

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003953
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	John O'Callaghan
Lead inspector:	Julie Hennessy
Support inspector(s):	Gemma O'Flynn;
Type of inspection	Announced
Number of residents on the date of inspection:	9
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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 September 2014 09:00	01 September 2014 17:30
02 September 2014 09:00	02 September 2014 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This report sets out the findings of an announced monitoring inspection of Group F Community Residential Services. This was the first inspection of the centre by the Authority.

Inspectors met with residents, staff members, the person in charge, the provider nominee and other members of the management team. The centre comprises two houses in residential community settings. The centre may accommodate 9 residents. A monitoring inspection was carried out in one of the two houses, which may accommodate 5 residents. There were no vacancies at the time of inspection.

Inspectors found evidence of good practice in a number of areas. The provider nominee demonstrated a commitment to the regulatory process. The person in charge was a suitably qualified, skilled and experienced person. There was evidence of good governance and management in a number of key areas. The provider nominee had completed an unannounced visit to the house and there was evidence that this visit contributed to improving the quality and safety of the service for residents.

The inspector found that residents' health and social needs were met by staff in the centre. Staff knew the residents well and interacted with residents in an appropriate, respectful and warm manner. Residents were supported to participate in meaningful activities, appropriate to their individual preferences and abilities. Residents' independence was maximised and residents' were supported to develop and maintain family links.

Inspectors found that the centre was not in compliance with fire safety legislation; the provider had engaged the services of competent persons in the area of fire safety to complete risk assessments and a plan was in place to bring the centre to a level of compliance.

Inspectors found other non-compliances in areas relating to record-keeping and documentation, personal planning, arrangements relating to the absence of the person in charge, staff training, health and safety and medication management, which will be outlined both in the body of this report and in the action plan at the end of this report.

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

This was the centre's first inspection by the Authority.

Findings:

Overall, inspectors were satisfied that residents were consulted with and participated in decisions about their care and the organisation of the centre. Some improvements were required in the documentation of complaints and the arrangements for ensuring residents were facilitated to vote, if they so wished, needed to be more robust. The documentation of intimate care practices required improvement to ensure consistency in approach to specific needs was maintained.

Residents were consulted as to how the centre was run and minutes of monthly resident house meetings were available to inspectors. Minutes documented that residents were happy in the centre and demonstrated that each resident had an opportunity to contribute to the meeting. Meeting minutes showed evidence that residents were informed of key events such as a change in staff. Inspectors found that in some instances the meetings lacked a structured agenda to further enhance the opportunity for feedback from residents. Where a resident raised an issue, it wasn't always clear in the documentation what action had been taken; however, staff with whom an inspector spoke were able to describe what follow up action had been taken. Residents were encouraged to advocate for themselves and had access to an external advocacy service. An inspector saw evidence that some residents had attended an advocacy learning day and a charter of rights was clearly displayed in the centre.

There were policies and procedures in place for the management of complaints and these were also available in an easy to read version. However, the complaints policy was inaccessible as it was obscured by other documentation upon a notice board; this was promptly rectified to ensure it was clearly displayed. There was evidence that complaints were documented and that complaints were discussed at staff team meetings to ensure all were aware, however, the documentation of complaints did not meet the

requirements of the Regulations. For example, whether the complaint was resolved or if the complainant was satisfied was not documented as required by the Regulations.

Inspectors found that staff treated residents with respect and dignity in all interactions. Bedroom doors were kept closed unless the resident requested otherwise. However, inspectors found that staff were unable to assist a resident who had specific care needs with dressing in the bathroom and the resident had to be brought from the bathroom, across the hallway, to her bedroom to be assisted with dressing. Although staff demonstrated that they had put arrangements in place to ensure that the privacy and dignity of the resident was maintained during such times, an intimate care plan was not in place to ensure that staff were consistent in their approach.

The centre was managed in such a way so as to maximise residents' capacity to exercise autonomy and choice in their daily lives. Routines reflected residents' choice and preference for example, residents were facilitated to lie in on a morning if they so wished.

Residents were facilitated in exercising their religious rights; however, there was a lack of robust arrangements in place to ensure all residents were given the opportunity to vote. Whilst staff told the inspector that two residents of one house in the centre had voted, it was not clear if the remaining residents had been registered to vote or if they had been asked about their preference to vote or not.

