

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003929
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd.
<b>Provider Nominee:</b>	Geraldine Galvin
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	12
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:	To:
01 September 2015 10:00	01 September 2015 18:30
02 September 2015 09:00	02 September 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This report sets out the findings of an announced inspection of Group F St. Vincent's Residential Services following an application by the provider to register the centre. This was the first inspection of the centre by the Health Information and Quality Authority.

The centre provides residential accommodation for adults with an intellectual disability. The centre comprises two bungalows or 'units' and can accommodate twelve residents, six residents in each bungalow. There were no vacancies at the time of inspection.

The provider nominee was actively involved in the governance of the centre. There was a suitably qualified and experienced person in charge of the centre, who was supported by a clinical nurse manager. Both the person in charge and CNM1 demonstrated that they knew the residents well and that a positive approach to supporting residents with behaviours that may challenge was promoted in the centre.

Staff interaction with residents was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

There were effective systems in place overall in relation to medication management, health and safety and risk management.

However, three major non-compliances were identified at this inspection:

Under Outcome 5 'social care needs', it was not demonstrated that the designated centre met the assessed needs of all residents, for example in terms of social and personal development. Under Outcome 6 'safe and suitable premises', the centre did not meet the needs of all residents for a quiet environment and for a suitable place to go to be alone. Under Outcome 8 'safeguarding and safety', the provider had failed to act in a timely manner to ensure that residents were protected from peer-to-peer abuse.

The Authority did not agree this action plan with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to Regulations 5(3), 17(1)(a) and 6(2)(d) under Outcomes 5, 6 and 11 (respectively) were not accepted as they did not provide re-assurance that failings identified during the inspection would be adequately addressed.

Other non-compliances were identified including in relation to ensuring access to day services for all residents, personal planning and input from the multi-disciplinary team and policies and procedures. Improvements were required to further develop links with the wider community. These findings are detailed in the body of this report and should be read in conjunction with the actions outlined in the action plan at the end of the report

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Inspectors saw that the many practices within the centre endeavoured to respect residents' rights, privacy and dignity. There was evidence of effective consultation with residents. However, some practices in relation to the promotion of privacy were not consistent. Restrictive practices to safeguard some residents impacted negatively on other residents' rights.

Staff with whom inspectors spoke outlined that a number of restrictive practices were in place to safeguard some vulnerable residents, including a restriction on water in sanitary facilities to prevent injury. The flow of water was blocked and centrally controlled in one unit. Staff informed inspectors that the water could be turned on at the request of residents. Even though there was a clear rationale for this restriction, there was insufficient evidence that all other alternatives had been considered that would safeguard residents but also maintain the rights of other residents to live with the least possible environmental restrictions.

Staff with whom inspectors spoke outlined that they endeavoured to promote residents' privacy at all times. Inspectors observed that information relating to residents was communicated in private. Each resident had their own bedroom and staff were observed to knock before entering. Appropriate privacy locks were fitted on the doors of bathroom and toilet facilities used by residents for personal care. However, inspectors observed and staff confirmed that the shower room in one unit was limited in space. As a result, it did not provide sufficient space to enable staff to assist residents to change in that room where necessary. While staff described how they endeavoured to maintain the privacy and dignity of residents in this situation, the current configuration of shower facilities did not fully promote the privacy and dignity of all residents.

Viewing panels were observed to be fitted on all six bedrooms in one unit. Staff informed inspectors that the panel could be frosted from the outside by staff but not from the inside by residents. The person in charge outlined that the panels were used to check on vulnerable residents at 15-minute intervals throughout the night. While a rationale was provided for this practice, it was not demonstrated that the necessity and/or the frequency of the practice had been considered by MDT, given the impact this practice had on the privacy of residents. Also, there was insufficient evidence that all other alternatives had been considered where available.

Residents were consulted about how the centre is planned and run. Inspectors saw minutes of regular residents' meetings. Items discussed included ideas for summer holidays, complaints, meal options, work areas and installation of a bench outside a unit. Where residents did not wish to participate in the collective meetings, there was evidence of individualised consultation. A regular advocacy group was in place and was attended by representatives from each unit. The person in charge outlined that these meetings took place three to four times per year. Minutes were made available to an inspector and the advocacy group had been supported to organise a recent day trip.

Staff interaction with residents was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

Inspectors reviewed the policies and procedures for the management of complaints, last reviewed in February 2015. The complaints process was user-friendly, accessible to all residents and an user friendly guide was available in a prominent location. An appeals process was outlined in the process and procedure. The complaints procedure was explained to residents and residents were asked if they had any complaints at residents' meetings. There was a nominated complaints officer. Inspectors reviewed the complaints log and an updated complaints report form. Complaints were recorded and fully investigated in a timely manner. Complainants were made aware of the outcome of the complaint promptly. Immediate measures required for improvement in response to the complaint were seen to be implemented. The updated complaints record form stated if the complainant was satisfied.

Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, clothing, meals, assisting residents in personalising their bedrooms and their choice of activities. Residents were observed to be facilitated to have a lie in, go for walks independently around the campus and visit peers. Residents' personal communications were respected and a mobile telephone was available for residents to have conversations in private.

Residents were encouraged and facilitated to retain control over their own possessions in line with the centre-specific policy, reviewed in May 2014. There was adequate space provided for storage of personal possessions. Bedrooms were personalised and reflected residents' personalities and interests. Records in relation to residents' valuables and furniture were maintained and updated regularly. Residents were supported to do their own laundry where appropriate with adequate facilities available in each house.

Residents were facilitated to exercise their civil, political and religious rights. The person in charge confirmed that support would be provided for residents to exercise their right to vote, if requested. The charter of rights was documented as being discussed at residents' meetings. The person in charge confirmed to inspectors that a process was in place to facilitate access to an independent advocacy service when requested and inspectors noted that the service had been offered to some residents. Information relating to rights, consent, advocacy and communication was seen to be available in an easy read and accessible format.

**Judgment:**

Non Compliant - Moderate

**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:**

Residents were facilitated to communicate in line with the centre-specific policy. Residents had diverse communication needs; some residents did not use verbal communication.

Personal care plans viewed by inspectors outlined individual requirements, interventions and goals in relation to effective communication. Staff demonstrated an awareness of the different communication needs of residents and implemented the information contained in personal care plans. Residents had access to specialist input from speech and language therapists who completed comprehensive communication assessments. Interventions recommended following these communication assessments had been incorporated into residents' personal plans. For example, staff were knowledgeable in relation to the meaning of a resident's signs and gestures and used communication visual aids and cues to ensure that the resident could communicate effectively. Staff confirmed that residents were facilitated to access assistive technology, aids and appliances, including tablet technology, when required, to promote their full communication capabilities.

