<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>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001439</td>
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<tr>
<td>Centre county:</td>
<td>Dublin 20</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>Mary Reynolds</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Valerie McLoughlin</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Shane Walsh;</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>17</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 23 June 2015 09:30  23 June 2015 18:00
To: 23 June 2015 14:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
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<tbody>
<tr>
<td>Outcome 01: Residents Rights, Dignity and Consultation</td>
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<tr>
<td>Outcome 02: Communication</td>
<td></td>
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<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
<td></td>
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<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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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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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10. General Welfare and Development</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
<td></td>
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<td>Outcome 13: Statement of Purpose</td>
<td></td>
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<td>Outcome 14: Governance and Management</td>
<td></td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<tr>
<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection
This registration monitoring inspection of Cedars Group- St Louise’s Residential Services, Daughters of Charity was announced and took place over two days. This is the second inspection of this centre by the Health Information and Quality Authority (the Authority). As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. The inspector received questionnaires from residents and relatives which were complimentary of the service being provided at the centre. The designated centre comprises three houses which form part of a larger campus. A support inspector
focused on the outcome related to premises and staff files and the lead inspector visited the three houses where residents lived and monitored all the outcomes and progress with the action plan from the previous inspection.

The provider nominee is accountable for St. Louise’s Residential Service and eight other centres. A fit person interview was carried out with the nominated person on behalf of the service on a previous inspection. She was found to be knowledgeable in her role and the requirements of the regulations. The provider nominee was supported by a team of nurse managers who were available to monitor the quality of care and supervise staff.

The design and layout of the premises was suitable for its stated purpose. It was a campus based service, with nine bungalows, a house used for administration, and a building that houses the kitchens, canteen and the day services. This designated centre was made up of three bungalows, located close to each other on the campus. Each bungalow has an outside seating area, and there was also a large enclosed garden. The grounds were well maintained and provided a pleasant outside environment for residents and visitors to enjoy. There was appropriate equipment to meet the needs of residents.

Residents were observed to be responding to staff in a positive way. A number of staff had worked at the service for a long time, and so knew the residents and their communication styles well. The detail in the residents care and support plans provided person centred information about the residents including their likes and dislikes, which supported newer staff to receive clear information about how support was to be provided.

Inspectors saw that residents were supported to maintain relationships with their families and friends. Families visited the centre regularly, and called for updates from staff. Families were also involved in planning meetings for residents where their interests and plans for the future were discussed.

The inspector found that residents were engaged in a range of activities during the day, and there were opportunities for them to take part in some activities of their choice but this was limited in the evening time and at weekends due to inadequate staffing levels.

Policies and procedures that were in place guided staff practice and were well known by the team. A number of policies had been updated to provide clearer guidance to staff, and this had resulted in improved practice in the centre.

Residents assessment, care plans, implementation and evaluation of health care were met to a high standard. Staffing levels and skill mix was not consistently adequate to meet residents current social care needs. The provider nominee was was actively recruiting additional staff to enable residents to have a better quality of life and it was envisaged that nine new staff would be in place by the end of July,
with a full staffing compliment in place by December 2015 as outlined in the previous action plan.

A judgment of major non-compliance was made because there were insufficient staff to support residents to avail of opportunities for social engagement and activities outside of the centre, and off campus. Also the staffing levels at certain times when only one staff member was present to support residents, some of whom had complex needs and required the support of more than one member of staff. Families who provided information for HIQA also raised staffing levels as a concern. Other non compliance related to complaints management, choice relating to male or female carer for intimate care, and garda vetting for one staff member.
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):
No actions were required from the previous inspection.

Findings:
Residents were consulted with and participated in decisions about their care and the organisation of the centre. They also had access to advocacy services and this information was accessible to residents and visitors. Information about residents’ rights was available to residents and residents were aware of their rights.

The inspector found that residents were consulted via the residents committee about how the centre was managed. There was weekly discussion with the residents to plan things like social activities, the menu, and planning birthday celebrations. The residents reported that they felt they were involved in making decisions about their daily routine, and decisions such as how they decorated and cared for their home.

