<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003927</td>
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<td>Centre county:</td>
<td>Limerick</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd.</td>
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<tr>
<td>Provider Nominee:</td>
<td>Geraldine Galvin</td>
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<tr>
<td>Lead inspector:</td>
<td>Philip Daughen</td>
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<tr>
<td>Support inspector(s):</td>
<td>Julie Hennessy;</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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</table>
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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 29 September 2015 11:00  To: 29 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 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 13: Statement of Purpose                     |

Summary of findings from this inspection
This inspection was primarily focused on determining the adequacy of fire precautions in this designated centre. Inspectors found that while some areas of good practice were identified, there were also a number of failings. These failings related to fire safety management and also the condition of the building itself. One of these failings lead the inspector to instruct the provider nominee to take immediate steps to mitigate the risk identified.

This centre provides residential accommodation for up to ten residents with an intellectual disability. During weekdays, the centre accommodated seven residents. At weekends, an additional two residents resided in the centre. Many of the residents on the date of inspection required assistance to mobilise and a number of residents had a hearing or visual impairment.

The inspectors were shown around the centre by the person in charge and various members of staff. They were also on hand to answer any queries of the inspectors. The provider nominee was also in attendance when necessary.

The centre is part of a larger building containing other designated centres as well as other uses such as offices and is a congregated setting. The building is located on a campus providing numerous facilities for people with disabilities including residential accommodation. The building was noted as being a single storey structure of
The centre was previously inspected on the 16 and 17 September 2014. The need for the building to be modernised and refurbished had been identified on that inspection. It also identified failings relating to Outcomes 5 and 13, which were followed up on this inspection in order to see if they had been addressed. Aspects of Outcomes 1, 8 and 9 were also assessed on this inspection due to failings identified by inspectors during the inspection and the impact those failings had on individual residents.

The inspectors identified both good practice and areas requiring improvement in relation to the fire procedures and fire safety management arrangements in place. In relation to the building itself, inspectors identified that the arrangements in place to contain fire and prevent fire and smoke spreading through the building were inadequate. Inspectors also identified two residents whose needs in the event of a night time evacuation had not been adequately addressed. This oversight, in conjunction with the failings identified in relation to the building, lead the inspectors to instruct the provider nominee to take immediate steps to mitigate the risk identified. These findings are explained in more detail within the report.

Staff were observed interacting with residents in a warm and appropriate manner. Good practices were found in relation to supporting residents with behaviours that may challenge and staff demonstrated that they were skilled and knowledgeable about how to support individual residents. Access to medical and allied health professionals was demonstrated.

However, major non-compliances were identified in relation to privacy and dignity, the suitability of the designated centre, the premises and safeguarding and safety. The provider had failed to demonstrate that the on-going use of long-term segregation for a resident in an unsuitable environment was meeting the resident's challenging behaviour needs or that a more suitable living environment and service had been satisfactorily explored and pursued. Until recently, the resident did not have access to an independent advocate. Documentation demonstrated that the provider was aware that there was no legal framework in place surrounding the use of long-term segregation for persons with an intellectual disability in this setting in Ireland. The provider nominee and clinical nurse manager (CNM) told the inspector that they were following the Mental Health Commission rules governing the use of seclusion and restraint as a framework.

In addition, two residents moved into the centre every weekend from another centre within the St. Vincent's service. Inspectors found that this practice was not person-centred.
Actions are contained at the end of this report and should be read in conjunction with findings outlined in the body of the report.

The Authority did not agree the action plan with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to actions required with respect to Regulation 9(2)(c) under Outcome 1, Regulation 5(2) and 5(3) under Outcome 5, Regulation 17(1)(a) and 17(7) under Outcome 6, Regulation 28(2)(c) and 28(3)(a) under Outcome 7 and Regulation 7(5) under Outcome 8 was not accepted by the Authority.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
A number of aspects of this outcome were inspected on foot of observations made by inspectors on the day of inspection.