There was a policy on residents' personal possessions and residents' property was kept safe via appropriate record keeping seen in the residents' personal files. Residents were supported to do their own laundry if they so wished and for some residents the folding and putting away of laundry had been identified as a life skill to focus on.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that residents' wellbeing and assessed needs were being met and that residents had opportunities to participate in activities that were meaningful to them. Improvements were required in relation to personal planning.

Inspectors reviewed residents' records and found that a comprehensive assessment of needs had been completed for each resident which identified their individual needs and requirements. The assessment of needs included an assessment of the residents' medical and health needs, their spiritual needs, psychological needs and social integration needs. Where multi-disciplinary input was required, it was provided and implemented in practice.

Each resident had a written personal plan. However, personal plans did not fully meet the Regulatory requirements. Information in personal plans was insufficient to direct care. For example; for a resident who was non-verbal, there was very little information in their file in relation to how to communicate with the resident and; for a resident who was not sleeping well, although a sleep chart had been commenced, there was no information in their file in relation to their sleeping difficulties. Information was disjointed and not easy to retrieve, for example current and discontinued programmes were filed together. Goals were mainly activity-based instead of outcome-focussed, making it difficult to see how the goal contributed to improving the residents' quality of life. Supports required to assist residents to achieve their goals were often non-specific or not stated. Family involvement in personal planning was not documented, although residents and staff confirmed that family were involved in the process.

The inspectors noted that the provider had identified gaps in relation to personal planning in the report arising from unannounced visits to the designated centre and had taken steps to address such gaps. For example, a new personal plan format based on an accredited model had been selected. The new personal plan was being trialled across the organisation with four individual residents. An information session in relation to the new personal plan had been held for all staff and training was being organised by the CNM3 (Clinical Nurse Manager). The person in charge was also fully aware of the gaps and was involved in the steps being taken to address the identified gaps.

There was evidence that residents were fully involved in the development and review of their personal plans. Residents described the contents of their own personal plans to inspectors.

The process involving the review of personal plans was clear and formal reviews took place every six months. An annual report of such reviews was completed by the person in charge for the provider. Such reviews included whether goals were being achieved and any challenges to achieving set goals.

Residents had the opportunity to participate in activities that were meaningful to them. All residents attended day services. Residents were supported to participate in meaningful activities, appropriate to their individual preferences and abilities; a number of residents were seen to participate in and enjoy a beauty treatment and engage in 'table-top activities'.

Residents confirmed that they had the opportunity to engage in activities outside of the centre such as go to the local pub or meet a friend in a cafe. The person in charge told the inspector of how some residents had taken part in 'The Great Limerick Run'. There was group run by the organisation whereby a resident could become friends with someone outside of the service and staff told the inspector of one resident who attended this group.

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):

This was the centre's first inspection by the Authority.

Findings:

Overall, inspectors found that the health and safety of residents, visitors and staff was promoted and protected.

The centre had an up to date safety statement and risk management policy. There were adequate arrangements in place for learning from adverse incidents. An incident report form was completed and the steps required to minimise the possibility of recurrence was recorded by the appropriate staff member. There was evidence that incidents were discussed with staff at house level to ensure that learning's were adequately communicated. There was up to risk assessments in place, however, routine hazard inspections were not being carried out so as to identify new or changing hazards and to ensure that existing controls were being implemented and were adequate. The centre was free from obvious hazards at the time of inspection.

There was general cleaning guidance and cleaning standards in place. However, not all procedures in place for ensuring that residents were protected against infection were clear. For example; management were unable to tell the inspector which standards were being applied in the centre in relation to the use of cloths and mops in different areas; staff were inconsistent in their understanding of the use of different mops and cloths in different areas of the house and; the centre's own cleaning standards were not being implemented in regards to the maintenance of mop heads as not all mops were washed daily after use.

An inspector found that there was leftover food stored in the refrigerator without a date or label in place which is not in line with relevant guidelines on food safety.

Staff were able to identify hand hygiene as an important means of infection control and were able to identify appropriate moments for hand hygiene. Senior house staff were

able to discuss what they would do in the event of outbreak of infectious disease and appropriate equipment was available in the house for the purposes of infection control. Alginite bags were available to launder contaminated clothing and staff were knowledgeable of appropriate temperatures at which to wash contaminated laundry.