There was a resident’s guide available for everyone in the centre, this included information about the services provided to them, and the procedure for making complaints. All of the residents spoken with said they knew who to speak to if they had any worries. There were complaints booklets available in word/picture format on a table next to the front door.

The complaints policy met the requirements of the Regulations, for example it clearly outlined the appeals process. A review of the complaints log showed that there had been one verbal complaint and it had been managed locally. The satisfaction of the complainant had not been recorded; it was therefore not possible to determine if the matter had been resolved to the satisfaction of the complainant.

Staff were responsive to residents needs, for example in planning meals and supporting residents to visit their GP, and going shopping or out for a walk.
Staff were respectful of residents’ privacy and dignity and were observed knocking on the main door of residents’ bedroom, and waiting for a response to enter.

Judgment:
Substantially Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Overall residents’ communication needs were met to a good standard. Personal plans detailed residents preferred method of communication, for example, the use of hand gestures, pictures and the use of plain sentences. This was in line with the centres policy which was in the process of being updated to reflect current practice, for example to include the use of “objects of references” as a means of communicating with some residents. The policy was due for completion due for completion in July 2015.

Residents were assisted and supported to communicate, appropriate to their identified needs. Staff were aware of the communication needs of residents and these were clearly described in the communication care plan maintained on file for each resident. Residents were communicating well with staff and other residents throughout the inspection.

Staff were seen to have a good knowledge of residents communication styles and for those who were did not communicate verbally, they were aware of how to interpret gestures and residents moving around the premises. For example pointing to their coat beside the door, to indicate that they would like to go out for a walk.

Some staff did have some sign language, and some pictures were used in the designated centre, for example pictures of the meal choices, and easy read versions of policies and procedures.

Judgment:
Compliant
Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
The centre was campus based. There was access to the community as part of activities, as discussed in outcome 10. Residents were seen to have access to radio, television, internet, social media and information on local events. There had been a family day recently that residents were said to have enjoyed.

The inspector found that residents were supported to develop and maintain personal relationships. However there was limited support available for residents to develop links with the wider community.

Residents told inspectors that they were able to see their family and friends at times that suited them, and that they could see them in private. The inspector observed staff supporting residents to visit their friends in other houses on the campus.

The inspector reviewed the policy in place about visitors. There are no restrictions on visits by friends, except when requested by the resident or when the visit or timing of the visit is deemed to pose a risk.

Family members told inspectors that they could visit any time and that the staff were very welcoming. Inspectors noted that family contact sheets are updated in care plans following contact with families. There is a social worker available to meet with family members if required.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

**Findings:**
There was a comprehensive policy in place which outlined the process to support residents moving in and out of the centre. Admission to the service is arranged through the admissions, discharge and transfers committee which is recorded in the statement of purpose as being guided by the philosophy and ethos of the Daughters of Charity. The policy stated that residents views would be sought from current residents prior to a new person moving in.

The admission process was in line with the statement of purpose.

Each resident had a contract in place that explained the service to be provided and any additional charges that may incur as required by the regulations.

In addition each resident had a financial agreement in place that outlined payment details for rent, food, ability bills and day care services.

**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):**
No actions were required from the previous inspection.

**Findings:**
Care and support provided to residents reflected their assessed needs and respected their wishes.

The personal care plans set out clearly resident assessed needs, including health, social and emotional needs. They were person centred and described the residents covering their likes and dislikes, and gave a good overview of their preferred way to engage with people and the environment. The detailed plans gave clear instructions to the staff about what prompting, supervision and support was needed in all areas. For example it was noted that some residents required a personal fixed routine such as having a late lie
on in the mornings, or have meals with a friend rather than with a group.

Also, intimate care plans recorded residents preferred time to bathe, preferred routines, and the time they liked to carry out their routines.

There were also risk assessments in place to identify areas where specific support was needed for the resident to maintain their safety, the safety of staff and for the environment they were in. For example accessing the environment as independently as possible, but with appropriate equipment to ensure the residents safety.

