# Compliance Monitoring Inspection report

## Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005162</td>
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<tr>
<td>Centre county:</td>
<td>Tipperary</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd.</td>
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<tr>
<td>Provider Nominee:</td>
<td>Breda Noonan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
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<tr>
<td>Support inspector(s):</td>
<td>Julie Hennessy;</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>5</td>
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<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 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

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<th>From:</th>
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<tr>
<td>22 May 2015 09:00</td>
<td>22 May 2015 17:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 11. Healthcare Needs</td>
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<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 was an inspection of a centre in St Anne’s which is part of the Daughters of Charity Disability Support Services. The Daughters of Charity provides a range of day, residential, and respite services to persons with an intellectual disability in North Tipperary and Offaly.

The centre was a semi-detached house on an estate in the local village and provided a home to three men and two women with a varying range of support needs. Inspectors found these premises to be visibly unclean and poorly maintained with cobwebs on the lightshades, mould and staining visible in a number of spots on the walls and one extractor fan in a shower room was completely blocked with dust. Paint was peeling from the walls in many areas and there were rusting radiators in a number of bathrooms.

While there was a defined management structure it did not provide for effective governance, operational management and administration of this centre as both the person in charge and the provider nominee were actively managing a number of other designated centres across a broad geographical area. As outlined in more detail throughout this report there were significant deficits in the quality of care provided to residents.
Inspectors found that residents’ needs were not being addressed appropriately as part of the personal outcome measure process or as part of the person centred planning review. The process for assessment of risk required review as staff were unclear as to how to complete risk assessments.

As part of the inspection, the inspectors met with the residents and staff members. Residents outlined that they had access to lots of activity in the locality including the Irish Country Women’s Association, the local GAA club and attending shops, pharmacy and the local doctor. Each resident attended a day service from Monday to Friday.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of 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.

The Authority did not agree the action plan response to Regulations 5(6)(c) and (d) or Regulation 6(1) with the provider despite affording the provider two attempts to submit a satisfactory response as the proposed timeframes were not acceptable.

Other areas for improvement included:
• Safeguarding residents personal property and possessions
• infection control
• fire safety
• management of behaviour that challenged
• management of healthcare needs
• notification of serious events
• medication management
• staffing
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):
This was the centre’s first inspection by the Authority.

Findings:
There was a lack of suitable storage throughout the premises. Wardrobes were seen on the corridors and walkways on the first and second floors. The wardrobes were unlocked and had items of residents’ personal clothing inside. Inspectors saw in the staff communication diary that other residents were “accessing these wardrobes to hoard items”. This meant that people living in the house were not able to store and maintain their personal property and possessions.

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

**Findings:**
Inspectors found that residents’ had opportunities to pursue activities and interests that were meaningful to them. However, inspectors found that the social care needs of residents in the centre were not fully met as there was an unsuitable mix of residents in the centre. Inspectors found that this failing was at the level of major non-compliance. In addition, the personal planning process required significant improvement.

Inspectors found that the designated centre did not meet the assessed needs of all residents. Two residents had been identified as requiring alternative more suitable accommodation. The environment did not meet residents’ need for either a quieter or calmer environment. There was documentary evidence that this was having a negative impact the behaviours of both the individual resident's themselves and other residents in the house. The inspector found that these issues had been identified and documented since July 2014 with respect to one resident and since August 2014 with respect to another resident. While the issues had been discussed at the multidisciplinary team, a referral had not been made to the organisation’s relevant committees that oversee such placement issues (the Admissions, Discharges and Transfers Committee or the recently convened 'service user review committee'). As such, there were no concrete plans in place to resolve the issue. In addition, one resident was not availing of a suitable day service. The inspector found that this was at the level of major non-compliance due to the negative impacts on individual residents of the unsuitable living environment and the unsuitable day service.

A specific tool was used to document each resident’s assessment of their health, personal and social care needs, abilities and wishes. However, the assessment of needs was not comprehensive, where needs supports or risks were identified other specific plans had not always been completed (including health plans, risk assessments and behaviour intervention plans) and some needs had not been appropriately assessed. For example, where a resident had behaviour that challenges, a risk assessment had not been completed; where a resident had mobility issues, there was no mention in an assessment or care plan that the resident had received surgery for such issues.