Inspectors observed that one resident lived in long-term segregation. The accommodation took the form of a secure locked apartment comprising a bedroom, bathroom, sitting room, four living rooms and an enclosed outdoor area. Access was controlled via electro-mechanical locks operated by magnetic fobs. Internal doors and access to the secure outdoor area from the apartment was not restricted. This outdoor area was secured with high walls and provided with a locked door at the end for use in an emergency. This arrangement had been in place for a number of years and was in response to the extreme risk of injury to the resident, other residents and staff. However, an inspector found that the environment was unsuitable and did not meet the resident's needs. Of note, until recently the resident has not had access to an independent advocate. It was not satisfactorily demonstrated how the on-going use of long-term segregation in an unsuitable environment protected the legal and human rights of the resident. This will be further discussed under Outcome 8, safeguarding and safety.

An inspector observed that Closed Circuit Television (CCTV) was in use in that part of the centre where one resident was accommodated separately. There were two cameras in each room, including the resident's bedroom and bathroom. CCTV was used for monitoring and images were not recorded. Staff explained that the rationale for the CCTV was to protect the resident and others from serious injury. The inspector found that the level of risk as described by staff was evidenced in a number of ways. CCTV
equipment was stored in a separate office, which was occupied by staff working with that resident only. There was guidance in place in relation to the use of CCTV, contained within the resident’s file. However, there was no policy on the use of CCTV in the centre. An inspector reviewed the guidance, which stated that CCTV equipment must not be accessible to other residents, members of the general public, or those not directly involved in the care of the resident. However, an inspector observed two other residents intermittently attempting to enter the office, although they were re-directed by staff during such times. The risk remained however of other residents observing images being captured on CCTV. A log was kept and signed of visual checks made of the resident at 15-minute intervals. The inspector was satisfied, based on staffing levels provided and the log of visual checks, that the use of CCTV was not to replace resident supervision by staff. The guidance also said that viewing panels on the screen should be minimised when the resident was using the toilet, bath or dressing to maintain the resident’s dignity. The inspector observed this to be the case. However, the inspector found that the resident's privacy and dignity was significantly compromised with the use of CCTV within areas which there would be a reasonable expectation of privacy and in particular, the bedroom and bathroom.

The inspector reviewed the restrictive practices document in relation to the use of CCTV. There was very little information in the restrictive practices document in relation to the use of CCTV and the document only stated "monitor in (the resident's) apartment - viewing screen in a closed room in (the centre)". As a result, while a rationale for using CCTV was provided, the restrictive practices document did not demonstrate that the intrusive way in which the CCTV was used was fully justified. This was discussed with the provider nominee at the close of and following the inspection.

The decision-making around whether to transfer the resident to a more suitable service was unclear and the inspector requested documentation from the provider nominee in this regard. It is noted that at the time, no independent advocate was sought for the resident.

The person in charge told an inspector that an independent advocate had been sought for the same resident in the recent past and had now commenced.

The design and layout of the premises impacted on the privacy and dignity of the majority of residents in the remainder of the centre. Excluding the apartment, two residents had their own bedroom. The remaining residents slept in one bedroom where partitions were present to provide privacy to the residents. These partitions were taller than head height but did not extend the full height of the room. There was a gap between the top of the partitions and the ceiling of the room. As a result, privacy and dignity was compromised as bedroom areas were not fully enclosed. This will be included as an action under Outcome 6, safe and suitable premises.

**Judgment:**
Non Compliant - Major

**Outcome 05: Social Care Needs**
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

**Theme:**
Effective Services

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

**Findings:**
At the previous inspection, it was found that some personal plans were not up to date and that improvements were required to the setting and monitoring of residents’ goals and outcomes. This action was due to have been completed by 30.11.2014.

An inspector reviewed a sample of personal files and found that the information in the file was individual and person-centred. For example, in one file, information was in a pictorial format. Goals had been developed and the outcome of the goal for the resident and supports required were specified.

However, the inspector found that the action since the previous inspection had not been completed in full. Three personal plans had not been updated within the previous 12 months or more frequently if necessary, as required by the Regulations. In addition, there was still no system in place to allow for residents' goals to be monitored in order to ensure that such goals are being achieved and the necessary supports put in place. Also, long-term goals were not always identified for residents.