The centre was not in compliance with fire safety legislation and the provider showed the inspector a recent fire risk assessment and subsequent recommendations undertaken by persons competent in the area of fire safety. Inspectors were satisfied that the provider was developing a plan to undertake these recommendations. The provider confirmed that the expected time-frame for such works to be completed was between three and six months.

Suitable fire equipment was available and service records were available and were found to be up to date. There was adequate means of escape and daily checks were undertaken and recorded to ensure that exits were unobstructed. There was a prominently displayed fire evacuation plan displayed in the centre and a personal emergency evacuation plan was displayed adjacent to the evacuation plan. The personal evacuation plan did not fully address the cognitive needs of all residents to ensure a prompt evacuation and where there was complex mobility needs, the inspector was not satisfied that the evacuation plan had been developed in conjunction with a suitably qualified person. This was discussed with the provider prior to the close of inspection and the plan was subsequently reviewed, amended and signed off on by a competent person in the area of fire safety.

There was evidence that fire drills were held monthly and the centre had recently introduced a new form to capture learning's from these drills. Inspectors found that the documentation required development to ensure that the location and time of the fire drill were recorded and that where an issue had occurred during a drill, for example, a resident not responding to the alarm, it was not clear what action, if any, had been taken to address the issue going forward. This is important to ensure that learning's from previous fire drills contribute to the development and improvement of future drills and potential evacuations in the event of an emergency.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. Residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted.

There were organisational policies in place in relation to the protection of vulnerable adults and behaviour that challenges.

Inspectors viewed training records that confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Inspectors spoke with staff who were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Although training for volunteers had not taken place, it was scheduled, as required by the organisation's volunteer policy.

Inspectors spoke with residents who confirmed that they felt safe in the centre and that knew who to talk to if they needed to report any concerns of abuse.

There was a nominated person to manage any incidents, allegations or suspicions of abuse and staff were able to identify the nominated person.

Inspectors found that there were two training programmes in place relating to the management of behaviour that challenges. Although all staff had attended one training programme, this training did not meet the Regulatory requirements as it did not include de-escalation and intervention techniques. However, inspectors noted that where staff were working with residents who had behaviours that challenge; those staff had received additional training that did meet the Regulatory requirements as this programme did include de-escalation and intervention techniques.

Inspectors reviewed personal plans, plans for support behaviour that challenges and risk assessments and spoke with staff in relation to behaviour that challenges. Residents were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour and consent was documented for supports in place.

An inspector reviewed a resident's file who had behaviour that challenges and found that there were clear strategies in place. Detailed psychiatric assessment had been completed for the resident that led to recommendations that were incorporated into the resident's personal plan. Staff were able to describe the strategies in use. Strategies demonstrated a positive approach to behaviour that challenges including the use of sensory strategies to keep the resident calm; the use of distraction techniques such as participation in activities and; pictorial prompts had been devised to aide communication.

However, some improvement to documentation was required; while information in the folder for relief staff contained detailed information in relation to an individual's behaviour that challenges; it did not include information about how to support the individual to manage their own behaviour or de-escalate certain situations. This will be further discussed under Outcome 18: Records and Documentation to be kept at a Designated Centre and in the associated action.

Restrictive practices were in place in the centre, including bedrails, a lap-belt for a shower chair and the disabling of a motorised wheelchair. Evidence of multi-disciplinary team review of restrictive practices was not available in the centre at the time of the inspection but this evidence was submitted by the provider immediately following the inspection.

Some improvements were required in relation to the documentation pertaining to the use of bedrails, which will be further discussed under Outcome 18: Records and Documentation to be kept at a Designated Centre and in the associated action.

Inspectors reviewed arrangements in place for managing residents' finances and found a clear and transparent system in place. Residents were involved in the management of their own finances, as far as reasonably practicable. Inspectors reviewed a sample of records and found a clear system of logging and tracking of all transactions, with receipts and records and an auditing system in place.

Judgment:
Non Compliant - Minor

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that residents were supported on an individual basis to achieve and enjoy good health.

Inspectors reviewed residents' personal plans as they related to healthcare and found that residents had timely access to their own general practitioner (GP) and access to other medical professionals as required. Inspectors found that residents had access to medical treatments where recommended, including ongoing monitoring of blood tests and scans. Inspectors found that residents had access to a range of allied health services and viewed referrals to a speech and language therapist, optician, psychologist,

dentist and dietician.

