<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Christopher's Services Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001838</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Longford</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>St Christopher's Services Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Clare O'Dowd</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Geraldine Jolley</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>6</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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</thead>
<tbody>
<tr>
<td>25 June 2014 11:00</td>
<td>25 June 2014 20:00</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 11. Healthcare Needs</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

This monitoring inspection was the first inspection of this Residential Service carried out by the Authority. It was an announced one-day inspection.

The centre provides residential accommodation and support services for 6 adults with a moderate to severe intellectual disability. The provider nominee, Clare O'Dowd who is the Residential Services Co-coordinator, has responsibility for the governance and management of all eight residential services within the organisation. This includes 14 houses in total.

As part of the inspection, inspectors met with residents, staff members, the Person in Charge (PIC) Paula Lloyd, and the Provider nominee. Inspectors observed practices and reviewed documentation such as personal plans, risk management documentation, medical records, policies and procedures.

The house is situated on a detached private site in a Cul-de-Sac on the outskirts of the town. It accommodates a maximum of 6 residents. Four residents live in the centre on a full time basis and two residents are part-time where care is shared between the centre and their parents. The centre also provides respite provision for three residents on a rotational basis. There were no vacancies on the day of inspection. The grounds were well maintained and a secure well-maintained garden was available for use by residents. Inspectors found that the house was also well
maintained and provided a comfortable homely environment.

Inspectors found evidence of a person-centred approach being promoted that met the health and social care needs of residents. Inspectors found evidence of good practice in a range of areas. Staff interacted with residents in a warm and friendly manner and displayed an in-depth understanding of individual residents' needs, wishes and preferences. Inspectors found evidence of residents being involved in decisions about their care and being supported to promote independence and exercise choice in their daily lives.

While evidence of good practice was found across all outcomes, areas of non compliances with the regulations and the National Standards were also identified. These included improvements in risk and medication management policies to comply with the regulations and the need for development of appropriate behavioural support plans for some residents with behaviour that challenges. These are issues are discussed further in the report and are included in the Action Plan at the end of this report.
### 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:**

Residents had personal plans in place and there was evidence that these were reviewed consistently and at a minimum annually. Inspectors found that there were opportunities for residents to participate in meaningful activities appropriate to his or her interests and capacities.

Inspectors viewed a sample of resident's personal plans and found that they were individualised and person centred. Resident's needs, choices, abilities and aspirations were clearly identified. Resident’s or family members were actively involved in the assessment and development of their plans. Resident’s personal plans were reviewed at a minimum annually and inspectors saw that the plans contained details of the supports and services needed to help residents achieve a good quality of life and achieve their personal goals. Inspectors saw that goals identified for 2013 had been realised which included going on holidays, going to concerts and going swimming regularly. Each resident was assisted to complete their own plan with the help of a key worker. There was evidence that communication tools and pictorial images were used to support resident's communication skills.

**Judgment:**
- Compliant
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:
A draft policy on risk management was available which identified the procedures on risk identification, description and risk rating. The policy was in draft format at the time of inspection and did not fully address the areas identified in the regulations. A final document has since been submitted which has remedied this breach.

A Health and Safety Statement was also available which had been reviewed in January 2014. An organisational risk register was included in the document and a separate risk register was kept in the house. Inspectors saw that this was kept up to date through monthly safety audits.

Accidents and incidents were recorded electronically by the Person in Charge and these were reviewed monthly by the provider. Inspectors found evidence of learning from accidents and incidents and measures in place to prevent re-occurrences were included in resident’s care plans. Staff files reviewed by inspectors had evidence that staff had completed manual handling training.

Individual risk assessments were documented in residents’ personal plans and inspectors saw that actions were taken to mitigate risks, for example, a bathroom light was left on for one resident who sustained a fall while going to the bathroom at night. Inspectors also saw that risk assessments had been completed for social activities that residents liked to participate in to ensure their safety. Inspectors observed some hazards which were not included in the risk register. The fire door leading from one resident’s bedroom was operated by push bar and was not alarmed. The resident occupying the room was not identified as at risk of absconding, but the risk of another resident absconding through this door had not been properly assessed. There was also a potential a trip hazards caused by a step and a door saddle leading to the office. These were brought to the attention of the Person in Charge during the inspection who assured inspectors they would be addressed immediately.

