### Centre name:
A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.

### Centre ID:
OSV-0003951

### Centre county:
Tipperary

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
Daughters of Charity Disability Support Services Ltd.

### Provider Nominee:
Breda Noonan

### Lead inspector:
Julie Hennessy

### Support inspector(s):
Kieran Murphy

### Type of inspection
Unannounced

### Number of residents on the date of inspection:
6

### 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, 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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 08 May 2015 09:00
To: 08 May 2015 17:00

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 report sets out the findings of a follow-up inspection in St. Anne’s Residential Service, ‘Group H’. This was the second inspection of this centre by the Health Information and Quality (The Authority).

The purpose of this inspection was to follow-up on the progress made by the provider to address failings identified during a previous inspection carried out on 27 January 2015. At that inspection, ten outcomes were inspected against the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Eight of the ten outcomes inspected against were found to be at the level of major non-compliance. The provider subsequently submitted an action plan to address the identified failings, which was accepted by the Authority. This inspection assessed whether the actions had been successfully implemented or were being progressed according to that action plan and within agreed timeframes. An additional outcome pertaining to records and documentation was included at this inspection due to the gaps identified.

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

Overall, significant improvement had been made since the previous inspection.

The findings from this inspection demonstrated that significant improvement had been made in relation to ensuring effective governance and management of the centre. On the day of inspection, the inspectors found that residents appeared happy and content and there was a calm atmosphere in the centre. Staff had received the training and specialist input that they required to better support residents to manage their own behaviours. Residents’ needs were being met in an individualised way and this was having demonstrable positive effect on their quality of life. Care planning was of a high standard and residents’ health needs were being met.

However, two outcomes were found to be at the level of major non-compliance. Outcome 5 pertaining to social care needs remained at the level of major non-compliance and this related to the finding that the centre was not suitable for the purposes of meeting the needs of each resident due to the number and unsuitable mix of residents in the centre. This continued to have an impact on residents. A timeframe of December 2015 had been proposed by the provider and accepted by the Authority to address this non-compliance in full. While interim steps required were on target, this outcome will remain at the level of major non-compliance until the action has been completed.

Outcome 6 pertaining to the provision of safe and suitable premises was increased to the level of major non-compliance at this inspection. It was found that the design and layout of the centre did not meet the needs of residents in terms of accessibility and the provider failed to demonstrate that sufficient action had been taken to address this finding within the required timeframe.

The Authority did not agree the action plan response to Regulation 21(3) with the provider despite affording the provider two attempts to submit a satisfactory response. The timeframe was not accepted.

Other improvements were required in areas relating to risk management, documentation, medication management and arrangements relating to the person in charge, which will be discussed in the body of this report and included in the action plan at the end of this report.
Section 41(1) (c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

At the previous inspection a number of areas were identified that required improvement. Three practices were identified that impinged on the privacy and dignity of the residents in the house. Staff were carrying out hourly checks on all residents throughout the night without a clear procedure to follow and how to ensure such checks did not disturb residents. A CCTV system was in place in one resident’s bedroom. The privacy of another resident was impinged upon due to the unsuitable mix of residents in the centre. Also, the complaints policy was not in a format that was user-friendly to all residents. Finally, the opportunities available to residents to pursue activities, interests and hobbies were limited. Since that inspection, significant improvement has been made as outlined below. Actions yet to be completed were within the timeframe proposed by the provider following the previous inspection and accepted by the Authority.

The practice of hourly checks during the night on service users had been reviewed at multi-disciplinary team (MDT) meetings since the previous inspection. The use of CCTV for monitoring in a resident’s bedroom had ceased. Written protocols now were in place for each resident that specified the supervision requirements of each resident and the nature and frequency of the checks required. Care plans had been completed. Residents were no longer being woken while being checked. Checks were recorded. The privacy of one resident was still being impinged upon by other residents; this was due to the number and mix of residents living in the centre. The provider nominee was working to address this non-compliance and was within the previously agreed timeframe to do so of December 2015. The mix of residents in the centre also resulted in environmental restrictions in place for some residents that had an impact on other residents. Inspectors found however that staff endeavoured to minimise this impact on residents; for
example, where access to taps had to be restricted, some residents were given keys to the cupboard under the sink so that their fluid intake was not restricted unnecessarily. This will be discussed further under Outcome 5: Social Care Needs.