Inspectors found that the health of residents was monitored on an ongoing basis and viewed records of monthly checks completed by staff and forwarded to the Clinical Nurse Manager (CNM). Such checks included monitoring of blood pressure and the weight of residents. Three-monthly breast checks were completed by a staff nurse for female residents.

Inspectors reviewed residents' files and found that resident's consent was documented in relation to intimate care and other aspects of healthcare including; who can give consent to attend medical or hospital appointments and consent by the resident to have bloods taken.

Staff told inspectors that residents had access to appropriate health information including in relation to exercise, healthy eating and protection against illness. Inspectors viewed information relating to healthy eating on the notice-boards. Residents had individual exercise programmes, which were encouraged by staff and which residents confirmed that they enjoyed.

There was evidence in resident's files that advice from a dietician and other specialists in relation to managing the specific dietary needs of residents was sought where required. However, improvement was required to documentation. For example, where a resident was on a special diet; there was no additional information in the resident's file in relation to this area of need. This will be further discussed under Outcome 18: Records and Documentation and in the associated action. It was evident however that staff were implementing the advice of the dietician as a food chart was being maintained for the resident, as requested by the dietician.

The house had a kitchen and dining area which was domestic in nature and clean. Residents were involved in weekly meal planning, shopping and in daily kitchen tasks.

An inspector observed a meal that had been prepared for lunch in one house and noted that it appeared nutritious and healthy. Lunch was a sociable and relaxed occasion. The fridge was well stocked and there was a plentiful supply of fruit and vegetables in the house. Staff were knowledgeable about residents' likes, dislikes and preferences. Residents had access to snacks throughout the day. Any assistance offered was done so discreetly.

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):

This was the centre's first inspection by the Authority.

Findings:

Overall, inspectors found that residents were protected by safe medication management policies and practices. Improvements were required to the medication management policy and inspectors found that the systems in place to ensure that medications were administered as prescribed were not sufficiently robust.

There was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications. One aspect of the policy required review: the policy stated that although medicinal products that require refrigeration should be stored in a dedicated fridge, that where there was no separate refrigerator in a house for medicines, it would be acceptable to store medications in a locked cash-box in the kitchen fridge. This is not in line with best practice due to the temperature differences between domestic and medication fridges and the difficulties with accurately monitoring the temperature of a domestic fridge. Inspectors found that in practice; any medicines that required refrigeration in the designated centre were actually stored in a dedicated locked fridge and a log of daily temperature readings was maintained. The need to address this issue at policy-level will be further addressed in Outcome 18: Records and Documentation to be kept at a Designated Centre and in the associated action.

The inspector spoke with staff and found that they were familiar with the guidance as outlined in the policy.

An inspector reviewed residents' files and found that individual medication plans were appropriately implemented and reviewed as part of the personal plan review process. Information relating to each resident's medication was maintained in their file in an easy-to-read format.

Prescription charts and administration charts were completed in line with relevant professional guidelines and legislation. All medications were individually prescribed. The inspectors noted that the maximum dosage of PRN ("as required") medications was prescribed and all medications were regularly reviewed by the GP.

There were no residents prescribed controlled medications at the time of inspection.

Medication errors were recorded and monitored. Where errors occurred, there was a record of what action had been taken, for example, whether the doctor was called. However, inspectors found that the system for managing medication errors was not sufficiently robust and that there was room for improvement in relation to recording actions to be taken to prevent a re-occurrence. For example, one action in response to an error was that "staff must be vigilant in administering medications", however, this is an expected outcome of an action and the steps necessary to support staff and improve practices relating to the safe administration of medication were not specified.

The inspectors reviewed medication management audits and found that there had been a number of medication errors in the preceding months including for example, a missed

dose; the person in charge and CNM3 had taken appropriate action to address this, including the scheduling of training and re-training of staff by a pharmacist.

While staff had received training in medication management, training records indicated that for one staff member this had taken place in 2011. The recent medication errors in the centre would indicate that refresher training in this area was required and as mentioned above, training was scheduled to take place. This will be further addressed under Outcome 17: Workforce and in the associated action.

Residents were supported to manage certain aspects of their own medication, as appropriate to their individual capabilities and wishes. An assessment had been completed for any resident who was involved in managing aspects of their own medication.