Staff reported, and records confirmed, that plans were reviewed regularly, and a full review was carried out annually. The information in the documents was seen to be current, however more consistent dating of documents would improve practice. A planning process was used by the provider to support residents and their families to identify goals and interests for the residents. Goals for residents to achieve were being set, and progress was noted. Where the new planning system was being used staff commented it was giving them much more information about the residents and their families and supporting planning around residents likes and interests well.

Care was overseen using a number of processes including a multidisciplinary review held annually and as required to which relatives are invited. The inspector found that the requirement to ensure resident’s needs could be met within the service and that the care was being effectively reviewed.

Through the inspection it was seen by inspectors that resident’s plans were being followed as agreed and residents care and support needs were met. Families were also positive about the quality of care and support provided by the regular staff teams. Relatives spoke of enjoying the recent family day, and of being involved in a family support group.

However, there were limits on the activities and pastimes outside of the bungalows, these are discussed further under outcome 10 and 16.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that the three bungalows were purpose built and thus were suitable in their design and layout to meet the needs of the residents.

The inspectors observed that there was suitable private and communal space for the residents in each bungalow. Each resident had their own room which most had personalised and decorated. Each bungalow had a large sitting room come dining room which were found to be homely and spacious. There was also a smaller sitting room which provided residents with some privacy if they wished. Each room was seen to have a sufficient amount of furniture and all rooms were seen to by clean and free from major hazards.

The inspectors observed that the bungalows were laid out in a manner that promoted accessibility for residents. The hallway was wide and well lit. There were two bathrooms in each bungalow with accessible toilets, showers and baths. The residents also had open access to an patio area at the back of each bungalow. Inspectors observed that these patios were being regularly used by the residents and were maintained well and free from any major hazards. Each patio was connected to a beautifully decorated larger communal garden to which residents had access to. The front door to each bungalow was locked; and residents are receiving training in how to use a fob to open the door independently.

Each bungalow had its own kitchen and laundry facilities. Although most meals were cooked in the main canteen for the centre, the inspectors observed that on some evenings food was prepared in the bungalows in order to provide life skills for residents.

The inspectors also seen that all equipment such as hoists were in good working order, were fit for purpose and had been recently serviced.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
There were systems in place to promote and protect the health and safety of residents,
visitors and staff.
The inspector reviewed the policies and procedures that covered health and safety in the house, this included policies on incident reporting, infection control, missing persons and safe storage of chemicals. There was also an up to date safety statement that covered residents, staff and visitors.

The risk management policy met the requirements of the regulations and it was implemented, for example there was a local risk register in place that was kept under review. The provider nominee had a system in place to ensure that the identified risks were being managed effectively. For example, the health and safety committee reviewed the risks and escalated areas of high risks to the senior management team for review as outlined in the policy.

Each resident had clinical and environment risk assessments in place. The information in these documents was used to support the allocation of resources such as making sure there was enough staffing to consistently meet residents needs.

Inspectors observed a range of measures in place in the centre to manage risks in relation to health and safety, including manual handling training and fire training.

Staff were vigilant in maintaining a safe environment for residents. They were kept up to date about the identified risks in the centre and they were knowledgeable of the risks recorded on the local risk register.

Inspector reviewed the incident report and found it had been fully completed and reported to the service manager in line with the policy. Appropriate control measures had been put in place following re risk assessment to minimise the risk of re-occurrence. For example the resident was referred to the multidisciplinary team and was fitted with specialised footwear.

The person in charge was aware that should there be a number of incidents and accidents that they would be reviewed to identify if there were any patterns or trends or any actions required to reduce the risk of recurrence.

There was a policy of the management and prevention of fire in place in the centre. The inspectors observed that there was suitable numbers of fire equipment and fire exits. All fire exits were seen to be unobstructed. All doors were fire doors and had self closing mechanisms. There was at least two fire drills held annually in the centre. A fire evacuation plan was in place for both day and night in each of the bungalows. Personal evacuation plans were in place for all residents which provided good detail on residents' mobility and cognitive understanding of a fire. These also contained information for day and night evacuations. Copies of these plans were held at the front door of each bungalow for ease of retrieval.