Vehicles used by residents were appropriately maintained and were checked monthly for safety by the services’ vehicle safety officer. Fire equipment was provided and there was evidence that emergency lighting and fire fighting equipment was serviced annually. The fire alarm connected directly to an external monitoring system. There was evidence of weekly and monthly fire safety checks recorded in the centres fire register. All fire exits were unobstructed and staff took part in regular fire evacuation drills which were documented. A personal evacuation plan was documented in each resident’s personal plan and a copy of this was also kept near the entrance to the centre.
Judgment:
Non Compliant - Minor

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 measures were in place to protect service users being harmed or suffering abuse. A centre specific policy was available for the prevention, detection and response to allegations of abuse. It included procedures to guide staff on the different forms of abuse and their responsibility if they suspected any form of abuse and the procedure for managing an allegation or suspicion of abuse. The name and contact details of the designated contact person was included in the policy. The Person in Charge confirmed that no allegations of abuse had been reported.

Staff interviewed confirmed that that they were aware of this policy, and of their responsibility to report any allegations or suspicions of abuse. Residents told inspectors they felt safe and could talk to staff. A procedure was also available on the provision of personal care to service users which included guidance on respecting residents’ privacy and dignity.

Inspectors observed that staff members interacted with residents in a respectful and dignified manner. A policy was available on the delivery of intimate and personal care which had been reviewed in April 2014. There was a policy available to guide staff on “responding to challenging behaviour. Staff confirmed that one resident presented with behaviour that challenged including self injurious behaviour. Although interventions were identified in the residents’ personal plan, there was no specific behavioural support plan in place to support this resident.

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

**Findings:**  
A comprehensive health assessment had been carried out for each resident and inspectors saw appropriate screening/checks were in place to ensure optimal health and well being among the resident group within the centre. Staff and residents described good access the local general Practitioner (GP) and there was evidence of this in the files reviewed. An out of hour’s service GP service was also available. There was evidence of residents been appropriately referred to specialist health services including physiotherapy, occupational therapy, chiropody and a dentist and inspectors saw that residents were supported to attend these appointments. Some residents described as showing early signs of dementia had been referred to the Mental Health consultant for the area.

Inspectors reviewed a ‘hospital passport’ document on resident’s files for use should the resident require transfer to hospital. The document was regularly reviewed and included information on aspects of the residents’ care including their emotional needs and preferences.

Residents ate their main meal in the house every evening and had lunch in day services. A menu for the week was also displayed in pictorial format in the dining room. Residents told inspectors that they enjoyed the meals and were involved in shopping for and preparing the food supported by staff. The inspectors found that there was an ample supply of fresh and frozen food, and residents could have snacks at any time.

Although there was evidence that communication tools and pictorial references were well used throughout the centre to support resident’s communication skills, inspectors observed a resident who had impaired communication. This resident had been appropriately referred to a communication specialist but the recommendations of the specialist had not been facilitated as the residents’ next of kin disagreed with the advice of the specialist. No other options had been explored to assist the resident with communication.

**Judgment:**  
Non Compliant - Moderate
### Outcome 12. Medication Management

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
The inspectors reviewed the centres written operational policies for the ordering, prescribing, storing and administration of medicines which had been reviewed recently. The policy required further minor review to accurately reflect practice in the centre, for example the colour coded for system referred to in the policy for distinguishing between long term and short term medication differed slightly from the colour coded system in use and the procedure for controlled drugs was not centre specific. Staff had completed training in the safe administration of medication.

A sample of medication administration records (MARS) was reviewed by inspectors which was completed appropriately and included photographic identification of the resident. Inspectors observed in two MARS, the maximum dosage for PRN or as required medication was not always stated on the individual prescription.

The inspector observed that medications were all stored securely in a locked cupboard in the staff office and that the medication keys were held by the house leader on duty. A system was in place to record medication errors or near misses in the organisations computerised accident and incident log. A medication incident template was used to record details of any incidents electronically.

**Judgment:**
Non Compliant - Minor

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### 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 a clearly defined robust management structure in place that identified the lines of authority and accountability. This was detailed in the centres Statement of Purpose.