Unused and out of date medications were secure and segregated from other medicinal products, as required by the Regulations and a record of returns to pharmacy was maintained.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that there was an effective management system in place, clearly defined management structures and the person in charge had the required skills, qualifications and experience to manage the designated centre.

The inspectors found that there was a clearly defined management structure in place in the designated centre. Inspectors spoke with staff and residents and found that staff were clear in relation to lines of authority and residents were able to identify the person in charge.

The person in charge was in a full-time post and was the person in charge for two designated centres. The person in charge had the necessary experience and qualifications, as required by the Regulations. The person in charge was fully aware of her responsibilities under the Regulations. The person in charge was involved in the day to day running and operation of the centre and visited the centre formally weekly and was in contact with the social care leader of the house informally on a frequent basis and as issues arose.

Residents' views were sought and in 2013 all residents were invited to participate in a service satisfaction survey. The provider nominee had completed an unannounced visit to the designated centre, as required by the Regulations. Audits took place within the service including in relation to medication management, fire safety, health and safety and hygiene. The provider outlined the system in place for carrying out an annual review of quality and safety of care of the service.

The provider outlined the types of arrangements in place relevant to the designated centre that ensured staff were facilitated to discuss issues relating to safety and quality of care and that staff could exercise their responsibility for the quality and safety of the services that they delivered. House meetings were held every three months and attended by the person in charge. Staff confirmed these meetings took place and inspectors reviewed minutes of such meetings which were very informative. Meetings between social care leaders (who supervise each house on a day to day basis) and the provider took place six times a year. Full service meetings took place three times a year and took the form of an open forum that all staff were encouraged to attend. Weekly management team meetings also took place that included the provider and person in charge.

The provider told inspectors that staff appraisals were completed on an annual basis and this was confirmed by staff. Records of staff appraisal were maintained on staff files.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:

There had not been any occasions where the person in charge was absent for 28 days or more from the centre.

There were support structures and staff in place for times that the person in charge was not in the centre, including support by a social care leader in each house, a CNM3 dedicated to oversee the centre and a CNM3 on call for the service outside of normal working hours.

However, formal arrangements were not in place that identified a specific deputising arrangement for any notifiable absence of the person in charge. This was discussed with the person in charge and the provider during the inspection.

Judgment:

Non Compliant - Minor

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors found that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents and that the staff rota was properly maintained.

Inspectors found that there was an accurate staffing roster showing staff on duty which included the times that all staff were on duty. Over the course of the inspection, staffing levels were adequate to meet the needs of the residents.

The provider outlined how protected hours for social care leaders of three hours per week had been introduced in the preceding weeks to support the person in charge in meeting regulatory requirements, particularly in relation to the need to improve residents' personal plans.

There was a training plan in place for 2014. The annual staff appraisal system facilitated the identification of staff training needs. Inspectors spoke with staff who confirmed what training they had received and records of training were reviewed. As previously

mentioned, the inspector found that not all mandatory training had been provided in accordance with the Regulations, specifically in relation to behaviour that challenges. Training for volunteers in relation to the protection of vulnerable adults was scheduled to take place. As previously mentioned in Outcome 12: Medication Management, the person in charge and CNM3 confirmed that staff required training and refresher training in relation to medication management. Training in first aid was scheduled.

Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to hand hygiene, safe moving and handling, food safety and specific topics such as ageing and intellectual disability, the management of diabetes and the identification and management of dysphagia.

Staff were aware of the Regulations and Standards. Inspectors noted that the organisation had held information and training sessions for staff and management in relation to the Regulations and Standards, in accordance with their roles and responsibilities.

There was a system in place for the management of volunteers within the organisation, which was overseen by the volunteer coordinator. There was a volunteer policy in place which clearly set out the roles and responsibilities of volunteers in writing; all volunteers provided a vetting disclosure; volunteers were interviewed prior to commencing as a volunteer; three references were sought for each volunteer and; there was a clear training and supervision system in place.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place.

Staff files were not reviewed on this inspection, however, files were reviewed on a number of occasions in recent months and the Authority were satisfied that there was a robust system and audit procedure in place to ensure completeness of files as required in Schedule 2 of the Regulations.

Judgment:
Non Compliant - Minor

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):

This was the centre's first inspection by the Authority.

Findings:

At organisational level, significant work had taken place in relation to policies required under Schedule 5 of the Regulations in the preceding months. Improvements were required to records and documentation to ensure completeness, accuracy and ease of retrieval.

