## 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>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004021</td>
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<td>Centre county:</td>
<td>Dublin 7</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<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>
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<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
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<tr>
<td>Support inspector(s):</td>
<td>Nuala Rafferty</td>
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<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>24</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>3</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 1 day(s).

The inspection took place over the following dates and times
From: 03 June 2015 09:00  
To: 03 June 2015 19:30

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

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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 15: Absence of the person in charge</td>
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Summary of findings from this inspection
This was an announced inspection and formed part of the assessment of the application for registration by the provider. This was the first inspection of the designated centre and took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of the centre were also sought. Feedback received from relatives and residents were positive about service provision, and residents enjoyed leisure and social activities.

The person in charge was found to be suitable, experienced and knowledgeable in
her role as a clinical nurse manager. The nominated person on behalf of the provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. However, the application did not include evidence of compliance with planning.

The designated centre is operated by the Daughters of Charity Disability Support Services Ltd and comprises three single detached bungalows within campus setting, close to many local amenities. The bungalows were built in 1992 and have operated as a residential care centre. The centre provides full-time nurse led long term residential care for up to 27 residents.

Evidence of good practice was found across all outcomes, with 11 outcomes found to be in full compliance Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013. Three outcomes were also found to be substantially compliant; social care needs and health and safety and risk management.

In addition to submission of planning compliance improvements were required relating to the following outcomes where moderate non-compliance was identified:

- safe and suitable premises
- safeguarding and safety
- medication management
- staffing

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.
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 some evidence that residents are consulted with and participate in decisions about their care and about the organisation of the designated centre. For example, the inspector heard that house meetings were an opportunity for residents to discuss choices in respect of food and activity planning. The inspector observed staff engaging with residents in a respectful manner. The inspector found that staff were familiar with the residents’ needs, capabilities, their life history and family supports. Staff provided appropriate support as required with residents with regard to daily financial management, and management of their personal property. Residents who spoke to inspectors confirmed that they had access to their money to plan outings and shop for their personal needs.

Residents had an allocated personalised bedroom which largely met their individual needs. All rooms were decorated with tasteful soft furnishings, pictures and items of interest. Screens were available in twin rooms, but some rooms were small with beds placed against walls, the usable floor space and access to side tables for person belongings was not in place for all residents.

There was a comprehensive complaints policy and procedure, in place which was clearly outlined in the service user guide shown to the inspector. The person in charge was the local complaints officer. Complaints were well managed and one complaint investigated by the provider had identified poor practice relating to maintaining privacy and dignity following personal care had been identified. The person in charge and provider acted appropriately to cease this practice in a timely manner. Measures to improve procedures around personal care practices and mitigate any recurrence were now robustly in place.
Some aspects of the management of any restrictive practices discussed in Outcome 8 did not fully consider alternatives to the use of restrictive practices and the rights of each resident. Some residents did not have frequent visits from relatives, and although documented efforts had been made to facilitate more visits. Staff who had been involved with residents in the past also visited, and a visitor's room was comfortably furnished in each house to allow for private visits when required. The inspectors clarified with the provider nominee arrangements in place for a small number of residents with no next of kin. Social workers were available and accessible to residents and relatives on a referral basis. Advocacy support was available on request, staff were identified in the resident’s guide as advocating for residents where required.

**Judgment:**
Compliant

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

**Findings:**
The inspector found that resident's communication needs were met to a good standard. Many of the residents living at the centre were found to have non-verbal communication skills. Individual communication requirements were highlighted in residents' personal plan and reflected in practice.

Communication books were completed from day service providers and close links were maintained. Each resident has a written communication passport document in place. Sensory reviews took place and were fully documented in the residents' records in order to inform care planning process.

Full assessments were available as part of the admission and review process, many residents had their abilities and communication requirements clearly outlined as they had a long history with the service provider. Inputs from speech and language professionals informed the personal plans and reviews of each resident where identified. For example, staff had objects of reference available to communicate and give visual references to activities. However, objects of reference relating to daily care activities and were not fully individualised and this area requires some development.