In addition, and as identified throughout the service, the review of the personal plan was not multi-disciplinary and the personal plan itself was not in an accessible format.

A major non-compliance was identified under this outcome as the designated centre was not suitable to meet the needs of all residents.

The provider submitted an action plan following the previous inspection. In that action plan, a resident was due to transfer from an apartment within this centre to a more modern apartment on campus within 12 months of the previous inspection. At this inspection, it was found that this action has not been satisfactorily progressed or addressed. While plans to create a more modern apartment have been drawn up, they were not time-bound or funded.

At weekends, two residents moved into the centre from another centre within the St. Vincent’s service. Inspectors found that this practice was not person-centred. In addition, this practice presented challenges in terms of meeting residents' privacy,
dignity and mobility needs as one bedroom became a shared bedroom at weekends and a resident had mobility needs. Issues relating to accessibility of the centre are outlined in Outcome 6, safe and suitable premises.

Overall, an inspector found that it was not demonstrated that the service provided to one resident in long-term segregation was suitable, appropriate or acceptable. The environment itself was not acceptable and this will be discussed under Outcome 6, safe and suitable premises. Environmental restraint had to be applied in the form of a wheelchair with lap belt, chest harness and leg/thigh strap to enable the resident to access the day service and occasional social activities on-campus. This was due to the high risk of injury to the resident and others during such journeys. Also, at the time of inspection, the day service was not being provided following an incident. The provider nominee told an inspector that the day service was due to resume again. However, the environment in which the day service was provided was also unsuitable in terms of space, stimulation and health and safety as it comprises a single room with a single point of entry/exit. This was evidenced by documentation in the resident's file and a recent staff injury. Efforts had been made to compensate for the current absence of a day service. Staff explained that they provided activation in the centre (such as table-top activities) and went for regular walks in the campus (twice daily).

Links with family were maintained, for example, in the form of home visits. Interaction with other residents was supported where possible, for example, the resident had been supported to attend a BBQ over the summer.

An inspector reviewed a letter from the resident's psychiatrist dated 2.2.2010 to the (then) CEO of Daughters of Charity, which stated that the centre is totally inappropriate to the resident's needs, that the resident required transfer to another service that could better meet that resident's challenging behaviour and needs and provide a better quality of life for the resident.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
At the previous inspection, it was identified that one bedroom was limited in size and did not accommodate a chair. As a result, the resident, who enjoyed watching television, did so while sitting on his bed. The resident had however stated he was happy with this arrangement. At this inspection, the finding was unchanged. An inspector found that while another bedroom had been made vacant in the centre, it's location further away from the staff office made it an unsuitable alternative for legitimate safeguarding reasons. The inspector observed that two bedrooms in the centre would not be suitable for residents with mobility needs or those requiring mobility adaptive aids or appliances.

At the previous inspection, while the premises were generally clean, one floor and some windows were in need of a more thorough cleaning. A number of bedrooms had scuffed paintwork and damaged walls. The centre had regular maintenance but the doorways were of a width that did not facilitate easy movement of wheelchairs in and out of rooms and a number of residents were wheelchair users. At this inspection, the premises was observed to be clean. However, cleaning logs were not always maintained. A ‘deep clean’ of parts of the centre was arranged where required. There were specific challenges to cleaning the separate 'apartment' and it was evidenced that deep cleaning of this area was also arranged where required. However, inspectors observed that the physical environment in which a resident lived was not acceptable due to the nature of the physical surroundings, which were grim and under-stimulating. In addition, outdoor access was limited.

Quotes to repair damaged paintwork in the centre had been obtained but painting and repair work had yet to commence. As on the previous inspection, walls, door and skirting boards throughout the centre were scuffed and damaged and holes were observed on the inner aspect of some doors. Painting and plaster repair work was meant to have been completed, in accordance with the previous action plan, by 31.1.2015 but was outstanding at the time of inspection (8 months later).