The centre was part of the local community within the campus. Residents attended a range of activities provided on the campus including complementary therapy and swimming. Residents used the campus canteen to enjoy a coffee or a meal with their peers. Inspectors observed that residents enjoyed walking in the pleasant gardens within the campus. Residents had access to a TV in the communal sitting room.

Information relating to rights, medicines, fire safety, consent, advocacy and communication was seen to be available in an easy read and accessible format.

**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):**

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

**Findings:**

Residents were supported to develop and maintain personal relationships. Families were encouraged to be involved in the lives of residents. However, links with the wider community outside of the campus required development.

Positive relationships between residents and family members were supported. Residents were supported to visit family at home for day or overnight visits. Residents were facilitated to keep in regular contact with family through telephone calls. Staff stated and inspectors saw that families were kept informed of residents' well being on an ongoing basis. Records confirmed that families and residents attended personal planning meetings and reviews in accordance with the wishes of the resident.

Residents were supported to develop and maintain friendships. Inspectors observed that residents were facilitated to dine with peers in the campus canteen. Visits to friends in the wider community were supported and facilitated for some residents.

Inspectors reviewed the policy in relation to visitors, which had been reviewed in June 2014. The policy outlined that residents were free to receive visitors except when requested by the resident or when the visit or timing of the visit would be deemed to pose a risk.

Residents were involved in activities in the local community within the campus. However, financial records and activity recording sheets indicated that involvement in the wider community outside of the campus required improvement. Many of the outings included shopping for essential items such as clothing and toiletries. Financial records for one resident indicated that she had accessed the wider community on four occasions during August; one for a takeaway and three to shop for clothing/toiletries. Some residents accessed facilities in the wider community such as cinema and restaurants through the day service. Staff with whom inspectors spoke confirmed that social outings were facilitated each weekend but these social outings could be on-campus, such as the



sensory garden or the canteen. Staff reported that transport was shared within three units and therefore the transport was not always available. Also, the shared vehicle was not suitable for all residents including wheelchair users but there was access to an accessible vehicle if required. Personal plans had however identified community inclusion as a goal for residents and there was evidence that efforts were being made to further develop this area.

**Judgment:**

Non Compliant - Moderate

**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:**

The policy on admissions, transfers and discharge of residents, which had been reviewed in July 2014, was made available to inspectors. The policy outlined the transparent criteria for admission but did not take account of the need to protect residents from abuse by their peers. Residents' admissions were seen to be in line with the statement of purpose which indicated admissions were made through the Admission, Discharge and Transfer Committee and in line with the policy. There had been no new admissions to the centre in a number of years.

Written agreements with residents and their representatives which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided for that resident had been provided to each resident. The fees and additional charges were not always included in these agreements.

**Judgment:**

Non Compliant - Moderate

**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:**

While personal plans were individualised and person-centred, improvements were required. In addition, it was not demonstrated that the designated centre met the assessed needs of all residents and inspectors found this to be at the level of major non-compliance.

A specific tool was used to document each resident's assessment of their health, personal and social care needs, abilities and wishes.

Each resident had a personal plan, which was individual and specific to the resident. Plans included information about residents' history, their family, what they enjoyed doing and any special events. Residents' likes and dislikes were clearly captured. Some personal plans were in an accessible (pictorial) format. However, findings in relation to personal plans were inconsistent. For example, the setting and reviewing of residents goals were inconsistent. Long- as well as short-term goals had not always been considered. It was not always clear what the outcome of goals were i.e. how they contributed to residents' quality of life. The supports required to ensure goals were met were not always identified. In addition, for some residents, goals were limited and included meeting health requirements. The tracking of goals was also inconsistent, with some goals clearly tracked and others not. The person in charge acknowledged that she was aware of this gap and was working to address it.

While each resident was reviewed by the multi-disciplinary team (MDT), this review did not inform personal planning, as required by the Regulations.

It was not demonstrated that the designated centre met the assessed needs of all residents due to the number and mix of residents in the centre and in some cases, the design and layout of the centre.

The mix of residents in the centre did not ensure that residents were protected from peer-to-peer abuse. The centre did not meet all needs for quiet, for a suitable space to go to be alone and the right to live with the least possible environmental restrictions. The centre did not meet each individual resident's need for social and personal

development.

It had been identified by the service that two residents required a more suitable living environment. Completion of this action would address a number of the failings outlined above. For one resident, this was documented in MDT minutes and confirmed by the person in charge, CNM1 and provider nominee. Records in the resident's file dated 27/2/2015 indicated that this move could not be facilitated due to lack of funding. With respect to the other resident, the inspector found a reference in the centre's risk assessment that the resident required alternative living accommodation and had been referred to the service's committee that oversaw transfers within the service. There was no information pertaining to this move in the resident's file or available in the centre.

Issues relating to peer to peer abuse will be further discussed under Outcome 8: safeguarding and safety.

**Judgment:**

Non Compliant - Major

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The design and layout of the centre was in line with the centre's statement of purpose. However, the design and layout of the centre was not suitable for its stated purpose as it did not fully meet the collective or individual needs of all residents.

The centre comprises two bungalows or 'units'. The centre was bright, warm and well-maintained. The premises was free from obvious hazards. There were sufficient furnishings, fixtures and fittings.

There were some challenges in relation to decorating all parts of the centre in a homely way, due to behaviours that may challenge. However, it was observed that efforts had been made to provide a pleasant home environment for residents. Residents' art work was displayed in one unit. Residents had input into decorating rooms, be it their own bedrooms or the communal rooms in one unit.

There was a kitchen and separate dining area in each unit. Each kitchen was clean and

suitably equipped.

Each resident had their own bedroom, which was personalised where residents wished it to be so.

There were two toilets with wash hand basin, an accessible shower and a bathroom with wash hand basin and additional toilet in each unit.

As previously mentioned under Outcome 1, the shower room in one unit was limited in space and did not provide sufficient space to enable staff to assist residents to change in that room where necessary. In the second unit, while the shower room met the needs of current residents, it was also limited in space and may not meet the increasing needs of residents in the future.

Bedrooms were limited in size. While most bedrooms met the current needs of residents, they did not meet the needs of residents with mobility needs. Staff described how the bed had to be moved each time before assisting residents to change in order to facilitate access to both sides of the bed.