The centre was part of the local campus and community and residents have access to radio, television, internet and information on local events. Residents were facilitated to
access assistive technology and aids and appliances where they were required to promote the residents' full capabilities. For example, the person in charge was actively exploring the use of assistive technology for one resident within the group.

The written communications policy was under review at the time of the inspection. The person in charge confirmed that residents enjoyed planned social outings. The inspectors noted that while computers were available in each house, no social media access was in place for residents. Television, DVD’s, books and newspapers were available for resident use.

Judgment:
Compliant

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

**Findings:**
Overall, it was clear that residents were supported to develop and maintain personal relationships and families and friends were actively welcomed and informed the goals of each resident. The centre had an open door policy and families were encouraged to visit and spend time with their relative or friend. Contact with relatives in distant parts of the country was maintained with Christmas and post cards, annual party, and invitations to meet for coffee or an outing.

Residents and staff referred to ongoing formal and informal communications from family members. Family members called in, and were also invited to take part more formally for reviews when required or requested. There was clear documentary evidence that some family members were fully involved in person centred meetings, and contacts with family members were recorded. In practice relatives were all invited be part of each individual annual personal care plan review. Many relatives attended and were active participants in the process, others requested the written minutes were sent to keep them up to date.

Staff confirmed that they supported each resident to maintain and develop their relationships outside the immediate environment of the designated centre. However, inspectors observed that supports and contacts relating to relatives living a long distance away could be developed further due to a large number of residents from a wide geographical distance from the centre.

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

Findings:
Each resident and their family had been given a written agreement which details support, care and welfare of the resident. Details of service provision were clearly outlined and the service is adult specific. A formal contract of care inclusive of fees (if any) payable was in place for 24 people living service.

A written admissions policy was reviewed by the inspector which included the involvement of the person in charge, the resident and his/her next of kin. Referrals come via social workers the person in charge told the inspector about admission criteria, and the process of admission and how this was managed from a governance perspective and confirmed her involvement relating to suitability for admission.

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

Findings:
The Inspector found that the wellbeing and welfare provided to the residents was to a good standard. Each resident's health, personal and social care and support needs were
fully assessed and reviewed regularly. Detailed evaluations were completed and personal care plans were fully reviewed on a yearly basis, or more frequently should there be a change in personal health or circumstance.

Each resident and their family were involved in the writing up of their personal plans and in outlining their own social goals. The Inspector spoke to residents and they were clear on what their specific goals were and discussed their progress in achieving these goals. There was clear evidence where family members attended a formal planning meeting annually and were kept informed of progress in relation to the plans. Some plans reviewed by inspectors were activity not outcome focused, and required further development to fully meet this requirement. Residents' relatives who did not attend reviews were provided with a copy of the minutes of the meeting following each review.

**Judgment:**
Substantially Compliant

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**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 design and layout of the premise was not found to be fully suitable for the its' stated purpose. The location had level access, and was bright, light and well decorated. Residents had access to a shared garden space.

The centre is located on a campus setting on the outskirts of the city centre, near a large city park in Dublin. Each of the bungalows on the campus was purpose built by the provider in 1992. Three bungalows make up this designated centre, with capacity of 9 people in each bungalow. Improvements were required to fully meet the legislative requirements. The provider had identified improvements to front doors of bungalows to allow for more independent access and accessibility for all residents.

Each of the three bungalows had seven bedrooms with hand-washing facilities; five bedrooms were single and two were twin rooms which were utilised as sharing rooms for long term residents. Screening was available in each shared room which could be used to maintain privacy and dignity, and all bedrooms had blinds and curtains in place. The bedrooms were generally of adequate size with good wardrobe and some storage space. Bedrooms were personalised and freshly decorated. Storage of assistive
equipment was inadequate, with a large portable hoist stored in the corridor and hoist
slings and shower chairs stored in the bathroom.