At the previous inspection, it was identified that toilets required upgrading to ensure that they were accessible for wheelchair users. At this inspection, inspectors were told that up to four residents at any one time were wheelchair users. Inspectors observed that there are three toilets in the centre; one room with toilet and wash hand basin and a second with two toilet cubicles, wash hand basin, and two additional sinks, one which was used for emptying waste and one which was used solely as a water supply. There were also two chairs in this room underneath the sinks, which the person in charge said had a dual purpose as commodes and shower chairs. The inspector observed that this room was limited in space in terms of accessibility. The action to make the toilets accessible was due for completion by 31.12.2014 (9 months ago). The provider nominee explained that the area had been assessed by an engineer in terms of meeting certain criteria for accessibility. However, the inspector found that further assessment in terms of the use of area was required. The provider nominee said that an OT assessment would be arranged.

It was not demonstrated that the centre met the needs of all residents with mobility needs. The inspector observed that the bath and shower room were limited in space. While there was an overhead hoist in the bathroom, this did not extend to the shower room next-door. As a result, a manual hoist had to be brought into the shower room for
one resident. Staff said that it was challenging to use a manual hoist in this space. Another resident had to be assisted to dress and undress in his/her bedroom before showering. Two bedrooms in the centre would not be suitable for residents with mobility needs or those requiring mobility adaptive aids or appliances.

The design and layout of the centre was such that adequate private accommodation was not provided for all residents. As previously mentioned under Outcome 1, the privacy and dignity of six residents was compromised due to the fact that partitions between sleeping areas were taller than head height but did not extend the full height of the room. There was a gap between the top of the partitions and the ceiling of the room. As a result, privacy and dignity was compromised as bedroom areas were not fully private. Inspectors observed that windows in five bedrooms were above head height with limited natural light. Curtains were also at ceiling height. Where a room was shared, a privacy screen was available to use.

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

Findings:
The previous inspection identified that the building was generally in need of refurbishment. On this inspection, there were a number of fire safety failings identified that related directly to the building and its state of repair. Many of these had been identified already to the provider by their own technical representative. The previous inspection also found that staff were not familiar with the procedures in place in the event of fire. Inspectors found that any staff spoken to on this occasion were familiar with the procedure.

Inspectors observed that the centre had a sufficient number of escape routes, all of which lead to places of safety outside the building. Inspectors found that all doors on escape routes were readily openable in the direction of escape in the event of a fire. Inspectors did note a number of doors on escape routes with key operated locks although these locks were all noted to be unlocked and did not appear to be in use. A number of fire exit doors were provided with magnetic locks but inspectors were informed that these were disengaged upon activation of the alarm. All escape routes were provided with safe flooring with any level changes provided by way of ramps.

The building was provided with emergency lighting and a fire alarm system. Inspectors
also noted that fire extinguishers were in place. A staff member was able to describe the training she received in the use of said extinguishers and important points of learning she took away from the training course. Staff informed inspectors that the fire alarm system was able to inform staff of the exact location of the fire activation. This information was displayed on a fire alarm panel adjacent to the staff office and also on pagers carried by selected staff on each shift. Staff informed inspectors that the fire alarm system was common to the entire building including the area within the building occupied by this designated centre.

The primary concern identified by an inspector in relation to the building and fire precautions was the adequacy of the arrangements in place to prevent the spread of fire and smoke throughout the centre. The building was not constructed in a manner capable of containing a fire. Many of the doors present through the centre were not fire resisting doors where required capable of preventing the spread of fire. A number of the fire resisting doors that were provided were either in a poor state of repair or were installed within a wall not capable of containing a fire, primarily due to the presence of fanlights or other non fire related glazing within the wall. Inspectors also noted a fire door provided that was damaging the wall adjacent due to impact on the wall from the body of the self closing device as no doorstop had been provided to prevent the door being opened beyond its required angle of opening. In general most rooms, including fire hazard rooms such as laundry rooms or rooms used for the storage of materials that can burn, were not constructed in a manner capable of containing a fire.