The centre did not provide adequate private and communal accommodation for residents. An appropriate room was not provided for all residents to go when they wished to be on their own. It was observed that in one unit, the only place that residents could go to be on their own (other than their bedroom) was a padded room with viewing panels that was intermittently used for seclusion. Inspectors observed a number of residents using this room over the course of the inspection. Also, on occasions that a resident may display behaviours that challenge, staff described that other residents may need to leave the communal room and go to their bedrooms or out for a walk during these periods for their own safety.

Residents had access to appropriate equipment which promoted their independence and comfort. The equipment was observed to be fit for purpose and properly used, maintained, tested and serviced.

**Judgment:**

Non Compliant - Major

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

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

Arrangements were in place to manage the health and safety of residents, visitors and staff in the centre. However, further improvement was required in relation to risk management.

There was a risk management policy in place that met the requirements of the Regulations. There was a safety statement in place that was within date.

An inspector spoke with a member of household staff who demonstrated knowledge of the cleaning procedures in place in the centre. Both units in the centre were visibly clean. Cleaning schedules were in place and maintained. Infection control audits had been completed, with identified actions and responsible persons for completing required actions within specified timescales.

There was a process in place for the completion of risk assessments in the centre. Both centre-specific and individualised risk assessments had been completed. While overall, the risk assessments were informative and provided guidance for staff in relation to the management of risks, some further improvement was required. An inspector observed that bedroom windows had a separate inner window with a shatter-proof window-pane. The inner window had two locks fitted and the CNM1 confirmed that all windows were locked. While a clear rationale was provided for this practice, there was no risk assessment that considered the locking of windows from a fire safety perspective. However, the inspector found that appropriate controls were being practiced in that all staff members held a key on their person to open these windows in the event of a fire. In addition, the risk rating of some risk assessments required review to more accurately reflect the residual risk outlined following implementation of control measures.

Staff demonstrated awareness in relation to fire safety. There was clear information in relation to how to evacuate each resident in the event of a fire that considered both cognitive and mobility needs. Staff had received training in fire safety. The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of servicing of fire alarm system, emergency lighting and fire extinguishers. The doors in the centre were fire doors for the purposes of fire containment. Fire exits were clear and unobstructed. Regular fire drills were carried out and night-time drills were simulated. Fire drill records indicated that residents were evacuated within acceptable timeframes.

**Judgment:**  
Substantially 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):**

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

**Findings:**

There were organisational policies in place in relation to the protection of vulnerable adults, behaviour that challenges, restrictive practices and the provision of intimate care. The provider had not demonstrated that residents were protected from all forms of abuse. Inspectors found that this was at the level of major non-compliance due to the duration of the situation and the impact that it was having on other residents.

Staff demonstrated that they had the knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour.

There had been no allegations of abuse against personnel working in the centre.

An inspector reviewed the use of seclusion or single-separation for a resident. The inspector found that documentation regarding the use of seclusion was in line with the Mental Health Commission rules governing the use of seclusion and other relevant guidance. There was evidence that seclusion was used as a last resort and that other techniques were tried first, including distraction, diversion and re-direction. There was evidence that the resident's rights to refuse interventions, including the use of PRN ("as required") medication was respected. Oversight of the use of seclusion was maintained by frequent review by psychiatry. Input from other medical and MDT members was provided. Complete records were maintained in the centre and were available for inspection.

Inspectors reviewed other restrictive practices in the centre. Therapeutic interventions were planned and approved by MDT. All staff had received training in the use of restrictive practices. However, while there was a clear rationale provided for all restrictive practices, it was not demonstrated that alternative measures had always been considered in relation to how a restrictive practice was implemented. As discussed under Outcome 1, while it was demonstrated that it was necessary to restrict access to water for one resident, it was not demonstrated that alternatives had been considered to enable other residents could access water without having to ask staff.

In both units, there was evidence that individual residents targeted more vulnerable residents. This took the form of verbal and/or physical assault and constitutes peer-to-

peer abuse.

In one unit, the situation had been on-going for a considerable period of time (years). While discussions in relation to addressing this situation were documented since February 2015, there was no funded plan to find suitable alternative accommodation for individual residents, as recommended by the MDT. Inspectors found that this had a negative impact on other residents. For example, residents may have to leave the communal area for their own safety and return to their bedrooms during such episodes and staff said that one resident in particular found such episodes upsetting. Impacts on residents were documented in the seclusion log and residents' files.

In the other unit, the situation was a relatively recent development and it was demonstrated that a range of appropriate steps were being taken to manage the situation and to support all residents. For example, MDT input was sought and on-going review of the situation was evidenced. There was frequent input from psychiatry, the resident's GP and other members of MDT as required, such as speech and language therapy. Therapeutic interventions were agreed by MDT and approved only for use as a last resort and for the shortest duration necessary. However, documentary evidence demonstrated that an identified antecedent or trigger to behavioural episodes was the cancellation of the same resident's day service, which was provided on-campus by the service. This was confirmed by the person in charge, who had discussed the issue with the provider nominee in an effort to address this. Inspectors found that the cancellation of activities that were enjoyed by the resident at short notice was unacceptable due to the significant impact it was having on the resident and the consequences of which were experienced by other residents in that unit. At the time of inspection, it was not demonstrated that satisfactory arrangements were in place to prevent such cancellations from occurring at short notice and/or to provide suitable alternatives in the event of such cancellations.

While chemical restraint was applied in accordance with national policy and evidence based practice, improvements were required to the documentation of such usage. An inspector observed that the documentation relating to the use of chemical restraint did not always adequately document the effect of the medicine to ensure that the use of these medicines is carefully monitored. A record of the administration of PRN ('as required') medicines was maintained but comments such as 'good effect' or 'settling effect' were often recorded. Inspector saw occasions where the effect was not recorded. Adverse effects such as drowsiness and sedation were not always recorded.

Environmental restrictions were in place in the centre. Where such restrictions were in use, it was demonstrated that they were applied in accordance with national policy and evidence based practice. However, inspectors found that environmental restrictions were in use for some residents due to behaviours that challenge of other residents in the centre. For example, all of the bedroom doors had magnetic sensors that could be activated during a behavioural episode to prevent entry to bedrooms. Of note however, all doors had a release button to allow any resident to exit their bedroom (i.e. residents were not locked into their rooms).