The centre also had a large lounge/dining room, a quiet/visitors room, kitchen area, a
utility room and a clinical room/office. A shower 'wet' room and separate fully equipped
bath room was in place, with a jacuzzi type assisted bath in place. Two separate toilet
(one assisted) were in place, all with privacy locks in place. The inspector reviewed all
bedrooms and communal spaces and found overall the standard of hygiene,
maintenance and provision of equipment in place was adequate. However, some
improvements were required;

- There was inadequate storage space for assistive equipment including hoists and
  shower chairs.
- The bathroom spaces were cluttered with equipment stored.
- Lack of directional pictorial signage in houses.
- One resident who is a wheelchair user needed the door frame of her room widened to
  facilitate access to her room.
- Beds against wall in shared bedrooms and usable floor space limited.
- Limited storage as shared storage (chest of drawers) was in place in shared rooms.
- One lock was found on outside of bedroom door in one house and needs removal.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
A safety statement was in place and reviewed by the inspector, and found to be
adequate. The inspector reviewed the centre's risk register which was centre specific
and sufficiently detailed to ensure that all identified risks were minimised. The inspector
saw that the controls outlined in the risk register were used in practice and referred to
by staff during the course of the inspection. Specific risk assessments to support
residents were also in place.

Overall there were safe systems in place to mitigate risk of fire. The centre had fire
extinguishers in place, at the time of inspection they were within service. There was a
monitored fire alarm with a fire panel at the front door of the house and weekly checks
were completed on such equipment. Inspectors noted that not all houses had a break
glass facility in place, and seven bedroom doors required keys to egress the building,
although quick turn key/swipe operated door exits are in place in the communal spaces.
One key was available on the corridor, and staff held a key to facilitate exit and evacuation. All staff had completed fire training as per records reviewed by the inspector, with fire drills taking place day and night. Each resident had a personal emergency egress plan which had been recently reviewed. All houses had three fire break glass facilities to activate the alarm.

The centre had a written emergency plan in place and arrangements in the instance of a full evacuation. There was a campus wide plan to facilitate any evacuation as a result of an emergency and a clinical nurse manager co-ordinates management of the campus overnight. A communication pager system operated over 24 hours if any staff member required additional assistance or was working alone at any time of the day and requires assistance. However, the written fire procedure in place did not fully reflect information found on inspection and requires review and updating to fully guide and inform staff.

The inspector saw the maintenance documentation for equipment such as hoists and wheelchairs. The centres vehicle was regularly serviced and staff that drove the vehicles to transport residents had their competency to do so review by the provider. Each resident had a moving and handling assessment completed and detailed in their records to inform and guide staff in supporting this aspect of their assessed care. Infection prevention and control practices were good, with a suitably equipped sluice room in place. Household staff maintained hygiene in the laundry and bathroom and shower room to a high standard. Waste disposal was in line with best practice and staff were observed using disinfectant hand gels on entering and leaving the centre.

The inspector reviewed the quality and safety report resulting from the centre’s health and safety audit which was completed by the provider. The report was followed up by the person in charge and provider where improvements were noted to be required. For example, the provider had actioned and changed internal fire doors in two of the houses and a wider door installed, one door in one house requires replacement and this work was scheduled to take place. One residents bedroom door requires additional work to ensure that it is fully accessible as described in Outcome 6.

The inspector reviewed the incident and accident log and saw that learning, where appropriate, had been gained from such events which were then communicated and documented in the minutes of staff meetings. A low level of incidents and untoward events were noted to be recorded relating to this service.

**Judgment:**
Substantially Compliant

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**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:**
The inspectors found that there were adequate measures in place to protect residents from abuse and keep them safe. All staff had received training in safeguarding vulnerable adults and were knowledgeable on what constituted abuse and on reporting procedures. Residents spoken with said they felt safe and could tell the inspector who they would speak to if they felt unsafe or needed particular support. There had been no statutory reports made to the Authority in line with legislative requirements prior to this inspection.

As outlined to the provider on a recent inspection the written policy on safeguarding vulnerable adults required updating to reflect the national implementation of the Health Services Executive (HSE) policy on safeguarding and protection of vulnerable adults (December 2014); as discussed under Outcome 18: Records and Documentation.

Personal and intimate care plans were found to be in place and provided comprehensive guidance to staff; ensuring a consistency in the personal care provided to residents. Generally it was found these plans focused very much on supporting residents to be as independent as possible in this area. Residents with higher support needs had detailed plans which respected their individual dignity and privacy.