The house manager had explained the process to make a complaint to residents at a residents meeting. An easy-read version of the complaints policy was visibly displayed. Where a resident had a visual impairment; the complaints process had been explained by their key worker and a referral to the speech and language therapist (SALT) had been sent on 26.3.2015 to determine whether additional means of communication could be used to aid understanding. A date for this assessment had yet to be provided and will be discussed further under Outcome 11: Healthcare Needs.

A clinical nurse manager (CNM3) had provided support to the staff team in relation to reviewing the opportunities available to residents to pursue activities, interests and new opportunities. Each resident now had a detailed activity programme, tailored to their individual needs, capabilities and wishes. Activity schedules included activities external to the centre such as visiting a park, going for walks, participating in dance class or music session. Activity schedules considered individual resident’s needs and choices to participate in activities in smaller groups and in individualised activities where applicable. The house manager said that the residents were really enjoying getting out of the centre more and trying new experiences. Within the centre residents participated in activities and interests such as listening to music and working in the garden. Life skills necessary to increasing independence such as cooking, ironing and hand washing were also supported.

Judgment:
Compliant

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:
At the previous inspection, it was not clear from the documentation that the residents’ personal plans were done in consultation with residents or their representatives, as
appropriate; the house was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the house and in some cases, the design and layout of the house and finally; the system in place for the review of personal plans did not meet the requirements of the Regulations. Since that inspection, significant improvement has been made, as outlined below. Actions yet to be completed were within the timeframe proposed by the provider following the previous inspection and accepted by the Authority.

Inspectors found that each resident had a comprehensive assessment of their personal, social and developmental and support needs. Each resident had a personal plan that had been reviewed and updated since the previous inspection. Inspectors reviewed a sample of personal plans and found that they were individual, person-centred and fully met the requirements of the Regulations. There was evidence of family involvement in personal planning and family were invited to attend MDT meetings and meetings pertaining to the review of personal plans. An MDT meeting had been held for each resident since the previous inspection and informed the review of the personal plan. Goals had been set for residents and these reflected the wishes, capabilities and interests of individual residents. Some further improvement was required to the streamlining of documentation to ensure ease of retrieval.

The provider nominee was taking steps to address the finding from the previous inspection that the centre was not suitable for the purposes of meeting the needs of each resident due to the number and unsuitable mix of residents in the centre and in some cases, the design and layout of the centre. This continued to have an impact on residents in terms of not meeting individual resident’s needs for quiet time and space and as previously discussed privacy and the right to live with the least possible environmental restrictions. In addition, the environment was not designed or laid out to meet the needs of residents with a visual impairment.

A timeframe of December 2015 had been proposed by the provider and accepted by the Authority to address this non-compliance in full. Interim steps required were on target; for example, a review group had been set up within the required timeframe to review the most suitable accommodation for the residents in the centre. This outcome will remain at the level of major non-compliance until the action has been completed.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

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

Findings:
Two previously identified issues relating to the premises remained outstanding in the centre. First, the environment was not designed or laid out to meet the needs of all residents. Second, some parts of the premises were difficult to access or damaged and could no longer be effectively cleaned.

Where residents had a visual impairment; the designated centre did not adhere to best practice in achieving and promoting accessibility. Documentation in a resident’s file and recent MDT minutes (dated 14.4.15) demonstrated that this issue had been identified several years previously. The MDT minutes referenced a previous OT assessment and recommendations that, according to the MDT minutes, had not been implemented “due to lack of funding”. The previous assessment, while referenced in other documentation, was not in the resident’s file for review. The MDT minutes recorded that a new OT assessment was required due to the negative impact the living environment was having on a resident in terms of independence where the resident was effectively confined to two rooms in the house. The action plan submitted by the provider following the previous inspection committed to a timeframe of 30.4.2015 for securing an OT assessment and this timeline had not been met. This was discussed with the provider nominee and person in charge at the close of the inspection and will also be discussed in the context of access to allied health services under Outcome 11: Healthcare Needs. Due to the duration of this issue, the lack of progress since the previous inspection and the impact on a resident, inspectors found that this failing is now at the level of major non-compliance.

Some parts of the premises remained in a poor state of repair or were difficult to access and as a result, could no longer be effectively cleaned. The kitchen units were dated and parts of the worktop was damaged. Parts of the bathrooms were also in poor state of repair, for example, grouting was missing from shower and sinks seals. Other parts of the premises were difficult to reach or access were not effectively cleaned including gaps between the cooker and kitchen units on both sides. In addition, the floor covering in the laundry room was also damaged and could no longer be effectively cleaned.

