| Centre name: | A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd. |
| Centre ID: | OSV-0004020 |
| Centre county: | Dublin 15 |
| Email address: | caroline.farrell@docservice.ie |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | Daughters of Charity Disability Support Services Ltd. |
| Provider Nominee: | Mary O'Toole |
| Lead inspector: | Michael Keating |
| Support inspector(s): | None |
| Type of inspection: | Announced |
| Number of residents on the date of inspection: | 14 |
| Number of vacancies on the date of inspection: | 0 |
About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times

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

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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 11 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. One outcome was judged to be in major non compliance, which related to inadequate staffing resources at specific times. Five additional outcomes were judged to be in moderate non compliance, relating to suitability of the premises, the admissions policy, the availability of social activities for residents’ and some inaccuracies in documentation. A minor non compliance was found in relation to governance and management.

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:
Overall it was found that residents’ were consulted with and participate in decisions about their care and running of the centre. Ongoing efforts were made to promote the rights of residents and 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.

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.

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. 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 person in charge was also provided with a balance sheet reflection the amount of money each resident had in savings. This had been introduced since the last inspection, and highlighted the vast variance in the amounts of money individuals held on account, and provided greater clarity and transparency on individuals’ expenditure to the person in charge as well as to the resident and their representative.

The centre had a complaints procedure that met all of the requirements of the Regulations. There was a complaints log in place, however no issues 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.

House meetings were also held every six to eight weeks and minutes of these meetings were recorded. The person in charge described these as information sessions, which were more effective for some than others because of capacity and communication issues. The key working system was used to try and keep residents informed and consulted more individually. A charter of rights was provided in an easy to read format.

The centre had a large dormitory style setting where 12 people lived with an additional 2 single rooms at each end of this dormitory. 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:**
Compliant

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**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 residents involvement 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. A number of residents had also trialled a 'talking photo album' which was deemed to be successful for some. Residents also had access to a clinical nurse specialist in assistive technologies to support them in this regard. Family members spoken with during the inspection also referred to a recent 50th birthday party that was held in the centre for their sister. They were highly impressed by the efforts of staff to celebrate this occasion and spoke about the numbers of staff who had attended in their own time. In addition,
they stated that 'Skype' technology had been used to share the celebrations' with the residents sister in Canada who was delighted with this.

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

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**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 had the opportunity to meet with family members during this inspection and they were highly complementary of the care provided to their sister. They had not been expected to visit, and decided to 'drop in'. They stated that they did this regularly and were always made feel welcome and were encouraged to visit at any time.

The inspector received a number of completed relative questionnaires from family members which were highly complementary of the service and referred in particular to the efforts made by staff to promote communication 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.

The person in charge commented on the need to enhance links within the broader community and to 'look more closely at what is out in the community'. In addition, persons participating in management stated discussion had taken place to plan ways in which to promote services available on the campus amongst the broader community which would promote community inclusion for residents. While these efforts reflect the fact the residents were accessing the community intermittently, this area for improvement is discussed further and actioned under Outcome 5: Social Care Needs.
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):
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
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. There was a very limited focus on outcomes and goals chosen reflected the provision of one off activity or infrequent social outings.

Each resident had a personal plan and the inspector reviewed a number 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, all care plans reviewed referred to the opportunity to go to a local shopping centre once a month as a meaningful social activity, while other care plans referred to going 'out for tea' (meaning off campus) once a month. Others referred to going to the on site canteen or going for a drive once a month. These basis expectations had not been met in some cases, reportedly due to staff shortages. A letter had been sent to the nominee provider by the persons in charge highlighting this as a service deficit due to staff having been reduced from 6 to 5 during the day, in recent months. An audit of all care plans and subsequent actions had also been completed by the person in charge. As a result, staffing had increased back to six over the past 3/4 weeks. Since then, evidence within plans reflected that social activities had increased. For example, during the days of inspection, three residents had been supported to go on day trips, two residents went to the Zoo and one went to the Dublin Horse Show. In addition, evidence within care plans suggested that family members and volunteers had also been used and encouraged to provide meaningful social outings to residents.

As the increased opportunities for social activity have been so recent, there has been limited opportunity to assess the effectiveness of these social activity plans. However, as opportunities improve effort must be made to demonstrate and ensure personal plans are drawn up to ensure residents participate in meaningful activity; appropriate to
his/her needs interests and capacities

Judgment:
Non Compliant - Moderate

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

One resident 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 this resident 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.

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 relaxation 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
**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. Recent drills had identified issues in relation to one resident refusing to evacuate the premises. A multi-element support plan was drawn up to encourage this resident to evacuate safely and independently. A behavioural specialist took the lead in devising and revising this plan, and the residents' family were involved also. Ultimately this led to the safe evacuation of this resident and the ongoing control measures includes the implementation of bi-monthly fire evacuation to ensure this resident's ability to evacuate remains constant at this time.