Quarterly reports on any form of restraint used were accurate and involved detailed risk assessment and communication with relatives. Inspectors found that all residents used bed rails and their use had been considered as part of each residents’ multi-disciplinary (MDT) reviews. Physical restraints described by the provider such as the the use of the door swipes did not restrict residents. Most residents confirmed to inspectors they felt safe in their home. A review of the policy on restraint found that alternative measures trialled before the use of any form of restraint were not always fully documented prior to its’ use; alternative measures were not fully considered as part of the overall multi-disciplinary review following incidents and accidents at the service. Inspectors acknowledge the comprehensive nature of the multi-disciplinary approach employed improvements are required to fully meet best practice and meet the aims and objectives of the centres’ policy. Additionally the records did not document the involvement of the resident fully with regard to the decision making process. The person in charge confirmed restrictive practices were used within the centre, as there was a policy of moving towards a restrictive free environment within the broader service. Residents were also involved in the creation of comprehensive positive behavioural support plans (as required). One resident had recently been assessed by a multi-disciplinary team as requiring a specialised lap strap on a wheelchair further to falls. However, a full review of staffing and supervision arrangements had not taken place further to the incident, despite staffing arrangements being identified at the review being a factor by a member of the MDT team. This was discussed with the provider at the feedback meeting in
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 record of all incidents occurring in the designated centre was maintained and where required notified to the Authority.

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

**Findings:**
Resident’s opportunities for new experiences, social participation and skill maintenance and enhancement were monitored closely and formed a key part of residents' care plans. Some residents had established links with their day centres, family and social networks which was maintained and developed. The inspectors found that the age profile of the residents in some of the houses varied, and was such that some residents had reached retirement age. Many residents had not been in an established full or part time employment during their life and had lived on the campus since childhood.

A strong social care focus was in place which allows for residents' choice of activities. Resident's personal plans identified opportunities for residents to develop their skills and maintain and develop their levels of independence, appropriate to the assessed needs and requests of residents. For example, a cooking class had been identified and
commenced for a resident interested in expanding her skills in this area. Opportunities for involvement in cooking at the centre were limited as most meals were prepared in a central kitchen and came to the centre in a heated system.

Residents were observed to be supported to develop and maintain their life skills in the house and each had in place an assessment in relation to financial management. The person in charge supported residents to retain control on their activities and make choices, relating to spending their own monies in line with their likes and dislikes. The person in charge also had in place a visual activity choice plan where residents could indicate their preferences, and make choices for activity related to an object of reference used to facilitate choices. For example, bead bracelet for jewellery making, or paint brush for art.

**Judgment:**
Compliant

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**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 the inspectors found that residents were supported on an individual basis to achieve, maintain and enjoy best possible health. The resident had full access to medical services, and could access the doctor on call service if required overnight. Residents were fully supported to maintain their medication and health care plans.

The standard of health care plans was found to be good overall and fully in line with legislative requirements. The inspector reviewed a number of residents' health care plans, records and documentation and found that residents were facilitated to access to allied health professionals. The inspector noted residents had local access and referral to psychology, psychiatry, social work, occupational therapy, dietician and speech and language on site. Resident could also access chiropody, ophthalmology, and HSE dental services. Significant health care issues had being comprehensively provided for and complex needs reviewed through a multi-disciplinary approach. Pain management and health care interventions and maintaining an active lifestyle in accordance with the needs and wishes of the specific resident. For example, detailed care plans were in place to monitor residents who experienced seizures and the appropriate health care supports were in place and well documented. Communication between day services was maintained on a daily basis.
The inspectors reviewed the menu and the food was seen to be varied and nutritious. Mealtimes such as breakfast, lunch, dinner and snack available were observed and found to be satisfactory. The meals service included hot and cold options, and choice and options were available. Inspectors were informed that residents were fully involved in choosing their meals from a four week rolling menu at the centre. The pictorial menu assisted residents with making their choices. Meals are provided in a heated trolley, and temperature checked by staff prior to serving. Details of each residents likes and dislikes inform the meals provided for residents. Staff were observed sitting with residents at mealtimes and provide support to residents where required in a discreet and sensitive manner. Independent dining was promoted.