Arrangements were in place to safeguard residents in relation to visits, where required.

Staff had up-to-date training in relation to the protection of vulnerable adults and the management of behaviour that challenges. While most staff had up-to-date training in relation to the application of therapeutic interventions, one staff member required such training and this had been scheduled for the following month.

Residents had easy access to personal monies and detailed records were kept of residents' financial transactions. Receipts were kept and countersigned by a second member of staff to ensure transparency. A check of financial transactions was completed by staff on a regular basis.

**Judgment:**

Non Compliant - Major

**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 being maintained and where required, notified to the Chief Inspector. Quarterly reports were provided. While most restrictions had been notified as required, the restriction of water had not been included in the quarterly report as required. The provider nominee and person in charge were aware of the requirements in relation to the submission of notifications. Incidents of peer-to-peer abuse had been notified to the Authority as required.

**Judgment:**

Substantially 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:**

Residents' opportunities for new experiences, social participation, education, training and employment were facilitated and supported. Improvements were required to ensure access to a suitable day service for all residents.

The policy on access to education, training and development was made available to inspectors. Improvements were required to the policy to ensure that it addressed relevant regulatory requirements.

Support was provided for all residents to attend a day service on the campus. A number of options were available including a service that developed skills in relation to training, employment and education, a retirement group and a day activation service. Activities within the day service included pottery, computers, woodwork, horticulture and social outings. Individualised art and music sessions were also provided within the units. A swimming pool and sports facilities were provided on the campus.

There was evidence of input from day services for some residents, which involved discussion of available options and trials of different options. Where residents refused to attend the day service provided, the resident's right to refuse was respected. An individualised service was provided from the centre at times that a day service was not available.

However, a robust assessment process was not incorporated into the personal planning process to establish each resident's training or skills development goals and ultimately, what type of day service may be the most suitable for each resident. As a result, where residents refused to attend their day service, it was not clear that the day service provided for the resident was suitable in the first instance to meet the resident's individual wishes and needs. For example, for one resident who refused to attend, an application to increase their day services hours had been made despite the resident frequently refusing to attend that service. The CNM1 described how an individualised 1:1 personal service for that resident was working very well and that this type of service may be more suitable and enjoyable to the resident.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors noted that residents' healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical officer was available to each resident and an "out of hours" service was available if required. Inspectors saw that residents were reviewed by the medical practitioner regularly. Medical advice and consultation in the event of clinical deterioration was seen to be sought in a timely fashion. Where referrals were made to specialist services or consultants, inspectors saw that staff supported residents to attend appointments.

In line with their needs, residents had ongoing access to allied healthcare professionals including dental, psychiatry, speech and language, optical, chiropody, dietetics and physiotherapy. However, inspectors noted that a resident with reduced mobility was on the waiting list for an environmental assessment by the service's occupational therapist for over a year and had not yet been assessed.

Evidence based assessment tools being used to identify and monitor residents' healthcare needs. Residents' weight was monitored on a monthly basis or more frequently in line with their needs. The Malnutrition Universal Screening Tool (MUST) was calculated for each resident on a monthly basis. Referrals were made to the dietetics service and recommendations were implemented such as fortification of meals.

Care plans were developed to meet residents' healthcare needs. Care plans were updated following assessments by allied healthcare professionals, consultations with medical practitioner and results of investigations and tests. Information within care plans was person-centred, comprehensive and would guide staff in meeting residents' needs.

The management of epilepsy was in line with evidence based practice. A personalised management plan was in place which guided staff in the administration of buccal midazolam. Residents were supported to visit the neurology clinic regularly and the appropriate recommendations were implemented. A comprehensive record of seizure including date, time, type of seizure, duration and recovery was maintained. A summary record of seizures was also maintained but inspectors noted some gaps in recording; this is covered in outcome 18.

Inspectors saw and the person in charge confirmed that that wishes in relation to care at times of illness or end of life had not been ascertained for some residents and a date had been arranged to discuss this with other residents and their representatives. The

person in charge outlined that palliative care services could be provided from the Milford Homecare Team.

Inspectors observed that residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Healthy eating plans had been developed for residents to support them in achieving and maintaining a healthy weight. Residents were encouraged to be active through swimming and walking.

Inspectors saw and the person in charge outlined that lunch and evening meal were prepared centrally and delivered to the units. At least two choices, one hot, was provided for each meal, a pictorial menu was displayed and staff were observed to ascertain each resident's choice. Where residents required food of a modified consistency, this was communicated to the kitchen effectively. Staff reported and inspectors saw that ample quantities of food was delivered and meals were presented in an attractive fashion. There was adequate provision to store food in hygienic conditions. Breakfast was prepared in each of the units and inspectors saw that a choice of cereals, breads, toast and drinks were offered. An adequate supply and choice of food was available on the unit to prepare breakfast, alternative meal options and snacks. Residents were observed to be offered refreshments and healthy snacks outside set mealtimes. The specialist advice of speech and language therapists in relation to the provision of food and fluids of a modified consistency was seen to be implemented by staff who prepare meals and snacks.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

There was a comprehensive medication policy that detailed the procedures for safe ordering, prescribing, storage, administration and disposal of medicines. The policy had been reviewed in July 2015. The policy was comprehensive, evidence based and would effectively guide staff in the safe management of medicines. However, the policy was not implemented in relation to transcription and this is outlined in outcome 18.

Medicines for residents were supplied by a community pharmacy. Staff with whom inspectors spoke outlined that medicines were delivered on a daily basis before 20:00. The person in charge stated that the resident and representatives were aware of the community pharmacy used in the centre. The person in charge stated that the pharmacy liaised with nursing staff but had not provided individually counselling to each resident, in line with with the 'Guidance on the supply by pharmacists in retail pharmacy businesses of medicines to patients in residential care settings' published by the Pharmaceutical Society of Ireland.

Staff demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. Residents' medicines were stored securely in each unit and there was a robust key holding procedure. Medicines requiring refrigeration were stored securely and the temperature of the refrigerator was monitored on a daily basis. Staff confirmed that medicines requiring additional controls were not in use at the time of inspection.

An inspector observed that compliance aids were used by nursing staff to administer medications to residents. References were available and compliance aids were clearly labelled to allow staff to identify individual medicines.

A sample of medication prescription and administration records was reviewed by an inspector. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medicines.

