed to assess their impact upon the lives of the residents to ensure that they were meaningful activities impacting positively upon the lives of residents.

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

Please state the actions you have taken or are planning to take:
The PIC will ensure that the personal plans are reviewed annually or sooner if needed to assess their effectiveness upon the lives of the service user and their participation in meaningful activities in accordance with their needs, interests and capacity.

Proposed Timescale: 30/06/2015

Theme: Effective Services

Outcome 06: Safe and suitable premises

Theme: Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathroom was not accessible to all residents.

**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 Bathroom will be accessible to all service users. Re-structuring of the bathroom will involve the installation of a ceiling hoist.

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Equipment was stored in the shower room reducing accessibility at all times for staff and residents.

**Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**
External storage will be made available adjacent to the building

**Proposed Timescale:** 31/12/2014

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In this case the need for education and training has been assessed as not required considering the age profile and ability of residents. However, in the absence of this need, there was minimal provision of external social activity to residents to provide for new experiences and to be linked to their broader community.

**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:
Short term activity sampling around new meaningful experiences outside the centre will occur for each service user monthly. These short term sampling activities will form the basis of the annual comprehensive assessment and goal setting that will be outcome focused and under continuous review.

Proposed Timescale: 30/06/2015

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:
The arrangement in place to carry out annual performance reviews with staff were not taking place as the person in charge did not have time to do so and was not allocated any designated management time/hours to do so.

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

Please state the actions you have taken or are planning to take:
The PIC will complete an annual performance review for all staff in this designated centre for the current year.

Proposed Timescale: 20/12/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lines of accountability in relation to the rostering of all staff in order to provide consistent care to residents was not clearly assigned.

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 system of night supervising manager signing off on annual leave for night staff will be phased out by the 31/12/14. This will then become the total responsibility of the PIC.
### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider had not ensured that the centre was adequately resourced after 18:00hrs to adequately meet the assessed needs of all residents personal care plans.

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

**Please state the actions you have taken or are planning to take:**
PIC plans to re-structure the current roster and order of the day to meet the identified service users needs at vital times within the current resources.

**Proposed Timescale:** 31/10/2014

### 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 medical and nursing records were not being adequately maintained in order to direct care provision in the documentation of residents intimate care guidelines and weight and nutritional management records.

**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 intimate care plans will be reviewed and will be more service user specific. The weight and nutrition management records have been reviewed and are now current. There is a process in place to audit these on a monthly basis.

**Proposed Timescale:** 30/09/2014