The centre was provided throughout with a suspended ceiling of lightweight construction with ceiling tiles constructed of particle board or similar material. This ceiling was in poor condition with visible gaps and warped tiles in various locations. The roof space and cavities above the suspended ceiling were largely continuous as observed by inspectors in a number of locations throughout the centre. The internal walls checked by an inspector terminated just above the level of this suspended ceiling, including walls provided with fire doors to prevent the movement of fire and smoke. This meant that in the event of a fire, heat and smoke would be able to enter the roof space from the room the fire had started in and travel unchecked throughout the centre bypassing all the walls and doors provided below the ceiling. This could lead to occupants being trapped due to the unseen movement of heat and smoke through the centre before it possibly descends in an area of the centre remote from the fire. Inspectors did note however, that a smoke detector linked to the fire alarm was provided in the roof void in one of the areas checked.

Inspectors noted that the procedure to be followed in the event of a fire as well as a reference sheet outlining the needs and capabilities of the residents had been provided in a conspicuous location adjacent to the staff office. Staff spoken to were familiar with its location and the contents of these procedures. An inspector noted a programme of day to day fire safety management in place with regular scheduled checks on daily, weekly three monthly and yearly basis. While the programme was comprehensive, It was observed by an inspector that the necessary checks and scheduled maintenance had not been recorded as being completed when required in numerous cases. Inspectors were provided with records of various fire drills that had taken place in the centre. From examination of the records, inspectors found that the level of detail was variable and it was not clear in some cases as to the successes or areas of improvement
identified during the drill. The scenario simulated was not clear in most cases either. Inspectors also found that while staff questioned were knowledgeable on the principles of fire safety, there were no records available to demonstrate that all staff in the centre had received the necessary training.

Inspectors noted that one resident within the centre was a smoker. The resident concerned had been provided with a suitable area outside in which to smoke. In line with good practice, there was a smoking risk assessment in place for this resident outlining the hazard, risk and control measures in place for the resident. However, this was noted as being out of date, being due for review in February 2015. Inspectors also noted the risk assessment for the risk of absconding was out of date for a resident.

From review of the residents' needs in the event of an evacuation, inspectors noted four residents who required evacuation by wheelchair at night. Two of the four were unable to transfer from their bed to the wheelchair without the use of a hoist. These residents were not provided with an evacuation aid to facilitate a fast evacuation such as an evacuation sheet, ski pad or similar device. Therefore, these residents would require to be hoisted in to their wheelchairs in the event of a fire at night. Due to the potentially time consuming nature of this operation coupled with the shortcomings in the construction of the building as described above, an inspector served an immediate action at the conclusion of the inspection on the provider nominee. This instructed the provider nominee to provide said residents with appropriate evacuation aids in order to assist evacuation in a timely fashion. The provider nominee responded by pledging to obtain suitable evacuation aids to support the efficient evacuation of both residents and to train all staff in the use of same. They pledged to complete this by 6 October 2015. The provider subsequently confirmed completion of same on that date and stated that the necessary arrangements had been put in place to evacuate the residents using their beds as an evacuation aid.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Safeguarding and Safety**

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

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
**Findings:**
Aspects of this outcome were inspected during the previous inspection as a relevant action issued under Outcome 6, safe and suitable premises, but had not been completed. At this inspection, it was found that it was not demonstrated that the ongoing use of long-term segregation for a resident in an unsuitable environment was meeting the resident's challenging behaviour needs or that a more suitable service and living environment had been adequately explored and/or pursued.

A comprehensive multi-element behaviour support plan was in place for the resident. The plan included proactive and therapeutic strategies, including strategies for communicating with the resident, the resident's likes and dislikes and specific proactive techniques. The plan also detailed restrictions in place (chemical, physical and environmental), the rational for such restrictions and there was clear guidance in relation to the use of restrictions. The multi-disciplinary team (MDT) met three to four times per year to review the multi-element behaviour support plan. There was evidence of regular support by psychiatry and the resident's general practitioner (GP). Access to allied health was demonstrated in relation to supporting behaviours that challenge, including psychology, speech and language therapy and occupational therapy. All staff had received training in relation to behaviour that challenges and the use of any approved physical restraint. Staff interviewed by inspectors expressed the view that staffing levels were sufficient to support individual residents with extreme behaviour that challenges.

Arrangements were in place to ensure that staff visually checked on a resident every 15 minutes, as was necessary.