The pharmacy that supplied medicines to residents was located over 100km from the centre. The person in charge and a clinical nurse manager outlined that, where medicines were required immediately, an alternative route of supply was available through a local community pharmacy. However, an inspector saw that evidence that this route was not used. This had led to an unacceptable delay of over 10 hours from the time of prescribing to administration for medicines including antimicrobials.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines. Nursing staff with whom inspectors spoke confirmed that no residents were self-administering medication at the time of inspection. An information booklet had been prepared for each resident which outlined information in relation to their individual medicines in an accessible format.

Resident specific medication administration procedures had been developed for each resident. The procedures were person centred and gave clear guidance to nursing staff in relation to administering medications to the resident in line with their wishes and needs.

Staff with whom inspectors spoke confirmed that there was a checking process in place to confirm that the medicines delivered correspond with the medication prescription records.

Staff outlined the manner in which medications which are out of date or dispensed to a

resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A record was maintained of all medicines returned to the pharmacy for disposal.

The results of a medication management audit were made available to inspectors that had been completed in August 2015. The audit examined many areas in the medicines management cycle including ordering, receipt, storage and documentation. Records made available to inspectors confirmed that training and competency assessments had been completed by nursing staff in 2014/2015. Inspectors observed that nursing staff were encouraged to maintain their competence in relation to medicines management including information displayed on the 'medicine of the week' at the nurses' station.

An inspector reviewed a sample of medication incident forms and saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents.

**Judgment:**

Non Compliant - Moderate

**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:**

There was a written statement of purpose that outlined the aims, objectives and ethos of the centre and the services provided in the centre. However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The specific care needs that the centre is intended to meet were not clear; the facilities which are to be provided to meet those care needs were not detailed; the criteria used for admission to this centre was not specified; the number, age range and gender of the residents required review; room sizes were not included either in narrative form or a floor plan; the organisational structure of the centre was not included; the management arrangements did not identify the person in charge, the provider nominee or the deputising arrangements in the absence of the person in charge; the arrangement for access to education, training and employment were not included; it was not clear whether residents rights not to attend religious services are respected and finally; the

arrangements for providing a day service from the centre were not included.

In addition, the statement of purpose had been last reviewed in April 2014, and not within the previous year as required.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Overall, inspectors found that there was an effective management system in place, clearly defined management structures and the person in charge had the required skills, qualifications and experience to manage the designated centre. Improvements were required to the annual review.

Inspectors spoke with staff and found that they were clear in relation to lines of authority. Staff confirmed that they were well-supported by management, including the person in charge and persons participating in the management of the centre (e.g. the CNM1, CNM3 and the provider nominee).

The post of the person in charge was full-time in this centre. The person in charge held the post of CNM2 and was a registered nurse in intellectual disability nursing and had completed a certificate in management in a third-level institution. Inspectors found that the person in charge had the necessary experience, skills and qualifications, as required by the Regulations. The person in charge demonstrated that she was aware of her responsibilities under the legislation and that she understood the needs of the residents in the centre well.

There were systems in place to support the role of the person in charge. The person in charge was supported by a CNM1, who also worked full-time in the centre. The CNM1 was a registered nurse in intellectual disability nursing and psychiatric nursing. Both the person in charge and CNM1 had significant experience in supporting residents with behaviours that may challenge.

The person in charge reported to the CNM3 and attended meetings with the CNM3 on a monthly basis. The provider visited the centre regularly (weekly) and was in contact other week days as necessary. In addition, the provider and the person in charge met monthly at CNM2 meetings. Recently, the provider nominee had introduced quarterly 1:1 meetings with the person in charge.

There were audits in place to monitor the quality and safety of the service in the designated centre. These included audits of infection control/hygiene, medication management, bedrails, fire safety, report handover, mealtimes and finances.

The provider had put in place a formal system for carrying out a bi-annual unannounced visit of the designated centre. A copy of the visit was made available to inspectors. While the unannounced visit considered aspects of the quality and safety of care in the centre and identified key issues relating to the premises and safeguarding, the plan in place did not address all of those identified issues. For example, the plan did not address the issues relation to safeguarding nor did it consider residents for whom the centre was not suitable. Also, not all key issues were identified, including for example the suitability of the designated centre for all residents.

A system was in place for carrying out an annual review of the service and a report was available for such a review. However, improvements were required to the annual review. The annual review did not provide for consultation with residents and their representatives. It was not demonstrated that the annual review reviewed the quality and safety of care in the centre nor that it considered whether the centre was suitable to meet the assessed needs of residents.

Arrangements were in place that ensured staff were facilitated to discuss issues relating to safety and quality of care and that staff could exercise their responsibility for the quality and safety of the services that they delivered. These included monthly team meetings. The inspector reviewed minutes that confirmed that such meetings took place and spoke with nursing, care and household staff who confirmed the relevance of such meetings.

There were arrangements in place to ensure oversight of key areas relevant to the provision of safe, quality care to residents. These included a; health and safety committee and fire committee, drugs and therapeutics committee, advocacy committee and restrictive practices committee.

**Judgment:**

Non Compliant - Moderate

**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:**

There were suitable arrangements in place in the event of the absence of the person in charge. The CNM1 deputised in the event of such an absence. The Authority had been notified in the event of an absence of 28 days or more and also within three days of the return of the person in charge, as required.

**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):**

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

**Findings:**

Inspectors found that centre was adequately resourced to ensure the effective safe and effective delivery of care and support to residents day to day in accordance with the Statement of Purpose. Inspectors observed that there was sufficient transparency in planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the Statement of Purpose and there was evidence of ongoing development of the centre such as renovation plans and recent redecoration.

**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:**

There was a planned and actual staff roster in place which showed the staff on duty at all times. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. The person in charge confirmed that a regular team of staff supported residents to ensure consistency. When additional staff were required, a panel of staff familiar with the residents who had worked in the centre before were used.

A sample of staff files was reviewed and one file of this sample was found to not contain evidence of the relevant qualifications or accredited training. Documentary evidence was available to confirm that all relevant members of staff had an up to date registration with the relevant professional body for their role. There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy which had been reviewed in June 2014.

Staff were observed to be supervised appropriate to their role on a day to day basis. Regular monthly staff meetings were held and items discussed included health and safety, medicines management, residents' needs, complaints/compliments, incidents, updated policies and documentation. A formal and meaningful appraisal system was in place and formal appraisals had been completed for all staff in the previous 12 months.