Each resident had a personal file that contained elements of personal planning. Files were individual and contained information such as key people in the resident’s life, favourite outings or places, residents’ strengths, likes and dislikes. However, the personal planning documentation required significant development to meet the requirements under the Regulations. Where other personal plans had identified individual social needs and choices, these were not fully met. For example, for one resident, 15 goals had been identified and were due for annual review in two months time (July 2015). Of the 15, only two had been competed (the remaining 7 had not been achieved and steps had been taken to arrange the remaining 6). One goal could not be described as a goal as it was a necessary health care need. In addition, for that resident the monthly review tool used by staff to track goals had not been completed for the previous two months. Also, it was not always clear who was responsible for each goals and within what timeframe. Finally, the supports required for residents to achieve their goals were not specified, as required.
There was evidence that each resident participated in a review of their personal plan. In addition, the most appropriate means of facilitating such participation was considered. A record of the review of the personal plan and any challenges to meeting goals was maintained for each resident. Any challenges to achieving such goals was documented as was progress made in relation to challenges encountered. Family involvement was documented. However, the review of the personal plan was not multi-disciplinary, as required by the Regulations.

Inspectors reviewed a sample of residents’ timetables that outlined what he or she did on a daily and weekly basis. Information included both day services and activities that the resident participates in and enjoys. Activities included swimming, Special Olympics practice, bowling and going for walks. Activity logs were maintained. Activities were varied and meaningful and based on the individual wishes of the residents. Residents told inspectors that they enjoyed their day service and various courses that they pursued including cooking and hairdressing.

Residents were involved in the local community in a meaningful way. Residents told inspectors that they enjoyed going for walks in the nearby ‘eco-village’, for a drink in the local pub or to the local church. This was facilitated by staff where required. One resident was a member of a local community group and attended along with neighbours.

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

**Findings:**
The centre consisted of a three storey house but it had not been well maintained. Paint was peeling from the walls in almost every room and in one resident’s bedroom plasterwork had been damaged and not fixed. A number of radiators in the bathrooms had rust visible on them. Throughout the premises radiator covers had been removed and the brackets had been left in place. There hadn’t been any painting around the areas where the radiator covers had been removed. There were light bulbs without lampshades on each of the corridors/walkways and on the second floor one light fitting
didn’t have any bulb at all. The house bells outside the front door and back door were not working and the door handles on both doors appeared broken.

Inspectors observed the house to be visibly unclean. There was a Daughters of Charity cleaning standard document available but the cleaning schedule outlined in this guidance document was not being complied with. Examples included cobwebs plainly visible on lightshades and walls and an extractor fan in one shower room was completely blocked with dust. Inspectors saw a log of a daily cleaning schedule but the log was not being filled in by staff as required every day. The floors in each bathroom were unclean. Taps, sinks, baths and showers had accumulated grime in them. The carpet on the landing on the first floor was stained and visibly unclean.

In terms of layout of the house the front door led to a hallway. Underneath a chair behind the main front door one of the tiles had been removed and there was rubble visible. There was a large kitchen/dining room with dining table and chairs. There was a large damp spot on the ceiling in the kitchen area and dust was clearly visible in this room. The washing machine and tumble dryer were also located in the kitchen. The kitchen led to a living room which had a large couch and two armchairs. Cobwebs were clearly visible in the living room. There was a large garden with a men’s shed for one of the residents who liked to go there for quiet time.

One resident’s bedroom was downstairs. This resident showed inspectors the room and it was well presented with many personal items, including certificates of achievement on display. There were four other residents’ bedrooms, two on the first floor and two on the second floor. As mentioned earlier in Outcome 1 there was limited storage available in some residents’ bedrooms. There were four bathrooms, one on the ground floor, two on the first floor and one on the second floor.

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

Findings:
Improvement was required in relation to how the designated centre was managing risk, including health & safety, infection control and fire.

The centre had completed two infection control audits, one in 2014 and the second in May 2015. These audits reviewed issues including hand hygiene, cleanliness of the
general environment, cleanliness of the kitchen and the management of waste. The results of both audits recorded a poor level of compliance and the results had reduced from 75% compliance in 2014 to 72% in 2015. While there was a process in place for hazard identification and assessment of risk throughout the designated centre, it was not understood by staff. For example there was a risk assessment of infection control which rated the hazard from infection as a low risk. This risk assessment had not been updated following the infection control audits which showed poor practice evident.

During the inspection face cloths and towels were observed drying on radiators and over the banister. It was unclear as to who owned the facecloth and the towels. In a number of bathrooms there were no paper towels to dry hands. One bathroom had an electric razor plugged in and there was no indication as to who owned the razor or if it was shared. One of the cloths available to clean surfaces in the kitchen area was worn. All of these issues were not in accordance with best practice for the prevention and control of infection.