The inspectors reviewed documentation that confirmed that all fire fighting equipment, emergency lighting and fire alarms were being serviced regularly as per the regulations. Records showed that all staff had had fire training within the last year. Staff spoken with were familiar in what procedure to follow if there was a fire.
**Judgment:**
Compliant

### 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:
There were systems in place to safeguard residents and protect them from the risk of abuse and evidence of a culture of safeguarding residents.

There was a policy and procedure on the prevention, detection and response to abuse for adults. It included the definitions of different types of abuse including neglect and psychological abuse. Staff members had all received training in adult protection since the previous inspection. Therefore this aspect of the action plan had been met. Staff spoken with were knowledgeable in relation to the prevention, detection and management of an allegation of abuse.

The person in charge was educated in safeguarding and very clear around the process of managing an allegation of abuse and its investigation. At the time of inspection, there were no cases of allegations of abuse recorded. Residents spoken with during inspection were unable to communicate whether or not they felt safe in their home. The inspector noted that residents appeared to be content in their home, there was a calm and homely atmosphere and staff were seen to manage behaviour that challenges well.

The inspector found that staff managed behaviour that challenges well. Residents had detailed positive behaviour support plans in place compiled by a multidisciplinary team. There was some evidence of family involvement in these meetings with the residents permission, however this could be improved.

Since the previous inspection a system of risk assessment had been put in place for the use of restrictive practices, such as the use of lap belts, bed rails, crash helmets and locked doors.

The inspector reviewed the risk assessments, care plans, and reviews and found that
evidenced based guidelines were being implemented, monitored and reviewed appropriately. There was recorded evidence that alternatives had been tried previously. Care plans were in place detailing the management and reviews and these were implemented. There was recorded evidence that the multidisciplinary team were involved in decision making about the implementation, monitoring and review of restrictive practices. As mentioned previously residents had care plans and training in place on how to use the fob to open the front door. Therefore this aspect of the action plan had been met.

There was a policy in place for providing personal intimate care and all residents had a detailed care plan on how their personal intimate care would be met. Residents were not provided with a choice of a male or female carer. The inspector reviewed a number of residents files and found there was no reference to providing residents with a choice except for one care plan where the parents had requested that male staff should not provide personal intimate care for their daughter. This request was outlined in the care plan and recorded as being implemented. Staff were familiar with the care requirements. On asking staff if residents are offered about their preference in having a male or female carer, staff said that the lack of staff impacted on providing residents with a choice. This action is recorded under outcome (16 resources).

**Judgment:**
Compliant

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**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe Services

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

**Findings:**
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding any incidents and accidents. The person in charge was clear of what incidents needed to be notified and the time scale in which they must be notified to the Authority. To the knowledge of inspector all incidents and accidents were reported clearly, and in a timely manner.

**Judgment:**
Compliant
### Outcome 10. General Welfare and Development

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

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

**Findings:**
The inspector was not satisfied that each resident had opportunities for new experiences, social participation and activities that matched their preferences.

There was a day service on campus that offered a wide range of sessions including accredited training courses, dance, singing, craft and exercise. Residents generally attended for one or two sessions a day, usually lasting 40 minutes to 1 hour.

Residents were also taken out for walks by staff, generally within the grounds of the campus.

Residents were seen to be going out for trips in the community, for example drives on the bus, lunch out, and to Mass.

However, as activities and trips were usually a one to one activity, this would leave one staff member in the centre with the other residents, and unless the resident was able to engage independently in an activity, they were left unoccupied for periods of time.

The action for this is made under outcome 16.