A directory of residents was maintained in the centre and this contained all of the items required by the Regulations. The centre was adequately insured against accidents to residents, staff and visitors.

A record of residents' assessment of need and a copy of their personal plan was available. The inspector found that a record of nursing and medical care provided to the resident including any treatment or intervention was maintained. However, residents' files were not fully complete as some information was held with their day service. This was previously addressed under Outcome 5: Social Care Needs in the context of personal plans and in the associated action.

Improvement was required to documentation relating to residents' healthcare needs. As previously discussed under Outcome 11: Healthcare Needs, where a resident was on a special diet; there was no additional information in the resident's file in relation to this area of need.

As previously discussed under Outcome 8: Safeguarding and Safety; improvements were required in relation to ensuring documentation maintained in a resident's file is consistent. While detailed information relating to a resident with behaviour that challenges was in the resident's file; not all of the relevant information was available in the relief staff folder. Information in the folder for relief staff contained detailed information in relation to the individual's behaviour that challenges; however, it did not include key information that was available elsewhere in the file about how to support the individual to manage their own behaviour or de-escalate certain behaviours. It is important that such information is available to relief staff who do not know the resident well in order to ensure a consistent approach is adopted between relief and regular staff.

Improvements were required in relation to documentation of the use of bedrails; a specific risk assessment for the use of bedrails had not been completed nor were there any monitoring records relating to its usage, as required by relevant national policy.

Records relating to money or valuables, other personal possessions, notifications and staff rotas were maintained, stored securely and were easily retrievable.

A significant amount of work had taken place in relation to the development of policies at organisational level in the preceding months. The majority of policies required under Schedule 5 of the Regulations were in place. The two outstanding Schedule 5 policies were in draft format; 'communication with residents' and 'access to education, training

and development'.

As previously discussed under Outcome 12 Medication Management; one aspect of the medication management policy required amendment. The policy stated that although medicinal products that require refrigeration should be stored in a dedicated fridge, that where there was no fridge in a house it would be acceptable to store medications in a locked cash-box in the kitchen fridge. This is not in line with best practice due to the temperature differences between domestic and medication fridges and the difficulties with accurately monitoring the temperature of a domestic fridge.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003953
Date of Inspection:	1 September 2014
Date of response:	3 October 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.

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Clear procedures were not in place to ensure that the residents' wish to vote had been identified.

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

Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

Information and template sent out to each House along with easy read for residents in relation to right to vote. Also highlighted at full staff meeting on 10th September.

Proposed Timescale: 10/09/2014

Theme: Individualised Supports and Care

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

Where residents' needs were complex, more detailed guidance was required to ensure consistency of approach from all staff and thus fully ensure that privacy and dignity needs were met.

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:

Personal Care Plans for residents are up to date and include detailed guidance to ensure consistency of support from all staff. This was highlighted at weekly house visits by the PIC as well at scheduled house meeting.

Proposed Timescale: 15/09/2014

Theme: Individualised Supports and Care

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

The documentation of complaints did not fully meet the requirements of the Regulations.

Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Highlighted to all PIC's and to all staff at full staff meeting the need to ensure that all complaints are logged and that the outcomes are documented. In particular it needs to

be documented that the person making the complaint is satisfied with the outcome and documented on the current complaint log.

Proposed Timescale: 10/09/2014

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:

Personal plans did not fully meet the Regulatory requirements. Information in personal plans was insufficient to direct care for the purposes of meeting the assessed needs of residents. Goals were mainly activity-based instead of outcome-focussed, making it difficult to see how the goal contributed to improving the residents' quality of life. Supports required to assist residents to achieve their goals were often non-specific or not stated.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Highlighted this to all staff at full staff meeting. New Personal Plan to be piloted by each House Manager. Meeting arranged for 01 October to pilot this with House Managers. This process to be reviewed by end of November 2014 with a view to rolling it out over a 6/8 month period.

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:

Family involvement in personal planning was not documented.

Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Highlighted this action to all PIC's and to all staff at full staff meeting on 10th September. Family contact sheet to be included in new Personal Plan. All family involvement and PCP goals to be circulated between Residential and Day Service.

Proposed Timescale: 14/10/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Routine hazard inspections were not taking place so as to identify new or changing hazards in the centre.

Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Since the inspection a template to complete hazard inspections to identify new or changing hazards in the centre has been drafted and given to house managers to trial and feedback by the end of October 2014.

Proposed Timescale: 31/10/2014

Theme: Effective Services

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

Not all procedures in place for ensuring that residents were protected against infection were clear. For example; management were unable to tell the inspector which standards were being applied in the centre in relation to the use of cloths and mops in different areas and the centre's own cleaning standards were not being implemented in regards to the maintenance of mop heads.

Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Cleaning Standards are based on the Community Infection, Prevention and Control Manual 2011. Since the inspection PIC has issued Memo and local cleaning standards to all staff highlighting the labelling of cleaning equipment as well as the frequency and management of cleaning equipment to include cloths and mops.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

Personal emergency evacuation plans did not fully consider the cognitive needs of all residents to ensure a prompt evacuation.

Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

Since the inspection Emergency Evacuation Plans for the Centre were updated to include the cognitive needs of all residents. Unannounced evacuation drills have been completed on two different occasions since the inspection to ensure the plans are robust and workable for each resident. The learning outcomes from these drills have been highlighted to staff to follow up and implement.

Proposed Timescale: 12/09/2014

Theme: Effective Services

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

The centre was not in compliance with fire safety legislation.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

Service Engineer and Health & Safety Officer, working in consultation with a qualified Fire Consultant, has identified priority works to be completed to ensure all houses are fire compliant. The plan of works needs to be costed by 30th November 2014 and a proposed timescale to address this to be completed within the following six month period.

Proposed Timescale: 31/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all staff had received training in relation to the management of behaviour that challenges that met the Regulatory requirements as it did not include de-escalation and

intervention techniques.

Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

The content of the Challenging Behaviour Mandatory Training for staff has been amended to include de-escalation and intervention techniques. Training in relation to management of behaviour that challenges has been arranged for 16th October, 27th November, 4th December and all training will be completed for all staff by 31st December 2014.

Proposed Timescale: 31/12/2014

Outcome 12. Medication Management

Theme: Health and Development

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

Systems relating to the administration of medications were not sufficiently robust. There had been a number of medication errors in the preceding months, including for example, a missed dose; some staff required refresher training in relation to medication management and action required to prevent a re-occurrence of medication errors was not clearly outlined.

Action Required:

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

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

Since the inspection staff two training sessions have been scheduled for 22nd October 2014. Medication audits will be completed every 6 months. A system to report and manage medication errors is in place and these will be reviewed by management each month to monitor any trends and follow up with appropriate actions.

Proposed Timescale: 30/10/2014

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

Formal deputising arrangements for any notifiable absence of the person in charge from the centre were not in place.

Action Required:

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

During the absence of the person in charge the person nominated to manage the centre during the absence is CNM3.

Proposed Timescale: 30/09/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not all mandatory training had been provided in accordance with the Regulations, specifically in relation to behaviour that challenges.

Also, staff required training appropriate to their roles in relation to medication management.

Action Required:

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

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

The content of the Challenging Behaviour Mandatory Training for staff has been amended to include de-escalation and intervention techniques. Training dates for staff have been set for 16th October, 27th November, and 4th December. Two training sessions for staff in relation to management of medication appropriate to their roles has been arranged for 22nd October 2014.

Proposed Timescale: 31/12/2014

Outcome 18: Records and documentation

Theme: Use of Information

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

One aspect of the medication management policy required amendment to reflect guidance by relevant professional bodies that all medicinal products requiring refrigeration should be stored in a dedicated refrigerator that is not used for any other purpose, accessible and reliable and capable of being secured.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Medication Management Policy to be amended to reflect that medication required to be stored will be done so in a dedicated refrigerator that is not used for any other purpose and is accessible, reliable and capable of being secured. One such refrigerator has been located in one Community House and available to any house that requires it.

Proposed Timescale: 31/10/2014

Theme: Use of Information

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

Improvements were required to the documentation relating to the use of bedrails; although a bed-rail in use in one house had been ordered by the occupational therapist and was not a restrictive practice, no risk assessment had been completed nor were there any monitoring records relating to its safe usage.

Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

Since the inspection monitoring records and risk assessments have been completed in the designated centre. Since the inspection staff will monitor the resident and the bed rails every 30 minutes when occupied by the resident and when staff are on waking duty.

Proposed Timescale: 30/09/2014