Staff with whom the inspector spoke were able to articulate clearly the management structure and reporting relationships. The inspector saw that copies of both the Regulations and the Standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

The person in charge confirmed that volunteers were not in use in the centre at the time of the inspection. A comprehensive volunteer policy was in place, reviewed in August 2013, which outlined robust arrangements for vetting and supervision.

Inspectors reviewed staff training records' and found that while mandatory and other required training for staff was up-to-date for most staff, one staff member required training in relation to a specific move approved for the Therapeutic Management of Aggression and Violence (TMAV). The person in charge confirmed during the inspection

that this training was scheduled for October 2015.

**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):**

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

**Findings:**

The records listed in Schedules 2, 3 and 4 of the Regulations were maintained in the centre.

Records were kept securely, were easily accessible and were kept for the required period of time. Residents' records were stored securely. The inspector found that the system in place for maintaining files and records was well organised.

Residents' records as required under Schedule 3 of the Regulations were maintained. The residents' directory was not complete and did not contain the date on which a resident first came to reside in the centre. As mentioned in Outcome 5, information pertaining to a resident having been referred to the service's committee that oversaw transfers within the service was not contained in the resident's file or in the centre. As mentioned in Outcome 11, inspectors noted that records relating to epileptic seizures were not consistently maintained and two seizures recorded on the detailed record were not included on the summary record.

Records listed in Schedule 4 to be kept in a designated centre were all made available to the inspector.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

All of the key policies as listed in Schedule 5 of the Regulations were in place and were made available to staff who demonstrated a clear understanding of these policies.

However, as mentioned in Outcome 12, inspectors noted that the medicines management policy stated that transcription was not undertaken in the service and the policy did not outline controls in place to mitigate the risk of this practice. All medication prescription records reviewed by the inspectors had been transcribed and there was no evidence that an independent check by another nurse had been completed. The admissions policy did not take account of the need to protect residents from abuse by other residents. The policy relating to access to education, training and development for residents did not consider all of the relevant Regulations. The management of anonymous complaints or allegations of abuse is not satisfactorily addressed in the relevant policies pertaining to complaints and the protection of vulnerable adults.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003929
<b>Date of Inspection:</b>	01 September 2015
<b>Date of response:</b>	16 November 2015

### 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:**

In relation to a restriction to water, there was insufficient evidence that all other alternatives had been considered that would safeguard residents but also promote the rights of other residents to live with the least possible environmental restrictions.

**1. Action Required:**

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

A full review of water restrictions in the centre will be carried out by the PIC, the Provider Nominee and the MDT. This will entail reviewing the needs of all residents in the centre and determine alternative means of water access for the residents where water is restricted for one resident ensuring the least impact on the rights of the residents and that all safeguards are in place. This review will be completed by 30/11/2015 and considerations of alternative strategies to reduce water restrictions for the residents will be documented.

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

**Theme:** Individualised Supports and Care

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

The current configuration of shower facilities did not adequately promote the privacy and dignity of all residents.

In relation to viewing panels on bedroom doors, it was not demonstrated that the necessity and/or the frequency of the practice had been considered by MDT, given the impact this practice had on the privacy of residents. Also, there was insufficient evidence that all other alternatives had been considered where available.

**2. 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 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:**

A full review of the shower facilities will be completed by the PIC, the Provider Nominee and the Service Logistics Officer. Works required to the shower facilities to promote the privacy and dignity of the residents will be costed and planned for completion by 31/01/2016.

A full review of the viewing panels on the bedroom doors in the centre will be carried out by the PIC, the Provider Nominee and the MDT by 30/11/2015. This will entail reviewing the needs of all residents in the centre and determining who requires the viewing panels for health and safety needs. All alternative means of monitoring a person whilst in their bedroom to safeguard the resident will be discussed and documented prior to implementing the viewing panels. If and when it is agreed by the MDT that a viewing panel is required as a means of monitoring a resident's health status, all other alternative means of monitoring that were discussed and the rationale for non-consideration of those alternatives will be documented.

Where a viewing panel is being used for monitoring, the viewing panel will only be in operation for the time the staff is observing the resident. The closed option of the viewing panel will otherwise be in operation. Where it is determined that a resident

does not require the viewing panel in his or her bedroom door, the closed option of the viewing panel in the bedroom door will be in operation. The use or non- use of a viewing panel will be documented in the resident's care plan and discussed with the resident, their family and all staff. The PIC will monitor and audit the use/ non-use of viewing panels in the bedroom doors to ensure that all residents' privacy and dignity are respected.

**Proposed Timescale:** 31/01/2016

### **Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

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

Residents' involvement in the wider community outside of the campus required improvement.

#### **3. Action Required:**

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

A full review of the resident's involvement in the wider community will be completed by the PIC and the named nurse and where required with each resident's MDT by 27/11/2015. A plan of each resident's community participation will be devised according to each resident's wishes, choices and needs. Each named nurse will track all community participation for each resident and will evaluate the outcome for the resident. The PIC will monitor and audit the amount of community participation and each resident's development of personal relationships and links with the wider community.

**Proposed Timescale:** 18/12/2015

### **Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

The admissions policy did not take into account the need to protect residents from abuse by their peers

#### **4. Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

The admissions policy is current being revised to include the need to protect residents from abuse by their peers.

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

**Theme:** Effective Services

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

The fees and additional charges were not always included in the contracts.

**5. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Fees and additional charges will be included in all contracts and all residents and their families will receive a copy of those charges.

**Proposed Timescale:** 06/11/2015

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

It was not demonstrated the review of the personal plan was multi-disciplinary.

**6. Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The PIC will ensure that all personal plans of residents' will be reviewed by the multi-disciplinary team.

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

**Theme:** Effective Services

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

It was not demonstrated that the designated centre met the assessed needs of all residents due to the number and mix of residents in the centre and in some cases, the

design and layout of the centre. The mix of residents in the centre did not ensure that residents were protected from peer-to-peer abuse. The centre did not meet each individual resident's needs for social and personal development. The centre did not meet each resident's need for quiet, for a suitable space to go to be alone and the right to live with the least possible environmental restrictions.

**7. Action Required:**

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

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

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**Theme:** Effective Services

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

Findings in relation to the setting and reviewing of residents goals were inconsistent. For example, long as well as short-term goals had had not always been considered. It was not always clear what the outcome of goals were i.e. how they contributed to residents' quality of life. The supports required to ensure goals were met were not always identified. In addition, for some residents, goals were limited and related to meeting health requirements. The tracking of goals was also inconsistent, with some goals clearly tracked and others not.

**8. Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the residents' personal development in accordance with his or her wishes.