Judgment:
Non Compliant – Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

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

Findings:
At the previous inspection, it was found that incidents were not being correctly recorded; the provider had not ensured that system in place in the designated centre for the assessment, management and ongoing review of risk was adequate; there was an unacceptably high level of risk to both residents and staff in the centre from frequent assaultive behaviours; improvements were required in relation to evacuation procedures and improvements were required to the prevention and control of infection.

On this inspection, the inspectors reviewed the incident book and residents’ files and found that incidents were being correctly recorded. The person in charge had commenced a quarterly review of all incidents. The inspectors reviewed a report arising from such a review and found that it contributed to learning.

Steps had been taken to improve the risk management system since the previous inspection. This included the commencement of weekly hazard inspections and the completion of a maintenance request form for any required repairs. However, inspectors found that the system in place in the centre for the assessment, monitoring and management of risk required review. This was evidenced by the quality of risk assessments, most of which were outside of their review date. One risk assessment had not been updated to reflect an identified increase in the risk behaviour. A risk assessment had not been completed for all identifiable hazards, such as the management of clean and dirty laundry and how to prevent cross-contamination. Of the sample risk assessments viewed, they did not provide adequate guidance to staff, nor was it clear who was responsible for monitoring and reviewing the effectiveness of the controls in place. Also, the completion of risk assessments had been delegated to the house manager, and it had not been demonstrated that this was appropriate. While the house manager had attended a training session in relation to risk assessments, due to the complexity of risks in this centre the delegation of this level of responsibility to the house manager without providing the required supports was not appropriate.

At the previous inspection, inspectors found that the evacuation plan was not current and the fire manager had not signed off on the plan in place for one resident. While steps had been taken and advice had been sought in relation to determining a safe plan for the resident in the event of an evacuation, this issue had not yet been satisfactorily resolved. This was discussed with the provider nominee at the close of the inspection.

Staff had received additional training in relation to infection control and hand hygiene, including environmental cleaning and household standards since the previous inspection. A hygiene audit was completed by a CNM3 with responsibility for hygiene and infection control in the centre. Cleaning logs were in place and maintained. The centre was clean and tidy. As identified in the previous inspection and in Outcome 6: Safe and Suitable Premises, some areas of the premises could no longer be effectively cleaned.
Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
At the previous inspection, a number of significant non-compliances were identified relating to the protection of vulnerable adults and the management of restrictive procedures. It was found that staff did not have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. Not all staff had up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques approved for use in the centre. It had not been demonstrated that every effort was made to identify and alleviate the cause of residents' behaviour; that all alternative measures had been considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, was used.

Systems in place for the use of physical restraint were not acceptable as all staff had up to date training in techniques that had been approved for use by the MDT. The use of PRN “as required” medication was not clearly documented. Finally, the provider had failed to adequately protect residents from abuse by their peers.

At this inspection, inspectors found that significant improvement had been made to address the previously identified issues.

All staff had up-to-date training in relation to the protection of vulnerable adults, behaviours that challenge and the use of any approved interventions, including breakaway techniques.

Each resident had an up-to-date behaviour management plan that guided practice. The inspector reviewed all six behaviour management plans in detail and found that they demonstrated a positive approach to behaviours that challenge and included positive supports such as the use of distraction, relaxation activities and techniques and the verbal tone required. Interventions were clearly outlined. Protocols were in place for the use of any PRN medication. Any physical restraint had been assessed by appropriate professionals, with a clear rationale provided and clear guidelines in place. Each
behaviour management plan was signed and dated by staff. A seclusion protocol that was previously documented had been reviewed and ceased since the previous inspection.

While the mix of residents in the centre remained unsuitable, the person in charge and house manager described the positive effect that changes in relation to how 1:1 supports were being used had had in terms of managing peer-to-peer injury or harm. In addition, staffing levels were being maintained and the house manager explained that this allowed staff the freedom to bring residents out if they wished to do so, which in turn had a positive effect on behaviours. Inspectors spoke with staff members who said that the application of the behaviour management plans in practice had made a positive difference to how they support residents to manage their own behaviours. The house manager and person in charge said that the range of improvements in the centre had resulted in a cumulative positive effect and that it was now a “calmer” house. On the day of inspection, the inspectors found that residents appeared happy and content.

The person in charge and house manager confirmed that there had been no incidents that constituted abuse between peers since the previous inspection. This was supported by a review of the incident book.