**Judgment:**
Non Compliant - Moderate

### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

**Findings:**
Inspector found that there were effective and efficient arrangements in place to provide a high standard of health care for each resident. Health care needs were met to a high standard, for example residents with a history of diabetes, dysphagia (difficulty swallowing), seizure management and specialist dietary arrangements. Residents had comprehensive care plans that guided staff to provide evidenced based practice. The person in charge ensured that staff had received training on the management of diabetes and epilepsy. Staff spoken with were knowledgeable about these conditions and the documentation was reflective of the residents assessed needs. Care plans reviewed were evidenced based and directed residents care. When required residents were assessed by allied health professionals such as speech and language therapists, dietician, chiropodist and their recommendations were reflected in the care plan, implemented and monitored closely. The service had qualified phlebotomists to take blood samples from residents while in their own home. There was recorded evidence that blood results were reviewed by the GP and medications adjusted accordingly in a timely manner.

Since the previous inspection the person in charge ensured that residents with a history of dementia had their needs met. Residents with dementia are referred and reviewed annually by a dementia nurse specialist, and care plans were in place to guide residents care. Staff had also received training in dementia related conditions. Therefore this aspect of the action plan had been met.

Staff were seen to interact with residents in an unhurried and appropriate manner. Plans were formally reviewed yearly, but more frequently if there was a change in the residents’ health status, for example evidence of difficulty swallowing, raised blood glucose and hearing loss and unexplained falls.

Residents had access to a range of medical and allied healthcare professionals based on their assessed needs, for example physiotherapist, diet, occupational therapy, chiropody, psychology, psychiatry and medical consultants. Residents were assessed for specialist seating, and the inspector noted that residents had been provided with suitable seating to meet their needs.

Residents had access to a general practitioner (GP) of their choice, and access out of hour’s service medical services. Health assessments had recently been put in place to ensure residents received appropriate health screening, for example osteoporosis. Residents planned their own menus with staff support. Inspectors were shown the pictorial menu that residents were supported to choose from.

Meals were distributed to the houses in hot trolleys. Twice a week staff assisted residents with meal preparation, which they said they enjoyed. Staff were available to provide discrete supervision as required. This had been a requirement from the previous inspection. Therefore this aspect of the action plan had been met. The inspector found that there was an ample supply of snacks available. Fresh fruit and juice was available during the day which residents could access whenever they wished.

**Judgment:**
Compliant
**Outcome 12. Medication Management**

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

**Theme:**  
Health and Development

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

**Findings:**  
The inspector found that there was evidence of good medication management practices. The inspector was satisfied that each resident was protected by the designated centre’s policies and procedures for medication management. The medication policy had been amended as required since the previous inspection. It now included the procedure on prescribing and met the requirements of the regulations.

The policy included a procedure for self-administration of medication; there were no residents managing their own medication on the day of inspection. The inspector observed the nursing staff administering medication in line with the policy.

Inspectors reviewed the prescription sheets for a number of residents and found each medication was accompanied by a signature from the prescribing GP. Inspectors found staff were knowledgeable in medication management. For example there were safe processes around the management of insulin and the potential risks associated with diabetes. Staff were vigilant in monitoring blood glucose levels and were aware of how to manage a low and a high blood sugar.

Inspectors reviewed a sample of residents’ medication files which were clear and legible. Resident identifiers were in place such as photographic identification for each resident to ensure the correct identity of the resident receiving the medication thus reducing the risk of a medication error. Medication was administered within the prescribed timeframe. Discontinued medications were signed off and dated by the Doctor.

Prescription sheets reviewed were clear and distinguished between “as required” (PRN) and regular medication. The inspector observed prescribing practices which promoted safety in medication management. For example, the maximum amount for PRN medication was recorded on prescription sheets and the purpose of the required medication. Since the previous inspection the process of prescribing medications that were required to be crushed had been put in place. Therefore this aspect of the action plan from the previous inspection had been met.

Inspectors observed that there were appropriate procedures for the handling and disposal of unused and out of date medicines in line with the policy. There was evidence of continuous quality improvement in medication management as the medication management system was the subject of a regular audit by the person in charge.
**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a statement of purpose that met the requirements of the regulations. Inspectors read the statement of purpose and found that it provided information about the service. It accurately reflected the services and facilities to be provided and described the aims, objectives and ethos of the service. The person in charge was aware of the need to keep this document up to date, and to notify the Authority of any changes.