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

The PIC is reviewing all residents' goals in consultation with each resident's named nurse. The goals will now have clear expected outcomes that are achievable and measurable. Goals will be determined as to whether they are long term, medium term or short term. All named nurses will track the progress of each resident's goals and make adjustments to them where required in consultation with the resident. The PIC will audit the documentation of all resident's goals and ensure that they are tracked and are progressing in accordance with each person's centred plan.

**Proposed Timescale:** 27/11/2015



## Outcome 06: Safe and suitable premises

**Theme:** Effective Services

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

The centre did not meet the requirements of Schedule 6 of the Regulations. For example,

The centre did not provide adequate private and communal accommodation for residents. An appropriate room was not provided for residents to go when they wished to be on their own. It was observed that in one unit, the only place that residents could go to be on their own (other than their bedroom) was a padded room with viewing panels that was intermittently used for seclusion.

The shower room in one unit was limited in space and did not provide sufficient space to enable staff to assist residents to change in that room where necessary.

While most bedrooms met the current needs of residents, they did not meet the needs of residents with mobility needs. Staff described how the bed had to be moved each time before assisting residents to change in order to facilitate access to both sides of the bed.

### **9. Action Required:**

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

The individual MDT assessment will also determine each person's requirement for space and time alone and these factors will also determine the numbers and mix in the centre. These factors along with a review of the use of some rooms in the centre will be completed by the PIC, Provider Nominee and the Service Logistics Officer with a view to affording the residents with more communal and personal space. The padded room in one centre will be converted to a second sitting room to afford more space for the residents.

A full review of the shower facilities will be completed by the PIC, the Provider Nominee and the Service Logistics Officer. Works required to the shower facilities to promote the privacy and dignity of the residents will be costed and planned for completion by 31/01/2016.

A review of residents' mobility needs has been completed and plans have been agreed to alter the bedroom area for those residents where more space is required to meet the present mobility needs of the residents'. This work will be completed by 12/02/2016.

**Proposed Timescale:** 12/02/2016

**Theme:** Effective Services

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

The design and layout of the centre was not suitable for to meet the number and needs of residents. On occasions that a resident may display behaviours that challenge, other residents may need to go to their bedrooms or out for a walk during these periods for their own safety.

**10. 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:**

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**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:**

Some further improvement was required to the management of risks. There was no risk assessment that considered the locking of bedroom windows from a fire safety perspective. In addition, the risk rating of some risk assessments required review to more accurately reflect the residual risk outlined following implementation of control measures.

**11. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

A review of all risks will be completed by the PIC, the Link Clinical Nurse Manager 3 and the Service Quality and Risk Officer. This review will determine the appropriate risk rating on residual risks following the implementation of control measures. A risk assessment on the locking of bedroom windows from a fire safety perspective has been completed on 02/09/2015 and all controls are in place. All risks will be discussed with ongoing review of the risk rating and management with the PIC and the Provider Nominee. All risks and their management will also be discussed by the PIC with the service Health and Safety Officer.

**Proposed Timescale:** 04/11/2015

## 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:**

While there was a clear rationale provided for all restrictive practices, it was not demonstrated that alternative measures had always been considered in relation to how a restrictive practice was implemented. For example, while it was demonstrated that it was necessary to restrict access to water for one resident, it was not demonstrated that alternatives had been considered to enable other residents could access water without having to ask staff.

**12. 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:**

A full review of the all environmental restrictions in the centre will be carried out by the PIC, the Provider Nominee and the MDT by 30/11/2015. This will entail reviewing the needs of all residents in the centre and determining the least restrictive environment that each resident can live in. All alternative means of supporting a person to live in the least restrictive environment will be discussed and documented.

A full review of water restrictions in the centre will be carried out by the PIC, the Provider Nominee and the MDT. This will entail reviewing the needs of all residents in the centre and determine alternative means of water access for the residents where water is restricted for one resident ensuring the least impact on the rights of the residents and that all safeguards are in place. This review will be completed by 30/11/2015 and considerations of alternative strategies to reduce water restrictions for the residents will be documented.

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

**Theme:** Safe Services

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

Documentation relating to the use of chemical restraint did not always adequately document the effect of the medicine to ensure that the use of these medicines is carefully monitored

**13. Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The documentation of chemical restraint will now detail the effect of the medicine so that a clear record of the time, the date that the medicine is administered, the medicine name and dosage, what the effect on the person is during and after the administration of the medicine and who administered and recorded the effects. The PIC and The Provider Nominee will liaise with the Pharmacy to adapt the present Pro Re Nata to reflect the actions and documentation.

**Proposed Timescale:** 22/10/2015

**Theme:** Safe Services

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

There was an unsuitable mix of residents in the centre and that this was leading to incidents of peer-to-peer abuse. In one unit, it was not demonstrated that the necessary steps were being taken to resolve this issue in a timely manner. In the other unit, it had yet to be demonstrated that adequate steps had been taken to address an identifiable antecedent, which related to the cancellation at short notice of a resident's day service.

**14. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

An assessment of all the residents' day and residential needs will commence by the person in charge and the multi-disciplinary team on 12/10/2015. The number and mix of service users will be reviewed in tandem with the design and layout of the centre to determine the suitability of the centre to the assessed needs of each individual. This review will determine which resident is suitable to live with each other within the centre. There have been previous recommendations for 3 residents in the centre and plans have been forwarded to Admission, Discharge and Transfer committee. The plans have been forwarded to the HSE for funding by the Provider Nominee and service ACEO (Assistant CEO). The service is committed to providing appropriate accommodation to meet each individual's needs. This is subject to additional funding. When funding is secured, a transition plan for relocation of the individuals' to their new house will be completed to facilitate and track each person's progress.

The Nominee Provider has prioritized those residents to attend day service where their cancellation of their day service is an identifiable antecedent. In the event that the day service is cancelled, the person in charge in conjunction with the Provider Nominee will source extra staff supports to support the resident attend scheduled activities and to their day service.

**Proposed Timescale:** 30/09/2016

## Outcome 09: Notification of Incidents

**Theme:** Safe Services

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

While most restrictions had been notified as required, the restriction of water had not been included in the quarterly report as required.

**15. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

Water restrictions where applied will now be included in the quarterly reports by the PIC.

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

## Outcome 10. General Welfare and Development

**Theme:** Health and Development

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

A robust assessment process was not incorporated into the personal planning process to establish each resident's training or skills development goals and ultimately, what type of day service may be the most suitable for each resident.