All incidents of behaviours that challenge were clearly documented and recorded. Tracking charts to record and track antecedents, behaviours and consequences were maintained following incidents as required. One area was however identified for improvement. Inspectors found that where residents’ behaviours had escalated, it had not been demonstrated that the follow-up was adequate. In one case, while the increased behaviours had been discussed by MDT and a risk assessment for a transport-associated risk had been completed; the risk assessment in the centre had not been updated nor had the behaviour support plan.

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

**Findings:**
At the previous inspection, Incidents of peer-on-peer abuse were not notified to the Authority as abuse. In addition, not all incidents of chemical or environmental restraint were included in the quarterly submission.
At this inspection, it was found that there had been no additional incidents that required notification to the Authority since the previous inspection. There had been no further incidents between peers that constituted abuse. A quarterly report was due to be submitted to the Authority and would be reviewed when received. As such, the actions arising from the previous inspection had at this point been satisfactorily implemented.

**Judgment:**
Compliant

### Outcome 11. Healthcare Needs
Resident 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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
At the previous inspection, it was found that where risks or needs had been identified, care plans had not always been completed. Also, access to allied health services was not always facilitated.

Inspectors found that all residents had an assessment of needs and care plans had been developed where required. The staff team had received training in this area from a clinical nurse manager (CNM3) since the previous inspection. Support had been provided to the house manager and staff team to review the care needs of each resident and how to document changing needs. Inspectors reviewed a sample of care plans in detail and found that they were person-centred and clearly directed the care to be given to each resident.

Residents had accessed allied health services including speech and language therapy for input in relation to communication and swallowing and a clinical nurse specialist had reviewed and provided input into residents’ meals and meal planning. However, inspectors found that where residents required access to allied health services, this was not always provided in a timely manner. Where an occupational therapy (OT) assessment was required, an assessment had not been completed nor had a date been received for an assessment.

**Judgment:**
Non Compliant – Moderate
Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
At the previous inspection, it was found that the centre's method of the transcription of medication was not as per the centre's policy or as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. In addition, staff had no knowledge of oxygen therapy, the dosage of oxygen, the precautions that should be in place or of how or when to administer oxygen to a resident prescribed oxygen.

At this inspection, it was found that neither failing had been satisfactorily addressed.

The previous action plan had committed to ensuring that all direct care staff would receive training in the administration of oxygen therapy by 30 April 2015. This action was not completed.

The medication management policy had been reviewed to provide a clearer process in relation to the transcription of medication since the previous inspection. However, practices relating to the transcription of medication were still not in line with per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily
Findings:
At the previous inspection, it was found that provider had failed to ensure that effective systems were in place to ensure that the service provided was safe, appropriate to residents’ needs, consistent and effectively managed.

Since the previous inspection, the provider had taken steps to address this non-compliance. There was a newly appointed provider nominee in the service and a newly appointed person in charge of the centre and house manager. Changes had been made to the staff team. The findings from this inspection demonstrated that significant improvement had been made in relation to ensuring effective governance and management of the designated centre. Recruitment for additional CNM2 and CNM3 posts had been completed.

The person in charge had over ten years experience of working with people with a disability in Britain and had been the area manager with the Daughters of Charity service since 2006. He had previously been involved in the centre in an acting role and demonstrated that he knew the residents and their needs very well. The person in charge had a General National Vocational Qualification (GNVQ) level 2 in health and social care from Britain. However, it was not demonstrated that the person in charge had the required qualifications to meet the requirements of the Regulations. This was subsequently discussed with the provider nominee who was aware of need to address this gap.

The house manager was identified as a person participating in the management of the centre. The house manager is a qualified nurse in intellectual disability nursing with experience in supporting residents who display behaviours that challenge. The house manager said that the person in charge had been very supportive in relation to assisting him in his new role and in implementing the improvements that had been required in this centre. The house manager said that the person in charge visited the centre most days and was accessible at other times.

However, inspectors found that the arrangements in place in relation to the person in charge of the centre required further review. While the person in charge had been very involved in the management of the designated centre since the previous inspection; he was the person in charge for four designated centres comprising seven houses in total. It was not demonstrated that this arrangement allowed the person in charge to have the required time to effectively fulfil his role as person in charge of this designated centre on an on-going basis and to ensure that the improvements made to date would be sustained. For example, the person in charge did not attend the MDT meetings for the six residents that took place (on the same day) since the previous inspection due to other commitments within the service. In addition, some tasks that were the responsibility of the person in charge under the Regulations had been delegated to the house manager. This led to gaps in some areas that are the responsibility of the person in charge, such as ensuring that all residents had timely access to allied health services and that risk assessments were current and reflective of changing circumstances.