**Judgment:**  
Compliant

### Outcome 12. Medication Management

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

**Theme:**  
Health and Development

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

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

**Findings:**

Overall inspectors found that many of the requirements relating to medication management systems were in place. However, some improvements were also identified as requiring action. Each resident was protected by the centre's policies and procedures for medication management. All prescribing and administration practices were largely in line with best practice guidelines and legislation and systems were place for reviewing and monitoring safe medication practices. Staff responsible for administering medication were registered nurses, who were observed to follow Bord Altranais agus Cnámhseachais na hÉireann safe medication administration practices. However, medications prescribed for administration at 9 were not observed to be administered until 11, and there was no maximum dose for "as required" medication, and medication found to be crushed for administration purposes had not been reviewed as suitable for crushing.

Weekly audits of medication took place daily with the staff nurse on duty responsible for the audit. This audit included the cross-checking of the amount of medication stored with the amount recorded as administered. Medication which requires special storage and documentation was satisfactory and all other medication was found to be appropriately stored. Local policies and procedures were also in place pertinent to the designated centre such as the medication ordering protocol and the weekly collection, and return of prescription medication. However, the practices described by staff relating to the disposal of spoiled medication was not reflective of the process described in the written medication management policy dated 26/1/15.
The inspector found that each resident's medication was reviewed regularly by the prescriber. Staff were clear on all medications prescribed for residents. Guidance was also available to all staff from a clinical nurse manager at all times, as well as from the provider's pharmacist.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The statement of purpose was provided to the Authority prior to the inspection which met most of the requirements of Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013.

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

**Findings:**
There was a clearly defined management structure in place, that identifies the lines of authority and accountability. There was a multi-disciplinary team who meet on a regular
basis which includes the nominee provider, senior manager and the person in charge.

All documents submitted by the provider nominee, for the purposes of application to register were found to be satisfactory. However, evidence of compliance with planning for this development has not been received to date and requires submission.

The provider nominee made regular unannounced visits to the centre and completed a report of each visit. The report has been developed with the group quality and safety and risk manager and identifies some areas for improvement. Further development with regard to obtaining quality of life feedback from residents and relatives was identified by the provider within the report given for review and this was being developed at the time of the inspection.

The person in charge worked full-time and was a dual-registered nurse. She had also completed formal management training at the time of the inspection. She was found to be providing good leadership to her staff team, and staff spoken to felt they were well supported in their role. She was well known to the residents and demonstrated sufficient knowledge of the legal responsibilities associated with her role.

**Judgment:**
Substantially Compliant

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**Outcome 15: Absence of the person in charge**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The person in charge had not been absent for a prolonged period since commencement of regulation and there was no requirement to notify the Authority of any such absence. The provider was aware of the requirement to notify the Authority in the event of her absence of more than 28 days.

The provider had appointed a person participating in management (PPIM), who deputised for the person in charge in her absence. The inspector was satisfied from a review of information regarding the nominated person that she was sufficiently experienced about service provision to undertake this role. She would also be fully supported by a clinical nurse manager 3 who is available on campus and visits the designated centre on a regular basis. The inspector met the person working to support this service as clinical nurse manager 3. However, the deputy manager was on planned leave and an interview did not take place at the time of the inspection.
### 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):  
This was the centre’s first inspection by the Authority.

#### Findings:
The inspector found that sufficient resources were provided to meet the needs of residents to ensure the effective delivery of care and support in accordance with the statement of purpose relating to this residential service.

Staffing levels were judged to be adequate to support residents to achieve their individual personal plans and to meet their assessed support needs. Flexibility was also demonstrated within the roster to meet specific support needs of residents.

#### Judgment:
Compliant

### Outcome 17: Workforce

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

#### Theme:
Responsive Workforce

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

#### Findings:
The inspector confirmed with the person in charge actual and planned staff rosters in place to provide for a full time residential service. Staff interviewed by the inspector confirmed that they were satisfied with the management support and training provided which enabled them to provide a high standard of care. Staffing was found to be guided by activities and outings planned for by residents which were person centred and not
lead only by the availability of staff. Residents received interventions and support from all staff in a respectful, timely and safe manner.