The centre is managed by a suitably qualified and experienced Person in Charge (PIC). Staff and service users were clear in relation to lines of authority and service users were able to identify the Person in Charge who worked on site. The person in charge reported to the residential coordinator who in turn reported to the general manager. The inspector found, through interview with staff, that in the absence of the person in charge, a shift leader on duty was responsible. On call arrangements were in place 24/7 and the inspector found that staff were aware of these and had ready access to the contact details. There was evidence of regular staff meetings and of meetings with the centres residential co-ordinator. There was a system of staff appraisal in place and evidence that these were held annually was seen on the staff files reviewed.

The quality of care and experience of the residents was monitored on an ongoing basis. The inspector found that a system was in place to carry out bi-annual inspections. The most recent inspection report from an inspection in May 2014 by the centres Policy Officer was made available to inspectors. Actions identified in the report were been progressed.

A Schedule of Audits was also available for the year and these included personal plans, food and nutrition, Health and Safety, staff files, medication audit, and complaints. There was evidence that actions had been taken to address issues identified in these audits and the inspectors found that further audits were scheduled.

The Provider had undertaken an unannounced visit to the centre in May and produced a written report as to the safety and quality of care and support provided as required by the regulations. There was evidence of regular meetings between the General Manager and the Residential Co- Coordinator and between the PIC and the staff.

Judgment:
Compliant

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

Theme:
Responsive Workforce
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspector reviewed the recruitment practices and found there was a system in place to ensure all the required documentation for staff employed in the centre was in place. The inspector reviewed three staff files which were held centrally and found that all required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Service users in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were in place. Documentation was well organised and easily retrievable.

A staffing rota was available and inspectors were advised by staff that staffing levels were adjusted to meet the needs of the residents in this centre, for example, an additional 20 hours staff time had been allocated to one resident who required one to one care. This was indicated on the staff rota. Inspectors observed from the rota that the normal staffing complement was two staff on duty in the evenings and in the morning to assist residents and one waking staff member on duty at night time. Staff supervision meetings were held every 8 weeks and each staff member had an annual performance review. These were recorded on the staff personnel files.

An emergency on-call policy was available and a pool of regular locum staff was available in the event of staff illness. Contact details for the PIC were included. Staff and residents interacted comfortably and staff supported residents to engage in the inspection process and meet with inspectors following consultation. Staff were knowledgeable of the residents living in the centre and of the positive support plans in place.

There was a training plan in place for 2014 to ensure staff were kept up to date. Inspectors saw that training on medication management, personal care planning, food safety, protection and safety of vulnerable adults, epilepsy awareness and manual handling had been provided to staff.

Judgment:
Compliant
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:

Geraldine Jolley
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Requirements

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

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

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The door leading from one resident’s bedroom was not alarmed to protect other residents at risk of absconding.

A door saddled in the area leading to the office posed a potential tripping hazard to residents.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
A Risk Assessment was completed on the door saddles on 26th June 2014 for the individual resident.
Bedroom Door Alarm will be fitted on 14th August 2014
Step from area leading to office will be ramped on 22nd August 2014

**Proposed Timescale:** 22/08/2014

**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:
There was no specific behavioural support plan in place to support one resident who had a history of challenging behaviour including self injurious behaviour.

**Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
The resident’s keyworker will develop a behaviour support plan for the individual resident in consultation with the resident, and the following persons.
- The Resident’s Family, the Psychologist and the Behaviour Support Therapist on 20th August 2014
- The keyworker from Day Services on 03rd September 2014

**Proposed Timescale:** 08/09/2014

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No refresher training on Adult Protection was scheduled and some staff members training was not current.
**Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
Adult Protection Refresher training will be scheduled and delivered to all staff in the designated centre.
In the meantime the person in charge will discuss the Non Accidental Injury and Abuse policy with each staff member and record same on the policy induction attendance sheet by 08th September 2014.

**Proposed Timescale:** 13/10/2014

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The recommendations of a communication specialist had not been implemented for a resident with impaired communication or alternatives examined.

**Action Required:**
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

**Please state the actions you have taken or are planning to take:**
A meeting has been scheduled on 20th August 2014 with the resident’s family and members of the Multi Disciplinary team to discuss the recommendation and devise an action plan to address the recommendation or alternatives.

**Proposed Timescale:** 20/08/2014

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**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:
The maximum dosage for PRN or as required medication was not always stated on the prescriptions reviewed.

**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:**
Each Resident’s PRN kardex has been reviewed by the person’s General Practitioner and now states the maximum dosage for PRN or as required medication.

**Proposed Timescale:** 02/07/2014