Chemical restraint was given as prescribed and with the consent of the resident. However, improvements were required to the documentation of restraint. The effect of chemical restraint was not clearly recorded as entries such as "good effect" were made. Other effects, such as whether the resident was drowsy following such restraint were not recorded. There was however evidence that the use of chemical restraint was logged and monitored. An inspector reviewed the log of instances where chemical restraint was used and found that its use varied between 3 and 11 occasions per month between January and August 2015 and oversight of such usage was demonstrated.

An inspector spoke with staff and the provider nominee who said that they were using the Mental Health Commission rules on the use of physical restraint. However, the inspector found that the Mental Health Commission rules were not being adhered to. For example, following all episodes of physical restraint, a medical review was not being completed within three hours, an MDT review was not held within two days and the resident's psychiatrist was not notified as soon as practicable, in accordance with Mental Health Commission rules. The provider nominee said that the service had discussed alternative criteria to be applied following such episodes for practical reasons, however, such criteria were not available for review in the resident's file. In addition, an inspector noted that on occasion, prone (face-down) restraint was used. Following the use of prone (face-down) restraint in July 2015, a body check and nursing assessment had been completed. However, the resident was not reviewed by a medical practitioner. Given the widely documented risks associated with the use of prone (face-down) restraint in particular, it was not demonstrated that such a deviation from the Mental
Health Commission rules in relation to the review of residents following the use of physical restraint had been adequately considered and demonstrated to be safe.

The restrictive practice review process and documentation required improvement. Long-term segregation was not identified as such, or in an alternative manner that would accurately reflect the arrangement (e.g. 24-hour seclusion). The provider nominee did however demonstrate an understanding that long-term segregation/seclusion was in use. Also, while the four approved TMAV (Therapeutic Management of Aggression and Violence) moves in use were outlined in the multi-element behaviour support plan viewed by an inspector, only one TMAV move was outlined in the restrictive practice document viewed by an inspector. A reference to "a hold" is made in the restrictive practice document, but it is not specified what hold this refers to.

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

**Findings:**
A record of notifications occurring in the designated centre was maintained and where required, notified to the Chief Inspector. However, some failings were identified in relation to notifications.

The type of physical restraint recorded in the centre's restraint log did not always correspond with the information provided on the quarterly return (e.g. in relation to an entry made on 7.7.2015).

In addition, the quarterly return incorrectly categorised long-term segregation as environmental restraint.

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

**Findings:**
At the previous inspection it was identified that the Statement of Purpose did not include a description, either in narrative form or a floor plan, of the rooms in the designated centre including their size and primary function. Since the previous inspection, floor plans had been submitted but these needed to be included in the Statement of Purpose.

**Judgment:**
Substantially Compliant

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

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

Centre ID: OSV-0003927

Date of Inspection: 29 September 2015

Date of response: 13 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:

It was not demonstrated that the intrusive way in which the CCTV was used was fully justified. In addition, while there was some guidance in relation to the use of CCTV in the centre, there was no centre-specific policy.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **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 Policy on the use of CCTV where used to monitor residents’ will be developed the Provider Nominee in conjunction with the MDT, Quality and Risk Officer and Senior Management. Date of Completion forecast for 28/01/2016.

In the interim, the guideline on the use of the CCTV in the centre will be reviewed by the PIC in conjunction with the resident’s MDT which is planned for the 29/10/2015 to ensure that the resident’s rights to privacy and dignity are ensured and in line with best practice.

**Proposed Timescale:** 28/01/2016

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The decision-making around whether to transfer the resident to a more suitable service was unclear. Until recently, the resident has not had access to an independent advocate.

2. **Action Required:**
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

**Please state the actions you have taken or are planning to take:**
An independent advocate has been sourced for the individual resident through the residents MDT and the advocate has had 3 visits with the resident to date. The advocate is continuing to meet with the resident and is exploring his wish and rights with him. The advocate is in regular contact with the PIC on the resident’s status and future transfer. We have engaged with the HSE on the provision of funding for the planned and costed new apartment for the resident. The Provider Nominee will forward a summary of all decision making around the transfer of the resident to more suitable service/ accommodation by 16/11/2015

**Proposed Timescale:** 16/11/2015

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not satisfactorily demonstrated how the on-going use of long-term segregation in an unsuitable environment protected the legal and human rights of the resident.
3. **Action Required:**
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:**
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.