**Judgment:**
Compliant

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**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The inspector found that there was a clearly defined management structure which identified the lines of authority and accountability in the centre. Arrangements were in place to ensure staff could exercise their personal and professional responsibility for the quality and safety of the services provided. There was
a cohesive team in place and staff were very clear about their role and the reporting structures in place. The person in charge was supported in her role by the supervisor/nurse manager (CNM 3) the service manager (provider nominee) and the staff team. The clinical nurse manager (CNM 1) / staff nurse (shift coordinator) reports to the person in charge on day duty. The person in charge reports to the supervisor who in turn reports to the provider nominee (service manager). There is a night manager on duty to support staff and an out of hour’s managers rota and staff were aware that they could seek advice at any time. The provider nominee manages a number of other designated centres. She was on sit during the inspection.

The centre is managed by a suitably skilled, qualified and experienced person in charge who works full-time, including some weekends. The person in charge had good knowledge of the legislation and her statutory responsibilities. She demonstrated good managerial and leadership skills.

She was enthusiastic about her role and strived to promote a high standard of care and a reasonable quality of life for residents. She was actively engaged in the governance, operational management and administration of the centre on a regular and consistent basis. She maintained her own professional development and had attended a number of courses and conferences. The person in charge had been employed in the centre for a number of years and was well known to residents and relatives. Residents said that the person in charge was very friendly and it was easy to talk to her.

A relative described the person in charge as being hands on and approachable. She worked full-time in the centre and she knew the residents and family members well.

The person in charge did not manage any other designated centres. The person in charge had undertaken a number of audits to improve practice. One of the results of the infection control audit found that handling and disposal of sharps (used needles), required some improvement to ensure residents and staff safety, for example the sharps bin required a label to indicate what the bin was being used for, and a poster was needed to guide staff in the prevention and management of a sharps injury. The inspector found that these measures had been put in place and staff were aware of the correct procedure to follow.

The provider nominee had carried out an unannounced six monthly review of the quality and safety of care in the designated centre. The provider nominee was aware of the requirement to provide a copy of same to residents.

**Judgment:**
Compliant
### Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days. The provider nominee had appropriate contingency plans in place to manage any such absence. There were satisfactory arrangements in place through the availability of the supervisor to cover short absences of the person in charge, and a period of absence greater than 28 days would be covered by the programme manager. The supervisor and the programme manager demonstrated a clear understanding of their role and responsibilities under the Regulations if required to deputise for the person in charge. The provider nominee was aware of the requirements to notify the Authority in the event of the person in charge being absent.

**Judgment:**
Compliant

### Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

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

**Findings:**
Inspectors found from a review of residents needs that the designated centre was insufficiently resourced to support the needs of many of the residents to achieve their individualised plans due to the deployment of staff in the bungalows.

The designated centre physically met the resident’s needs, and there was access to vehicles to facilitate trips out. However, as there were periods of time with only one staff in each house, there was a negative outcome for residents. For example, most residents were only leaving the campus occasionally, some as little as twice a month.
Each day there was a period of time when all residents in a bungalow would only be able to spend time in the bungalow or garden, or for a walk in the nearby park as there was insufficient staff to provide support other than supervision, and prompting. Residents were seen sitting in chairs in the late afternoon with no meaningful activity or interaction from staff, as staff were busy preparing supper.

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

Findings:
Inspectors observed that at times there were insufficient staff available to meet the assessed needs of the residents at the time of the inspection. Adequate supervision arrangements were in place, but some improvement was needed to the training for staff members.

The inspector found that the staffing levels and skill mix were not sufficient to meet the residents assessed needs consistently, for example residents were not supported to leave the centre very often to participate in activities they enjoyed. While there continued to be a reliance on agency staff a review of the records in one of the houses indicated that the use of agency staff had reduced since the previous inspection. The inspector found that the staffing levels and skill mix were not sufficient to meet the residents assessed needs consistently, for example residents were not supported to leave the centre very often to participate in activities they enjoyed. While there continued to be a reliance on agency staff a review of the records in one of the houses indicated that the use of agency staff had reduced since the previous inspection. Staff were seen to treat residents with kindness and respect, and staff worked diligently to meet residents needs. Feedback from relatives were complimentary about the caring nature of the staff.