Agency care assistant staff were also available to cover unanticipated leave, and the use of agency staff was not assessed as being excessive in this service. As mentioned under Outcome 16, the person in charge managed the three houses well. The inspectors met intern students completing their nurse education training working at the centre.

The inspectors saw that during the inspection there were appropriate numbers and skill mix of staff were adequate to meet the needs of all 24 residents at the time of the inspection. Staffing levels included the person in charge, who worked full time, and 20 whole time equivalent nursing (WTE) and 8.27 WTE care assistant staff. The person in charge and day staff were also fully supported by a clinical nurse manager 3, who was involved in governance and management of parts of the overall the service, and knew the residents well. Each house had a member of household staff responsible for hygiene and food service. At night each house had one allocated staff nurse and the three houses were supported by two "runners" co-ordinated by the clinical nurse manager on duty at night. Residents with high levels of assessed nursing dependency and residents with complex medical needs lived at all three houses. Nursing staff (four staff nurses WTE were allocated to the night time staffing roster) had access to a bleep to call in support when required over night through the night sister on duty. However, the rosters clearly identified in one house the regular members of staff on duty at night, two houses appeared more reliant on agency and relief staff who were not named on the actual rosters given to inspectors. No detailed evaluation of the staffing provision for the night service had taken place relating to the use of relief and agency staff at night.

The inspectors discussed that as part of the provider's quality and safety review that a staffing is reviewed on a regular basis by the person in charge and the provider at management meetings. The provider has undertaken work to review agency use and employ less agency staff, and efforts were evidenced to appoint to permanent posts. However, inspectors discussed with the provider the need to monitor and review staffing at night and during the evenings as part of the current staffing review.

The inspector reviewed staff training records and saw evidence that staff employed had mandatory training in place including fire, safeguarding and risk management training and those spoken with had a good knowledge of procedures to follow. Overall, staff were found to be up to date with clinical training. However, as outlined in Outcome 8 of this report some staff members were identified as requiring some refresher training, in the application of policy relating to the use of restrictive practices, and the documentation of alternatives used. Inspectors also recommend that staff requirements relating to cardio-pulmonary resuscitation skills are considered as part of the next training needs analysis completed. The provider informed the inspectors that four dates in June had been identified to implement basic life support training for staff requiring updates.

The recruitment process was found to be safe and robust, three staff files were centrally reviewed prior to this inspection date, and all documents outlined in schedule 2 were available in each of the files reviewed by inspectors on a recent inspection visit to review staff files. There were five volunteers identified as working in the centre, who were
appropriately vetted.

**Judgment:**
Non Compliant – Moderate

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**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

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

**Findings:**
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Residents and Adults) with Disabilities) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Records reviewed were maintained to a high standard and clinical documentation was clear and easy to read and clearly informed practice.

An insurance certificate was submitted as part of the registration pack and it showed that the provider had adequately insured against accidents or injury to residents, staff and visitors. There was a directory of residents available which included all the required information.

The centre had all of the written operational policies as outlined in schedule five available for review.

The inspector acknowledges that the communication policy was under review.

**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:

Leone Ewings
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>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004021</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>03 June 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06 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 05: Social Care Needs**

**Theme: Effective Services**

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

Some written personal plans had goals which were activity based not outcome focused.

**Action Required:**

Under Regulation 05 (3) you are required to: Ensure that the designated centre is

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Goals in personal plans to be evaluated by keyworker to ensure they are outcome focused.

Proposed Timescale: 31/10/2015

<table>
<thead>
<tr>
<th>Outcome 06: Safe and suitable premises</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Effective Services</td>
</tr>
</tbody>
</table>

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident who is a wheelchair user needed the door frame of her room widened to facilitate access.

Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
The door frame of bedroom is to be widened. A carpenter/builder has been engaged to assess the bedroom and to determine how access can be improved for the resident. Application has been made to the organisation’s financial director for funding to carry out the work.