Judgment:
Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
At the previous inspection, it had not been demonstrated that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents and the size and layout of the designated centre. In addition, mandatory training as required under the Regulations was outstanding. Not all staff had received up-to-date training in the protection of vulnerable adults. Not all staff had received up-to-date training in the management of behaviour that challenges or refresher training for the Therapeutic Management of Aggression and Violence (TMAV). Other training relevant to staff roles and responsibilities was outstanding: some staff required training in food safety; staff had not received training to support residents to avail of meaningful activities nor had they received training in oxygen therapy.

At this inspection, inspectors found that the staffing levels were being maintained at the level required to meet the assessed needs of the residents. The person in charge, house manager and other staff said that the staffing levels were sufficient to allow for residents needs to be met. For example, the house manager explained that staffing levels allowed for residents to pursue activities and interests both within and outside of the centre, in accordance with residents’ needs and wishes.

Inspectors spoke with staff and reviewed training records. All staff had received mandatory training in the protection of vulnerable adults, the management of behaviour that challenges and refresher training for the Therapeutic Management of Aggression and Violence (TMAV). Staff had also received support from a CNM3 in order to support residents to avail of meaningful activities. While training in oxygen therapy was outstanding, this was previously addressed under Outcome 12: Medication Management.

Judgment:
Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of
retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

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

**Findings:**
This outcome was not inspected during the previous inspection. However, due to gaps identified over the course of this inspection, specific aspects were included.

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

In addition, not all records relevant to the care that was being delivered to residents in the centre were maintained in the centre. As previously mentioned under Outcome 11: Healthcare Needs; a record of an OT assessment that had been completed was not available in the centre.

**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

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<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003951</td>
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<tr>
<td>Date of Inspection:</td>
<td>08 May 2015</td>
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<tr>
<td>Date of response:</td>
<td>05 June 2015</td>
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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 05: Social Care Needs

Theme: Effective Services

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

The centre was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the centre and in some cases, the design and

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

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

**Please state the actions you have taken or are planning to take:**
- An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. This house will accommodate 5 individuals in total. Residents from this centre and one other designate centre will be prioritised to determine who will reside in the new centre. The number of residents in the centre will then decrease. The needs of the service user with a visual will be prioritised as part of this review group.
- The service users who will move from the centre will be determined through a service user review group which will include participation from the service users and families. The review group has commenced on 20/03/2015.
- The nominee provider, mdt, person in charge and staff from the centre will review each individual service user in the centre, and who have friendships and would enjoy residing together. Also current restrictions imposed on others due to the current environment and peer group will be taken into consideration.

**Proposed Timescale:** 31/12/2015

<table>
<thead>
<tr>
<th>Outcome 06: Safe and suitable premises</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> Some parts of the premises remained in a poor state of repair or were difficult to access and as a result, could no longer be effectively cleaned.</td>
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<td><strong>Action Required:</strong> Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.</td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong> The nominee provider has discussed the findings with the Director of Logistics, who will complete a review of the premises and outline an action plan for completion of all necessary works to the centre.</td>
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<td><strong>Proposed Timescale:</strong> 30/10/2015</td>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The designated centre did not adhere to best practice in achieving and promoting accessibility. Residents were restricted in their movements and accessing areas due to the poor design of the building.
**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 nominee provider has discussed the findings with the Director of Logistics, who will complete a review of the premises and outline an action plan for completion of all necessary works to the centre. The person in charge will seek the advice from the national council for the blind around particular service user’s specific needs.

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

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system in place in the centre for the assessment, management and ongoing review of risk required review. This was evidenced by the quality of risk assessments, most of which were outside of their review date and one which had not been revised as a result of an identified increased risk associated with behaviour that challenges. Of the sample risk assessments viewed, they did not provide adequate guidance to staff, nor was it clear who was responsible for monitoring and reviewing the effectiveness of the controls in place. Also, the completion of risk assessments had been delegated to the house manager, and it had not been demonstrated that this was appropriate.

**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:**
All risk assessments of service users will be reviewed, and where control measures are not adequate to support the service user to manage in relation to their challenging behaviour, there will be additional control measures included. These will be reviewed by the newly appointed person in charge, who is a registered nurse in intellectual disability. The person in charge will be responsible for monitoring and ensuring that risk assessments are up to date and reviewed on time.