The provider nominee explained that staff are allocated to designated centres and moved within the centre and between centres. The provider nominee told inspectors
that they still require more nursing staff and it was challenging. She said that three new staff will commence duty at the beginning of July 2015, and additional staff would be in employment by the end of July 2015. This was in line with the action plan time frames, which was due in December. The provider nominee was aware of the potential negative impact on residents in using unfamiliar agency staff. Where possible the management team tried to use the same agency staff member to care for residents.

The person in charge explained that they use agency staff to cover sick leave, and that they book staff that are familiar with the centre. Not all agency staff were experienced in intellectual disabilities. The person in charge explained that all agency staff had an induction to the centre on their first day or first night on duty. Agency staff also worked alone on night duty. The inspector read the induction and saw that it covered how to manage emergencies and provided contact details of senior staff on duty on campus and also of the on-call staff.

The previous inspection found there was an over reliance on the use of agency staff which was not a suitable arrangement in meeting the needs residents with autism, as they required familiar staff and familiar routines to maintain their psychological well being. Staff spoken with during inspection told the inspector that there was not enough staff on duty and that they felt it was inappropriate to have agency staff on night duty as they did not know the residents well, and that a number of residents get very upset when unfamiliar staff/people are around them. The staff explained that annual leave and sick leave are covered by regular staff from other units, and these units then book agency staff to cover their unit. Again, staff expressed dissatisfaction with this arrangement and stated, “I don’t think its right, and it’s not good for the residents, they (the residents) often refuse to take their medications from unfamiliar staff”. Another staff member told the inspector that the use of agency staff on nights is particularly “distressing” for one resident, and “there are only two staff on duty on Sunday’s during the daytime, so there is no opportunity to take residents out. If we do manage to take one resident out in the morning we have to rush back to do the medications, then its supper time”. Staff said, “It’s a bit of a strain to take residents out with the staffing levels”. When one staff member takes residents out the house is managed by one staff member. Staff said that this system works up to a point, “but if more than one resident becomes upset it can be very difficult to manage the residents alone for more that ninety minutes as the residents require a lot of reassurance”.

The inspector met with relatives who said, “The level of permanent staff at the centre has been appalling in recent years, our family member has been particularly disturbed by this”. There was recorded evidence of a change of behaviour in this residents care plan and the inspector noted that the resident had been reviewed by the psychiatric team at the request of the parents.

Staff told the inspector that they would love to take the residents out more often but were unable to do so as there was not enough staff on duty. Depending on the needs of residents and the staffing levels, staff got moved from house to house on a regular basis. Staff explained that this made it extremely difficult to plan outings with the residents. Staff in one of the houses said that agency staff is used every week to cover their days off.

There were arrangements in place for using agency staff. An inspector saw a copy of the
service level agreement, which included the arrangements for assuring staff used, had been through appropriate recruitment checks. There was an induction programme in place for all agency staff to ensure they knew how to respond to emergencies. Agency staff were provided with a written summary of residents needs and a verbal handover prior to commencing duty.

The provider nominee explained that two new staff had commenced and additional staff had been recruited and would be in place by the end of July. This was within the time frame specified in the action plan, where by the full staffing compliment was required to be in place by December 2015.

Since the previous inspection staff had been provided with additional training such as safe administration of medication, safeguarding and training on epilepsy and diabetic management. This had been a requirement from the previous inspection; therefore this aspect of the action plan had been met.

Not all staff had received training or refresher training on positive behaviour support, This had been a requirement form the previous inspection. Therefore this aspect of the action had not been met.

The inspector noted that not all staff had received refresher training on manual handling refresher training. While there were a number of resident with autism, very few staff had completed training around autism. The provider nominee told the inspector that additional training was planned for the remainder of the year and the training plan was seen by the inspector.