Inspectors identified a number of areas for improvement in relation to fire safety. The door in the front hallway had a chair behind it which prevented it opening fully, thus blocking a fire exit. The other fire exits were unobstructed and each final exit door had a key in a break glass unit. In relation to emergency planning there was a document called a fire risk assessment mobility status which outlined the help that residents would need in the event of an evacuation. However, this document was unsigned and undated and it was unclear if the information contained in it was valid. The risk and quality manager had completed an annual review of the centre in 2014 and one of the actions was that fire evacuation arrangements were to be displayed at each fire exit. However, these were not available during the inspection.

The evacuation route from the second floor included accessing an external stairwell via an exit on the first floor. A risk assessment was required on the access to this external stairwell from outside. The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel April 2015
- fire extinguisher servicing and inspection November 2014
- servicing of emergency lighting April 2015.

Inspectors saw evidence that the vehicles owned by the centre, and used to transport residents, were roadworthy, regularly serviced and insured.

Judgment:
Non Compliant - Major
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 improvement was required in relation to the management of behaviours that challenge and restrictive practices. Inspectors found that the systems in place, including specialist input and specialist behaviour support were not sufficient to support staff to manage behaviours that challenge in this centre. Also, the unsuitable mix of residents in the centre was contributing to peer-to-peer verbal abuse in the centre.

Relevant policies were in place, including in relation to the protection of vulnerable adults, restrictive practices, behaviours that challenge, the provision of personal intimate care and residents' personal finances and possessions.

With respect to behaviour that challenges; staff were able to articulate how 'triggers' to individual resident’s behaviours and how to respond to specific signs in a positive way, such as using distraction or diversion. Staff were observed to support residents to prevent escalation of any such signs. Incidents were recorded accurately and corresponded with behaviour logs. Charts that tracked 'antecedents, behaviour and consequences' to a particular behaviour (known as 'ABC charts') were maintained as required.

However, a number of areas relating to practices and documentation of the management of behaviours that challenge and restrictive practices required improvement. While residents had access to the multidisciplinary team in relation to managing their own behaviours, there had been no multidisciplinary input into the behaviour support plans viewed in the centre. Inspectors reviewed behaviour support plans for residents with behaviour that challenges and found that they did not provide adequate guidance for staff. For example, one plan included “PRN in place” as a reactive strategy with no other guidance in relation to its use. Another plan identified protective measures that were unclear, such as “staff work from the one sheet” and the guidance for dealing with behaviour that escalates did not guide staff as to how they should respond to the resident.

In response to a risk of a resident absconding, the kitchen door to the yard was locked when a staff member had to go upstairs, preventing access to the outside. As a result, no resident could go outside during such times. As a result, it had not been
demonstrated that all alternatives had been considered before putting in place this restrictive practice nor had it been demonstrated that this was the least restrictive practice that could be used. In addition, this practice had not been identified as a restrictive practice so the required documentation was not in place when this practice was in use.

Incidents that met the criteria for peer-to-peer abuse occurred in the centre and took the form of verbal abuse. These incidents were being recorded and multidisciplinary involvement had been sought. Documentation in the form of meetings with the social worker confirmed this to be due to an unsuitable mix of residents in the centre. It was not demonstrated that action had been taken to resolve this issue. This was previously discussed under Outcome 5: Social Care Needs and in the associated action.

The inspectors spoke with a sample of staff on duty and they articulated what to do in the event of an allegation or suspicion of abuse. Staff training records were not available in the centre on the day of inspection. However, records were subsequently submitted and indicated that one staff required up-to-date training in relation to the protection of vulnerable adults and all staff required up-to-date training in relation to the management of behaviour that challenges. Training records for agency staff were not available for review at the time of inspection.

Judgment:
Non Compliant - Moderate

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

**Findings:**
A written report at the end of each quarter in relation to incidents occurring in the house was submitted as required. Adverse incidents were notified in writing to the Authority. However, while incidents of peer-on-peer abuse were being recorded they had not been notified to the Authority in line with the Regulations.

**Judgment:**
Non Compliant - Major
### Outcome 11. Healthcare Needs

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

#### Theme:
Health and Development

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

#### Findings:
Overall, residents’ healthcare needs were met. However, there were significant deficiencies in relevant documentation pertaining to health assessments and care planning. As a result, there were gaps in ensuring that all identified needs were addressed.

Inspectors reviewed a sample of resident healthcare files. Each resident had access to a general practitioner (GP). There was evidence in the healthcare records that residents had timely access to GP services. There was also regular monitoring of residents’ healthcare needs, including regular weights and blood testing where indicated.