Proposed Timescale: 30/11/2015

| Theme: Effective Services               |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises was not fully laid out to meet the aims and objectives of the service and the numbers and needs of the residents:
- there was inadequate storage space for assistive equipment including hoists and shower chairs
- the bathroom spaces were cluttered with equipment stored
- lack of directional pictorial signage in houses
- beds against wall in shared bedrooms and usable floor space limited
- shared storage (chest of drawers) in shared rooms
- one lock found on outside of bedroom door in one house needs removal

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed
and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
1. The PIC has organised with maintenance for the removal of any equipment not currently in use to an external storage facility.
2. The practice of shared storage has ceased.
3. The PIC is to consult with the service engineer regarding the requirement re window restrictors as service users are non ambulant and cannot open or close windows.
4. Speech and language therapist is to carry out a review of signage required in the house, while ensuring the home like environment for residents is not impacted.
5. The service engineer will carry out a review of current storage in the designated centre and make recommendations as to how this could be maximised.
6. The P.I.C will carry out a comprehensive review of service user’s personal assistive equipment used in double bedrooms. In addition an environmental safety checklist will be completed in the designated centre.
7. Following review, the recommendations will be implemented and reviewed yearly or as necessary and staging of equipment used will be actioned.

**Proposed Timescale:** 03/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Put in place the improvements identified by the provider to front doors of bungalows to allow for more independent access for each resident.

**Action Required:**
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

**Please state the actions you have taken or are planning to take:**
The service engineer will carry out a review of current access to the front doors of the bungalows and make recommendations regarding how access can be improved for residents.

**Proposed Timescale:** 30/11/2015

**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 written fire procedure in place did not fully reflect information found on inspection
Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
The written fire procedures will be reviewed to ensure that they accurately reflect the procedures in place for training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Proposed Timescale: 30/08/2015

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Alternatives to the use of any form of restrictive practice were not fully considered and documented as part of the MDT meetings in line with best evidenced based practice, before a restrictive procedure was used.

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:
P.I.C will ensure that all alternative measures are fully considered, trialled and documented in service user’s care plans Where the use of restrictive practice is deemed necessary by the MDT, the least restrictive option will be applied and the rationale clearly outlined and detailed.

Proposed Timescale: 30/11/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of informed consent relating to the use of restrictive procedure not always documented in line with centres' own policy on restraint.
**Action Required:**
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**
Service users will be consulted and clear information given with regards to restrictive practices/equipment in place. This will be documented clearly in Individual care plans.

**Proposed Timescale:** 30/11/2015

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### Outcome 12. Medication Management

<table>
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<tr>
<th>Theme: Health and Development</th>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The practices described by staff relating to the disposal of spoiled medication were not reflective of the process described in the written medication management policy dated 26/1/15.

**Action Required:**
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

**Please state the actions you have taken or are planning to take:**
Local medication management guidelines have been amended to include the accurate disposal of spoiled medication.

**Proposed Timescale:** 06/08/2015

<table>
<thead>
<tr>
<th>Theme: Health and Development</th>
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</thead>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Practices relating to the administration of medication outside prescribed times require review.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.
Please state the actions you have taken or are planning to take:
PIC will speak to all Staff with responsibility for medication administration and advise them of the requirement to focus on this activity and not engage with or talk to other staff/visitors/HIQA inspectors while carrying out a medication round. Administration of medication does not routinely occur outside prescribed times. PIC will audit and review medication practices within designated centre and all recommendations will be actioned.

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

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence that crushed medication administered by nursing staff had not been reviewed as suitable for crushing was not in place.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
Medication for one individual which needs to be crushed has been reviewed by Speech and Language therapist and pharmacist and documented in her MPARS.

**Proposed Timescale:** 06/08/2015

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of compliance of the designated centre with planning requirements not received by the Authority with application to register.

**Action Required:**
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Was submitted on 13/07/15
Proposed Timescale: 06/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing arrangements at night time were not regularly reviewed with regard to the complex needs of residents in the centre.

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:
A review of staffing at night has been carried out by the Provider nominee the with Director of Nursing and Director of HR and the skill mix is deemed to be adequate to provide support. Additional supports can be deployed when the need arises.

Proposed Timescale: 06/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Refresher training in practices and policy relating to restrictive practices was required.

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:
1. Training will be provided in the area of restrictive practices to staff.
2. PIC will identify the refresher training requirements of staff for the year and link with the training department to allocate training on a priority basis.

Proposed Timescale: 31/12/2015