**16. Action Required:**

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

The Provider Nominee is currently organising the development of an assessment tool that will be incorporated into each resident's personal plan which will assess each person's level of skill and training to date. From this assessment goals will be devised that will enhance each resident's skills development and personal development. The assessment tool will also inform the type of day service that is most suitable for each person. A review of all resident's day service provision will be co-ordinated by the Provider Nominee with day service managers to ensure that each resident is receiving the appropriate day service as assessed.

**Proposed Timescale:** 12/02/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

A resident with reduced mobility was on the waiting list for an environmental assessment by the service's occupational therapist for over a year and had not yet been assessed.

**17. Action Required:**

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

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

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

## Outcome 12. Medication Management

**Theme:** Health and Development

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

There was an unacceptable delay of over 10 hours from the time of prescribing to administration for medicines including antimicrobials.

**18. Action Required:**

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

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

The Provider Nominee has met with the pharmacist in relation to accessing medicines in a timelier manner. A system is now in place whereby medications following prescription will be delivered within a 2-3 hour time frame. The PIC has informed all staff of this system. The administration of prescribed medications including antimicrobials is now occurring in a timelier manner. The timing of the receipt and administration of prescribed medication is now included in the service medication audit tool. Auditing the centre medication management practices will support the PIC in monitoring that medications prescribed are delivered and administered in a timely manner.

**Proposed Timescale:** 23/10/2015

**Theme:** Health and Development

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

The pharmacist had not provided individually counselling to each resident, in line with the 'Guidance on the supply by pharmacists in retail pharmacy businesses of medicines to patients in residential care settings' published by the Pharmaceutical Society of Ireland.

**19. Action Required:**

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

A review of all risks will be completed by the PIC, the Link Clinical Nurse Manager 3 and the Service Quality and Risk Officer. This review will determine the appropriate risk rating on residual risks following the implementation of control measures. A risk assessment on the locking of bedroom windows from a fire safety perspective has been completed on 02/09/2015 and all controls are in place. All risks will be discussed with ongoing review of the risk rating and management with the PIC and the Provider Nominee. All risks and their management will also be discussed by the PIC with the service Health and Safety Officer.

**Proposed Timescale:** 12/10/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The specific care needs that the centre is intended to meet were not sufficiently clear; the facilities which are to be provided to meet those care needs were not detailed; the criteria used for admission was not clear; the number, age range and gender of the residents required review; room sizes were not included either in narrative form or a floor plan; the organisational structure of the centre was not included; the management arrangements did not identify the person in charge, the provider nominee or the deputising arrangements in the absence of the person in charge; the arrangement for access to education, training and employment were not included; it was not clear whether residents rights not to attend religious services are respected and finally; the arrangements for providing a day service from the centre were not included.

**20. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Provider Nominee and the PIC will review the Statement of Purpose for the centre and will include all the requirements containing the information as set out in Schedule 1 of the Health Care Act 2007 (Care and Support of Residents in Designated Centre for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Proposed Timescale:** 23/10/2015

**Theme:** Leadership, Governance and Management

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

In addition, the statement of purpose had been last reviewed in April 2014, and not within the previous year as required.

**21. Action Required:**

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The Statement of purpose has been reviewed and revised. The PIC will ensure that the Statement of Purpose will be reviewed and revised at intervals of not less than one year.

**Proposed Timescale:** 07/10/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The annual review did not provide for consultation with residents and their representatives.

**22. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

The annual review completed by the Provider Nominee will include consultation with



residents and their representatives.

**Proposed Timescale:** 12/02/2016

**Theme:** Leadership, Governance and Management

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

A system was in place for carrying out an annual review of the service and a report was available for such a review. However, improvements were required to the annual review to ensure that it was in accordance with standards.

**23. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The Provider Nominee will amend the annual review template to support the documentation of more detailed review of the quality and safety of care and support in the designated centre.

**Proposed Timescale:** 23/10/2015

**Theme:** Leadership, Governance and Management

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

While the unannounced visit considered aspects of the quality and safety of care in the centre and identified key issues relating to the premises and safeguarding, the plan in place did not address all of those identified issues. Also, not all key issues were identified, including for example the suitability of the designated centre for all residents.

**24. Action Required:**

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

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

The Provider Nominee will amend the annual review template to support the documentation of more detailed review of the quality and safety of care and support in the designated centre. When completing the unannounced visit, the Provider Nominee will review the suitability of the designated centre for all residents and put a plan in place to address any concerns arising regarding the standard of care and support.

**Proposed Timescale:** 23/10/2015

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

A staff file was observed not to be complete in line with Schedule 2.

**25. 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 Provider Nominee with the HR department will review all staff files in the Centre and ensure all staff files are completed in line with Schedule 2.

**Proposed Timescale:** 07/11/2015

## Outcome 18: Records and documentation

**Theme:** Use of Information

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

The medicines management policy was not implemented in relation to transcription.

The admissions policy did not take account of the need to protect residents from abuse by other residents.

The policy relating to access to education, training and development for residents did not consider all of the relevant Regulations.

The management of anonymous concerns or allegations of abuse is not satisfactorily addressed in the relevant policies pertaining to complaints and the protection of vulnerable adults.

**26. Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The medication management policy is currently being reviewed and amended by the Provider Nominee in conjunction with members of the centre Drugs and Therapeutics committee. On this review, all aspects relating to the regulations will be considered and the process of transcription will be reviewed and will reflect best practice.

The Provider Nominee will review the Education, Training and Development policy for residents' with the service Quality and Risk officer and MDT to ensure all aspects of the policy consider all relevant regulations.

The Admissions policy is currently being reviewed to incorporate the protection of

residents from peer to peer abuse.

The Protected Disclosure policy had been finalized and is now available for all staff and residents within the centre.

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

**Theme:** Use of Information

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

Improvement was required to the maintenance of residents' records. Records in relation to epileptic seizures were not consistently maintained. Information pertaining to a resident having been referred to the service's committee that oversaw transfers within the service was not contained in the resident's file or in the centre.

**27. Action Required:**

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

All epilepsy records have been reviewed and are now updated. The PIC has discussed the importance of accurately recording all aspects of documentation in recording residents' epilepsy with staff and the PIC has this item on the agenda for discussion at the next centre's meeting.

Information pertaining to a resident transfer will be documented in a residents' care plan to accurately reflect the process of proposed and actual transfers to new accommodation.

**Proposed Timescale:** 23/10/2015