Referrals to medical consultants or allied health services and completed assessments were documented in residents’ files. There was access to allied health services including chiropody, orthotics, social worker, dentistry, physiotherapy and psychology. Inspectors reviewed a sample of assessments that considered residents’ healthcare needs. Overall, these assessments were not comprehensive and required significant improvement. For example, many assessments did not indicate whether a care plan was required. Information relating to continence and urinary needs for one resident was inaccurate and contradictory and a recent surgery was not referenced.

There was evidence that residents’ weight was monitored and of referrals to dietetics and speech and language therapy, where indicated. A nutritional assessment had been completed by a dietician and was accurately described by staff. However, this advice was held in the resident’s file in the upstairs office and was not readily accessible in the kitchen, as necessary given the number of agency staff used in the centre. In addition, where a resident displayed weight loss, an assessment for malnutrition screening had not been organised by the person in charge, as recommended in 2014.

Healthy eating plans were completed if required and residents were supported to follow such plans. Residents could choose when or where to take their meals and inspectors observed this to be the case. Inspectors observed that the evening meal appeared balanced and nutritious.

#### 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:

On the day of inspection the medication prescriptions were at the doctor’s surgery for signing. They were subsequently provided to the Authority following the inspection.

Medication was dispensed from the pharmacy in a monitored dosage system which packaged the medication for each resident for the correct time each day. The monitored dosage system also contained the name, address and date of birth of the resident. The medication was checked by staff on delivery from the pharmacist and was kept securely in a locked cabinet.

The inspectors found that the practice of transcription of medications was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais. Medication prescription records did not contain the signature of a second nurse to check the transcribed record which was required by their medication policy.

As an example of good practice a medication management audit had been completed in 2014 with a number of findings and actions identified. Staff had received medication management training within the last three years in accordance with their medication policy.

**Judgment:**
Substantially Compliant

## Outcome 14: Governance and Management

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The centre was part of the St Anne’s Service which was under the overall management of the Daughters of Charity Disability Support Services. St Anne’s Service provided supports to persons with an intellectual disability in the North Tipperary/Offaly areas. There was an executive committee of the Daughters of Charity Service which provided oversight of the centres in St Anne’s. Following the inspection a sample of the executive committee minutes from March 2015 were provided to the Authority. The minutes recorded that the St Anne’s service in general was discussed. However, there wasn’t specific discussion around each designated centre in St Anne’s service. In particular there wasn’t evidence of discussion around response to deficiencies identified in inspections undertaken by the Authority.

The nominee on behalf of the Daughters of Charity Services was a registered general nurse and a registered nurse in intellectual disability. She had been appointed in February 2015 as services manager in this service in North Tipperary/Offaly and had previously worked as services manager in the Limerick region. Management for the provision of residential services in North Tipperary/Offaly was delegated to the area manager who supervised and supported service provision in a number of houses in the region. The provider nominee outlined that she had responsibility for a number of other centres across a wide area. The area manager was the nominated person in charge and had a General National Vocational Qualification (GNVQ) level 2 in health and social care from Britain. He 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. However, he was also appointed as person in charge for a number of other centres across a broad geographical area. The inspectors outlined concerns that these management arrangements across a number of centres could not ensure effective governance, operational management and administration of the designated centres concerned. There was a part-time house manager who also had responsibility for another centre located 10 miles away.

The quality and risk manager for the Daughters of Charity services had completed an annual report of quality and safety of care and support for this centre in 2014. This report contained a review, with a detailed action plan to address any deficiencies identified in the areas of care planning, the provision of meaningful activities, fire evacuation procedures and provision of training to staff on the prevention of abuse. However, a number of these issues had not been addressed at the time of this inspection. For example the quality and risk manager identified that the reviews of the person centred plans for residents needed to be up to date. However, as outlined in more detail in Outcome 5 improvement was still required in relation to this process.

The provider had arranged a visit to the centre in August 2014 to assess quality and safety as required by the regulations. Some actions identified in this visit had not been addressed. For example, it identified the house needed to be painted and this had not been done. These provider visits to review quality and safety are required by regulation to be done every six months. However, inspectors were not shown records of any visit since August 2014.
Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that it was not demonstrated that staffing levels and skills mix met the assessed needs of residents. Inspectors found that this failing was at the level of major non-compliance.

The person in charge and staff said that there was one staff member on duty at all times when the residents were in the house. For planned events, a second staff member was made available. There was evidence that the individual needs of residents were considered by staff where determining required staffing levels for such events. For example, one staff recently brought residents to a party while a second staff brought a resident who did not like crowds for a drink so that he would not miss out on the outing. However, it was not clearly demonstrated how, outside of one-off activities or events, it had been determined that the number of staff met the assessed needs of the residents in the centre.