The staff rota matched the staffing in each apartment. Since the previous inspection the person in charge had begun the process of supervision and appraisal. Records reviewed by the inspector indicated that a formal system of supervision was in place to support staff and to identify training needs. Staff confirmed that they had met formally with the person in charge and said that they found her to be very supportive. Therefore this part of the action plan had been met.

Minutes were seen of staff meetings, covering issues such as care planning, residents finances, restrictive practices and the risk register with staff.

A review of staff files found that one permanent staff member did not have garda vetting in place. The provider nominee told inspectors that the application was in progress.

**Judgment:**
Non Compliant - Moderate
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:
The inspector found that there were systems in place to maintain complete and accurate records and the required policies were in place.

All written operational policies were in place as required by the Regulations to inform practice and provide guidance to staff. Inspector found that staff members were sufficiently knowledgeable regarding these operational policies.

Inspectors found that medical records and other records, relating to residents and staff, were maintained in a secure manner.
The directory of residents was maintained up-to-date.

There was satisfactory evidence of insurance cover was in place.

Inspectors Inspector read the residents’ guide and found that it provided detail in relation to all of the required areas. This document described the terms and conditions in respect of the accommodation provided and included a summary of the complaints procedure.

Judgment:
Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Valerie McLoughlin
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001439</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>23 June 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>11 August 2015</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
 Residents were not provided with a choice of a male or female carer.

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
All staff working in the designed centre will have the appropriate qualification and undergo Garda vetted. HR department are currently waiting on the return of garda clearance for one staff member.
All staff completes a 6 week induction which includes the intimate care guidelines for each resident.
If an unfamiliar staff is working temporarily in the centre they are supported by familiar staff.
When completing the intimate care assessment the PIC/key worker will discuss with the resident/representative their preference for a male/female carer and will ensure that this preference is noted and supported within the available resources and skills mix of the designated centre.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The satisfaction of the complainant had not been recorded; it was therefore not possible to determine if the matter had been resolved to the satisfaction of the complainant.

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

**Please state the actions you have taken or are planning to take:**
Outcome 1 – complaint.
The complaints form has been revised to incorporate the level of satisfaction with the outcome of the complaint. This will be implemented across the whole organisation.

**Proposed Timescale:** 30/09/2015
### Outcome 16: Use of Resources

**Theme:** Use of Resources

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

The service was not sufficiently resourced to facilitate residents to fully avail of opportunities for new experiences, social participation and activities that matched their preferences.

**Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

The designated centre has an approved staff complement which is agreed as part of the service level agreement signed with the HSE annually.

An annual needs assessment to be carried out by CNM3. This to be updated more frequently if the needs/identified risks for the residents change.

A review of staffing to be carried out annually by the Service Manger, Director of Nursing, Director of HR and CNM3 using information obtained from the needs assessments of residents in the designated centre to inform staffing requirements.

Any requirement to increase the staff complement as a result of the annual review will be submitted to the HSE for approval of funding.

Vacant posts in the designated centre as outlined in action for outcome 17 will be filled through an active recruitment process and will result in sufficient staff being available to ensure residents have access to increased outings and activities.

The weekly roster will be planned in a flexible manner to ensure sufficient staff resources are available to enable residents to access activities and outings as per their personal plan.

There will be a monthly audit of activities and outings for each resident, carried out by their keyworker to ensure the residents social needs are met according to their personal plan.

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

### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

One permanent staff member did not have garda vetting in place.

**Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as
specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The Garda vetting form had been submitted to the garda vetting bureau prior to the inspection date. Department of HR currently awaiting a response.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were periods when there were insufficient staff available to meet the assessed needs of the residents at the time of the inspection.

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:
Responsive Workforce
Two care staff have been interviewed with starts date of the 6th July and 14th August respectively.
Interviews for staff nurses are taking place on the 30th July and 1.5 WTE staff nurse posts to be filled.
Interviews for Care Staff taking place on the 30th July, 13th & 14th August. A relief panel will be formed from which vacancies created by sick leave and annual leave will be filled.
Interviews for CNM1 post to take place on 17th August 2015 and 1 WTE post to be filled.

Proposed Timescale: 31/12/2015