A Clinical Nurse Manager 3 from another part of the organisation with responsibility for supporting centres in risk assessment will provide in house support to staff and managers in the centre, on the identification of risks, identifying control measures and additional control measures and rating the risks. This CNM3 will give direct support and guidance to the staff and the person in charge in the centre on the actual completing of risk assessments.

The person in charge assigned to the centre will audit incidents reports 3 monthly. They will feedback to the house manager and staff and nominee provider, and detail actions required from the audit. From each action there will be an identified responsible person...
to complete the action.
There is a weekly walk around hazard inspection as part of the service policy on management of risks, this will continue to be completed weekly by the house manager and any new hazards identified will be risk assessed and control measures put in place. This will be overseen by the person in charge.

**Proposed Timescale:** 30/07/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The provider did not demonstrate that the arrangements in place for evacuating all persons in the designated centre and bringing them to safe locations were adequate.

**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:**  
The fire evacuation plan for the centre will be reviewed by the fire manager and Director of Logistics. Fire evacuation plan to be reviewed for one service user to address issues re Fire Door and evacuation procedure. A fire evacuation drill will be carried out in the centre following review of the evacuation plan to ensure that the revised plan supports the needs of all service users.

**Proposed Timescale:** 15/06/2015

**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:  
Access to allied health services was not always facilitated.

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

**Please state the actions you have taken or are planning to take:**  
Please state the actions you have taken or are planning to take:  The Director of Human Resources has commenced the recruitment process for a Senior Psychologist and Occupational Therapist who will provide clinical support to the centre.  
Any clinical support required by a service user will be bought in by the nominee provider as required.  
The outstanding occupational therapy assessment for one resident was completed on the 27/05/2015.

**Proposed Timescale:** 30/09/2015
**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
- The practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais.
- All staff had not received training in relation to oxygen therapy, the dosage of oxygen, the precautions that should be in place or of how or when to administer oxygen to a resident prescribed oxygen.

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

**Please state the actions you have taken or are planning to take:**
The medication management documentation with regards to transcribing will be reviewed by the person in charge, medication management co coordinator, the director of nursing and a pharmacist to bring the practice in line with An Bord Altranais agus Cnaimhseachais na hEireann.
The document will be brought to the service Drugs and Therapeutics committee, where changes will be agreed, signed off and it will be included in the service policy on medication management.
The medication management co coordinator and the CNM3 appointed to the area will monitor and audit the medication practices in the centre.
BOC Gas is putting a training pack together and will deliver this training to the Staff team in the storage, transporting and administration of oxygen.

**Proposed Timescale:** 30/08/2015

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**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:**
It was not demonstrated that the person in charge had the required qualifications to meet the requirements of the Regulations.

**Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
The Clinical nurse manager 2 has been appointed to the centre who will be the person in charge. This person is a registered nurse in intellectual disability. The clinical nurse manager 2/person in charge commenced employment on 02/06/2015.

**Proposed Timescale:** 02/06/2015  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements in place for the person in charge required review. The person in charge manages more than one designated centre and it was not demonstrated that the arrangements in place to ensure the effective governance, operational management and administration of the designated concerned could be sustained.

**Action Required:**  
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
With the appointment of the Clinical nurse manager 2 to the centre who will be the person in charge, there is also a clinical nurse manager 3 commenced in post since the inspection. Both managers are registered nurses in intellectual disability. The newly appointed person in charge is now responsible for 4 houses and not 7 as at the time of inspection.

**Proposed Timescale:** 02/06/2015

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**Outcome 18: Records and documentation**  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all records relevant to the care that was being delivered to residents in the centre were maintained in the centre. A record of an OT assessment that had been completed was not available in the centre. Also, documentation pertaining to a review of residents' accommodation was not available in the centre.

**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:**
All documentation and records following consultations, assessments and meetings will be delivered to the centre and maintained in the service users care plan file. The record of the completed OT assessment has since inspection been placed in the service users file.
**Proposed Timescale:** 05/06/2015

**Theme:** Use of Information

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

**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:**
The person in charge and the clinical nurse manager will review all care plans in the centre, to ensure that relevant and most up to date information is on file ensuring the service user’s needs are appropriately met in a timely fashion.
The person in charge and the clinical nurse manager will complete audits of the care plans and make recommendations and identify responsible people to complete the actions. The nominee provider will be updated following each audit.

The Authority did not agree this action plan response to Regulation 21(3) with the provider despite affording the provider two attempts to submit a satisfactory response. The timeframe was not accepted.

**Proposed Timescale:** 30/08/2015