Staff were experienced and demonstrated that they knew the residents well and endeavoured to provide an individualised service to the residents. However, it was not demonstrated that staff had the appropriate skills and qualifications to meet the assessed needs of residents. This was evidenced by the poor quality of healthcare assessments, restrictive practice documentation and behaviour support plans. In addition, staff did not demonstrate an understanding of risk management or restrictive practices. Peer-on-peer abuse had not been recognised as such and a restrictive practice had not been recognised as such. Hygiene standards in the centre were unacceptable.

A number of staff in the centre did not possess a relevant qualification in the area of health or social care. The provider nominee had identified this gap and said that a funded plan was in place to ensure that all non-nursing staff have a minimum training course at Further Education and Training Awards Council (FETAC) Level 5, or equivalent, relevant to the role of healthcare assistant.
The person in charge was the person in charge for this centre since January 2015 and the house manager was in the role six weeks. The house manager worked two days per week in this centre. The person in charge said that formal 1:1 communication meetings with the house manager were due to commence soon but none had taken place to date. There was a system in place for the induction of new staff and an induction log was completed for new staff members. This included centre policies, routines, observation skills, incident reporting and fire safety. However, the log had been signed by the staff member only and not by any supervisor or manager, as indicated on the form.

As previously mentioned under Outcome 8, not all mandatory training was up-to-date. Staff training records were not available in the centre on the day of inspection. Records submitted following the inspection for staff employed directly by the organisation indicated that mandatory training in relation to behaviour that challenges was not up-to-date for all staff and one staff required up-to-date training in relation to the protection of vulnerable adults. Two staff required training in hand hygiene, which was noteworthy given the poor standards of hygiene in the centre. Training records for agency staff were not available for review.

A volunteer visited the centre and was affiliated with the HSE and subject to vetting by the Health Services Executive (HSE).

Judgment:
Non Compliant - Major
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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

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<thead>
<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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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005162</td>
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<tr>
<td>Date of Inspection:</td>
<td>22 May 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02 July 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of suitable storage throughout the premises.

Action Required:
Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Nominee provider together with the Clinical Nurse Manager 3 and the Person in Charge with Director of Logistics will review the storage and appropriate wardrobe space for each service user in the centre and ensure the necessary adaptations are made to provide a personal space for each individual.

Proposed Timescale: 22/07/2015

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 assessment of needs was not comprehensive, where needs supports or risks were identified other specific plans had not always been completed (including health plans, risk assessments and behaviour intervention plans) and some needs had not been appropriately assessed.

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

Please state the actions you have taken or are planning to take:
All service users care plans will be reviewed by the person in charge, the house manager and with the support and training input from the clinical nurse manager (CNM) 3. Where needs have not been appropriately assessed an assessment will be completed by a registered nurse and members multi disciplinary team where required, and will have plans of care developed. The plan of care will have review dates with a named person responsible for the review. The person in charge will monitor and the CNM3 will audit the effectiveness and ensure the completion of these assessments and plans of and reviews as recommended. Where risks are identified for a service user, this team will complete a risk assessment and this will be incorporated into the service user's personal plan.

Proposed Timescale: 31/07/2015

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. Two residents had been identified as possessions.
requiring alternative more suitable accommodation.

**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:**
A service user’s accommodation review group has been established in the service, and commenced meeting in March 2015, the purpose of this review group is to identify the wishes and needs of individual service users around their accommodation needs. Service users, their families or representatives, multi disciplinary team members and the HSE are involved in this process. The two service users, whose needs are not being met currently in the centre, will be prioritised through this group. The first meeting for both service users will take place 21/07/2015. The initial meeting will be with the service user their family/representative and the nominee provider and Director of Nursing, to establish what the service users own wishes for future accommodation/ living arrangements are.

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

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The review of the personal plan was not multi-disciplinary, as required by the Regulations.