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. 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 the use of an alarm mat to alert staff to the fact that a resident had got out of bed, who had an inconsistent sleep pattern and had a history of falling from bed, including when bed rails had been used.

Intimate care plans were implemented for each resident and had been reviewed in June 2014. However, some did not identify individuals' 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. There was no record of physical restraint within any care plans and the person in charge confirmed that this was not used.

Judgment:
Compliant

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. Both the person in charge and the
person who deputised in her absence were aware of all incidents the needed to be notified to the Authority.

**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 a day activation centre, that was accessed by residents for on average between one and two hours per day. Services provided to residents in this way included music therapy, art, massage, reflexology, spirituality, advocacy group, and walks. Some residents had also been assisted to access community activities by staff from the activation centre, by family and by volunteer staff.

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 were engaged in social activities internal and external to the centre. Records from the first six months of 2014 suggested that residents' opportunity to experience external activities had been minimal, although it was recognised that there had been some improvement in this in recent weeks.

**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):**

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 multidisciplinary 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 and to review regular medication to introduce 'cleaner drugs', with the aim of reducing the side effects associated with long term use of anticonvulsants.

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, dementia care, skin integrity, renal function and mental health supports. Pressure relieving cushions and mattress were used for one resident who had a detailed physiotherapy assessment which introduced the use of a 'sleep system' aimed at improving postural and positioning issues. The person in charge has also received specific training in phlebotomy and warfarin reading (International Normalised Ratio [INR] Testing).

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. Fluid and nutritional observation sheets were used for one resident due to an erratic sleep pattern to ensure her calorie assessment was monitored over a 24hr basis. This resident was also written up for nutritional supplements as required and IV fluids if necessary. The point at which either of these interventions would be used was clearly documented upon her food and nutritional care plan.

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 weight
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 were not actually being calculated for any residents, including for one person identified as having unintended weight loss. This resident has a recorded weight loss of 6kg (5% of body weight) between February and April 2014. In addition, her weight had not been recorded in March 2014. While the person in charge suggested the dietician may be calculating and recording 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. The last 'action plan' from this audit identified the need to strengthen the link between monitoring the effect of any PRN (as required) intervention. While the outcome of the intervention was documented within the resident's medical notes, the notes in the comments section within the administration sheet were inconsistent. This inconsistency had been resolved as a result. An audit of all PRN medication had also been recently introduced to ensure that the medication in storage matched the administrating records.
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 included 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.

The inspector found that the person in charge and the person deputising in her absence were appropriately qualified and had continued their professional development with ongoing training including appropriate management training. The person in charge returned from annual leave on day 1 of this inspection as she wanted to be there to support the inspection process. The person deputising in her absence also supported the inspector throughout both days of inspection. Both persons were interviewed during the inspection and were found to be suitably experienced, qualified and knowledgeable to carry out their roles effectively.

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 were referred to within Outcome 5 earlier in this report. Following this letter, the concerns raised were addressed promptly by the nominee provider, for example, the staffing numbers had returned to the assessed levels.
Judgment: Non Compliant - Minor

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 named person to deputise in the absence of the person in charge, the appointee was an experienced clinical nurse manager. The roster also clearly identifies a staff nurse as being in charge on occasions when both the person in charge and her deputy were not on duty.

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

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 six staff on duty from 08:00hrs to 18:00hrs every day. However, this dropped to two staff on duty between the hours of 18:00hrs and 20:00hrs before increasing again to 3 staff from 20:00hrs to 23:00hrs. Staffing was again then reduced to two during the night when residents were in bed which was deemed suitable to meet support requirements during night time hours. 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. Therefore, 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.

**Judgment:**
Non Compliant - Major

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**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

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**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.

Six 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 2013.

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. Additional centre specific training had also been provided as required in the areas of phlebotomy and warfarin management.
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

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**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

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

**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 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
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<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-0004020</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>07 August 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>05 September 2014</td>
</tr>
</tbody>
</table>

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 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 is reflected in the statement of purpose.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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 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 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 person in charge will ensure that the personal plans are reviewed annually or sooner if needed to assess the effectiveness upon the lives of service users and their participation in meaningful activity in accordance with their needs, interests and capacity.

Proposed Timescale: 30/06/2015
**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathroom, with the accessible Jacuzzi bath 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. Restructuring of the bathroom will involve installing a ceiling hoist.

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

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**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 of the centre will occur for each service user monthly. These short term activity samplings 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 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 person in charge.

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

### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no assessed or identified reasons as to why the staffing resources reduced so significantly between the hours of 18.00 and 20.00.

**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:**
Person in charge plans to re-structure the current roster and order of the day to meet the identified service user’s 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: 31/10/2014