**Action Required:**
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

**Please state the actions you have taken or are planning to take:**
All service users care plans will be reviewed by the person in charge, the house manager and with the support and training input from the clinical nurse manager 3. Where needs have not been appropriately assessed an assessment will be completed by a registered nurse and members multi disciplinary team where required, and will have plans of care developed. All plans of care will be reviewed yearly and more frequently as required. The service is currently in the recruitment process for psychologist and occupational therapist to support service users in the centre. In the interim where multi disciplinary support is not available the nominee provider will ensure that this support will be contracted in as required for an individual. The nominee provider, assistant CEO and psychologist have had meeting to highlight the lack of evidence of multi disciplinary input into the personal plans in the centre, with particular emphasis on the behaviour support plans of service users. The nominee provider, psychology team are scheduled to meet managers and persons in charge on 22/07/2015 to ensure as team, that all team members input is evident in personal plans of all service users going forward. To ensure that all team members input is an integral part of the service users Plan there will be a named person who takes the lead in ensuring this plan is implemented with
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system in place for the review of personal plans did not meet the requirements of the Regulations. For example, the setting and monitoring of personal goals required improvement. Also, it was not always clear who was responsible for each goals and within what timeframe. Finally, the supports required for residents to achieve their goals were not specified, as required.

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

Please state the actions you have taken or are planning to take:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale: 30/09/2015

Outcome 06: Safe and suitable premises

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It had not been well maintained. Examples included plaster coming off the walls, rubble left where a tile had been removed and radiators rusting.

Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The nominee provider and the Director of Logistics will review all aspects of the premises, and a plan of works to be completed in the centre will be outlined, detailing cost and time frame for completion. The identified works as per the plan will be completed, to the time scale set out in the plan. This plan will be completed by 10/07/2015.
**Proposed Timescale: 30/10/2015**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The house bells outside the front door and back door were not working and the door handles on both doors appeared broken.

**Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
The general maintenance needs of the centre will be addressed immediately by the maintenance manager of the service.

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**Proposed Timescale: 03/07/2015**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Throughout the premises radiator covers had been removed and the brackets had been left in place.

**Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
Immediate items requiring attention will be completed as a matter of urgency coordinated by the local maintenance manager. The brackets will be removed from the walls, and the repair to paint and plaster when they are removed will be completed.

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**Proposed Timescale: 03/07/2015**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The floors in each bathroom were unclean. Taps, sinks, baths and showers had accumulated grime in them.

**Action Required:**
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.
Please state the actions you have taken or are planning to take:
The nominee provider contracted the services of a professional company to do a thorough deep cleaning of the centre, inside and outside. This is completed 18/06/2015. The Clinical nurse manager 3 will provide training and input to all staff in the centre around the completion of the daily cleaning logs in the house, and ensure that a standard of cleanliness will be adhered to at all time, this will be completed 30/06/2015. The completed hygiene audit will be reviewed by the person in charge, and all areas outlined for action, will be completed. The person in charge will identify a responsible person for the completion of each action identified. Learning and feedback will be shared at the centre monthly meeting.

**Proposed Timescale:** 31/07/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Paint was peeling from the walls in almost every room

**Action Required:**  
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:  
The nominee provider and the Director of Logistics will review all aspects of the premises, and a plan of works to be completed in the centre will be outlined, detailing cost and time frame for completion. The identified works as per the plan will be completed, to the time scale set out in the plan. This plan will be completed by 10/07/2015.
The completed hygiene audit will be reviewed by the person in charge, and all areas outlined for action, will be completed. The person in charge will identify a responsible person for the completion of each action identified. Learning and feedback will be shared at the centre monthly meeting.

**Proposed Timescale:** 30/10/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Cobwebs clearly visible throughout the premises.

**Action Required:**  
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.
Please state the actions you have taken or are planning to take:
The nominee provider contracted the services of a professional company to do a thorough deep cleaning and high dusting of the centre, inside and outside. This is completed 18/06/2015. The completed hygiene audit will be reviewed by the person in charge, and all areas outlined for action, will be completed. The person in charge will identify a responsible person for the completion of each action identified. Learning and feedback will be shared at the centre monthly meeting.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Extractor fan in one shower room was completely blocked with dust.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The maintenance manager will address the fan in the shower room and ensure that there is a working and clean fan in the room.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The carpet on the landing on the first floor was stained and visibly unclean.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The carpet on the landing will be replaced immediately. This will be co-coordinated by the maintenance supervisor. The person in charge will ensure that service users choose the colour of the carpet.

| Proposed Timescale: 17/07/2015 |
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 process for hazard identification and assessment of risk throughout the designated centre was not understood by staff.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A CNM3 from another part of the Service will support staff in the centre with onsite training in relation to the identification of hazards and risks and control measures. This CNM3 will also support the staff in the completion of centre specific, and service user specific, risk assessments.

Proposed Timescale: 17/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear if the information contained in the fire risk assessment mobility status was valid.

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:
The Person in Charge and staff team will review all fire risk assessment mobility status of residents, and ensure that they are accurate, in date, and appropriate to each service users evacuation needs. These will be signed and dated.

Proposed Timescale: 22/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Face cloths and towels potentially being shared.

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:**

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

In a number of bathrooms there were no paper towels to dry hands.

**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:**

There will be paper towels available for service user use in all bathroom areas in the centre. The house manager will assign this responsibility to a staff member on a daily basis. The Clinical nurse manager 3 will provide in house training to all staff and the person in charge, on the recognised standards for the prevention of infection in the designate centre.

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

One bathroom had an electric razor plugged in and there was no indication as to who owned the razor or if it was shared.

**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:**

The house manager and the person in charge will complete an inventory of each service users personal items/belongings and ensure that all service users use only their own
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One of the cloths available to clean surfaces in the kitchen area was worn.

**Proposed Timescale:** 03/07/2015

**Theme:** Effective Services

**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:**
The clinical Nurse Manager 3 and the person in charge will provide input to all staff of the centre on infection control guidelines and ensure that systems are in place to provide high standards of infection control for all service users of the centre. The clinical nurse manager 3 will carry out regular audits and the actions from these audits will be actioned and dated with a named person responsible to ensure their completion. Learning will be shared at the staff meeting on a monthly basis. The person in charge will ensure that all necessary items such as cloths and mops etc are good quality and available in quantity necessary. These items will be purchased where necessary.

**Proposed Timescale:** 31/07/2015

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Fire evacuation arrangements were not displayed at each fire exit which had been a recommendation from the risk and quality manager in January 2015.

**Action Required:**
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

**Please state the actions you have taken or are planning to take:**
The person in charge with the house manager will ensure these fire evacuation arrangements are displayed at each fire exit within the next week in the centre 26/6/2015
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The door in the front hallway had a chair behind it which prevented it opening fully, thus blocking a fire exit.

**Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
The person in charge has since inspection ensured that all fire exits are kept clear to ensure a safe and unobstructed fire escape route in an emergency, this part of the action is completed. The person in charge will reiterate the importance of compliance with the daily fire check list and its reference to unobstructed emergency exits, this is completed. This will also be an agenda item at the centres monthly meetings, where shared learning can take place.

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**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:**
One staff required up-to-date training in relation to the protection of vulnerable adults and all staff required up-to-date training in relation to the management of behaviour that challenges. Training records for agency staff were not available for review at the time of inspection.

**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 staff member in question received training in protection of vulnerable adults on 17/06/2015, the staff requiring training in challenging behaviour received same on 16/06/2015.

| Proposed Timescale: 17/06/2015 |
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that every effort was made 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. In addition, the required documentation was not in place, in accordance with national policy.

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:
There will be a review of each service user and their behaviour support needs. The clinical nurse manager 3 and person in charge along with the multi disciplinary team will be involved in this review, and behaviour support plans will be developed where a service user requires this. All restrictive practices will be reviewed, through a multi disciplinary team review, and where restrictions can be removed, they will and where restrictions are required there will evidence to support that they are the least restrictive means. Any restrictions in place will be documented in each person’s plan of care and also will be on the restrictive practices register for the area, all restrictions will be further discussed at the restrictive practices committee meeting.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that staff had 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.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff 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.

Please state the actions you have taken or are planning to take:
All staff have since the inspection received training in the management of behaviours that challenge, last of the staff were trained on the 17/06/2015. An instructor in the Therapeutic Management of Aggression and Violence from another part of the service will provide support to the staff and person in charge in the centre in the reviewing of the behaviour support needs of the service users and developing an appropriate
behaviour support plan to meet their needs.

**Proposed Timescale:** 31/07/2015

### Outcome 09: Notification of Incidents

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Incidents of peer-on-peer abuse were being recorded but had not been notified to the Authority in line with the Regulations.

**Action Required:**
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

**Please state the actions you have taken or are planning to take:**
The nominee provider has discussed the responsibility of the person in charge to make notification of incidents to the authority. The Clinical Nurse manager 3 will monitor the reporting of incidents and support the person in charge to ensure all incidents are notified to the authority in the specified timeframe.

**Proposed Timescale:** 29/05/2015

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Assessments that considered residents’ healthcare needs were not comprehensive and required significant improvement. For example, many assessments did not indicate whether a care plan was required. Information relating to continence and urinary needs for one resident was inaccurate and contradictory and a recent surgery was not referenced. Also, a nutritional assessment was held in the resident’s file in the upstairs office and was not readily accessible in the kitchen, as necessary given the number of agency staff used in the centre. In addition, where a resident displayed weight loss, an assessment for malnutrition screening had not been organised by the person in charge, as recommended in 2014.

**Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

**Please state the actions you have taken or are planning to take:**
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:** 31/08/2015

**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.

**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 clinical nurse managers 3s are both in post full time. The clinical nurse manager 3 will be the second nurse available to sign the drug prescription sheet when transcribed and checked.

**Proposed Timescale:** 30/06/2015

**Outcome 14: Governance and Management**
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was a defined management structure this required review as both the person in charge and the provider nominee were actively managing a number of other centres across a broad geographical area.

**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:**
Since the inspection date, a clinical nurse manager 2 has been appointed by the organisation, to take responsibility for 4 centres, two of which were under the
responsibility of the person in charge at the time of this inspection, thus reducing the number of centres to this person in charge by two centres. The second clinical nurse manager 3 appointment has commenced since inspection, the person in charge now has a named clinical nurse manager 3 support and supervision. The person in charge prior to the appointment of the clinical nurse manages 3 worked in an “on call” capacity; this is no longer the situation Monday to Friday.

Proposed Timescale: 15/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There wasn’t evidence of discussion at an executive level around response to deficiencies identified in inspections undertaken by the Authority.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The nominee provider has met with the CEO and executive members, to ensure that all inspection reports are discussed at executive meetings, it has been agreed that on a weekly basis the members of the executive team and the nominee provider will meet specifically to discuss inspections and actions required.

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Actions from reports undertaken by the quality and risk manager in 2014 had not been completed by the date of this inspection.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
All actions outlined will be completed. The nominee provider, Clinical Nurse Manager 3 and the person in charge will review the reports and name responsible persons for completing the actions in specific timeframes. The nominee provider has detailed the importance of following up on actions outlined and seeking advice and support where necessary to ensure completion of these actions. The person in charge has now a
reduced number of designate centres in his remit, with the support of a newly appointed CNM3 to support and mentor him in his role.

**Proposed Timescale:** 31/10/2015  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Provider visits to review quality and safety are required by regulation to be done every six months. However, inspectors were not shown records of any visit since August 2014.

**Action Required:**  
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**  
The nominee provider, assistant CEO, Director of Nursing and the clinical nurse managers 3 will collectively ensure that all provider audits are completed in the timeframe outlined. The provider audit for this centre will be completed by 31/06/2015.

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

**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
It was not demonstrated that staffing levels and skills mix met the assessed needs of residents.

**Action Required:**  
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**  
The Service Human Resources Director, Nominee Provider, Person in Charge and Clinical Nurse Manager 3 are reviewing staffing in the centre. Service users support needs will be the basis of this review to ensure that appropriate skill mix and safe practices are in place, this process commenced on 20/06/2015. Rostering of staff will be reviewed, to ensure that both service users and staff are safe in the centre at all times.
The review will include reviewing the existing roster and ensuring that staff hours are rostered in the most effective manner possible to meet the service user needs and to support activities outside of the house in the evenings and at weekends. The review of staffing to the designate centre will be completed 31/07/2015, recruitment of additional required staff supports will be commenced following the completion of the review

**Proposed Timescale:** 31/07/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
It was not demonstrated that staff were adequately supervised. Formal 1:1 communication meetings between the person in charge the house manager had not taken place since the house manager commenced in her role in the centre. The induction log for a new staff member had been signed by the staff member only and not by any supervisor or manager, as indicated on the form.

**Action Required:**  
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**  
Since the inspection date formalised meetings between the person in charge and house manager have commenced. The newly appointed Clinical nurse manager 3 has formal meetings with the person in charge. The nominee provider has meets with the persons in charge and the clinical nurse manager 3 on a regular basis to discuss both current issues and actions requiring immediate attention. The nominee provider has had meetings with the assistant CEO, CEO, Director of Nursing, Human Resource Director, Director of Finance and Director of Logistics to discuss the designate centres within the organisation.

**Proposed Timescale:** 15/06/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Not all mandatory training was up-to-date. Records submitted following the inspection for staff employed directly by the organisation indicated that mandatory training in relation to behaviour that challenges was not up-to-date for all staff and one staff required up-to-date training in relation to the protection of vulnerable adults. Two staff required training in hand hygiene, which was noteworthy given the poor standards of hygiene in the centre. Training records for agency staff were not available for review.

**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:**
Since the date of inspection all staff training is up to date for staff in the centre. The person in charge with the house manager will ensure that all training for staff is maintained up to date, and where training is not available in service the nominee provider will ensure that it is sourced externally.

**Proposed Timescale:** 17/06/2015