**Proposed Timescale:**

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**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:**
Three personal plans had not been updated within the previous 12 months or more frequently if necessary, as required by the Regulations. In addition, there was still no system in place to allow for residents' goals to be monitored in order to ensure that such goals are being achieved and the necessary supports put in place. Also, long-term goals were not always identified for residents.

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

**Please state the actions you have taken or are planning to take:**
The PIC has scheduled a review of the outstanding Personal Plans and all will be completed by 25/11/2015. The PIC with the named nurse of each resident is reviewing all goals for each resident and categorizing according to their achievement whether they are long term, medium or short term.

The Provider Nominee has provided dates for PCP training to staff to support their documentation in monitoring and tracking goal achievement. The PIC will audit all PCPs using the PCP audit tool to ensure that they are reviewed annually or more frequently if there is a change in a resident’s need or circumstances.

The Provider Nominee will refer the finding on goal setting and tracking to the regional service PCP committee for discussion and further staff support. This regional service PCP next meeting is scheduled for 26/11/2015.

**Proposed Timescale:** 26/11/2015

**Theme:** Effective Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of the personal plan was not multi-disciplinary.

5. 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 review of the personal plan will include any reports or goals provided by the relevant MDT professional where involved with the resident. Where the MDT have reviewed a plan of care, The review will be documented and signed by the MDT professional.

Proposed Timescale: 18/12/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plan itself was not in an accessible format.

6. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
The personal plan will be provided in an accessible format to all resident’s.

Proposed Timescale: 18/12/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not suitable to meet the assessed needs of all residents.

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.
8. **Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet 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.

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9. **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.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As on the previous inspection, walls, door and skirting boards throughout the centre were scuffed and damaged and holes were observed on the inner aspect of some doors. Painting and plaster repair work was meant to have been completed, in accordance with the previous action plan, by 31.1.2015 but was outstanding at the time of inspection (8 months later).

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

**Please state the actions you have taken or are planning to take:**
Repair work and painting of the centre will be completed by 25/11/2015

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**Proposed Timescale:** 25/11/2015

**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 such that adequate private accommodation was not provided for all residents. The privacy and dignity of six residents was compromised due to the fact that partitions between sleeping areas were taller than head height but did not extend the full height of the room. There was a gap between the top of the partitions and the ceiling of the room. As a result, bedroom areas were not fully private. Inspectors observed that windows in five bedrooms were above head height with limited natural light. Curtains were also at ceiling height.

It was not demonstrated that the baths, showers and toilets were of a sufficient number and standard suitable to meet the needs of residents. Further assessment of the accessibility of two toilets was required. The bath and shower room were limited in space.

Two bedrooms in the centre would not be suitable for residents with mobility needs or those requiring mobility adaptive aids or appliances.

11. **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 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.
**Outcome 07: Health and Safety and Risk Management**

**Theme**: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk assessments relating to smoking and a resident absconding as referenced in the findings were overdue review indicating there is no system for the on-going review of risk in the centre.

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

Please state the actions you have taken or are planning to take:
The risk assessments relating to smoking and absconding have been reviewed and updated. The Provider Nominee in tandem with the Health and Safety Officer will ensure that PICs will audit all risks to ensure that staff are completing a review of all risks during the weekly health and safety check. The risk register will be provided to the PIC by the Health and Safety Officer which identifies the dates where all risks should be reviewed by the PIC.

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

**Theme**: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The means of escape were not adequate in the following respects:

While not noted as being locked, some doors on escape routes were identified as being provided with key locks that could potentially prevent a timely escape in the event of a fire.

The escape routes were not adequately protected as they were not constructed in a manner capable of keeping them free from heat and smoke in the event of a fire.

**13. Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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.
Proposed Timescale: 16/10/2015
Theme: Effective Services

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

14. **Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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.

Proposed Timescale: 16/10/2015
Theme: Effective Services

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

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

Please state the actions you have taken or are planning to take:
The PIC will ensure that all fire safety management checks will be documented in the Fire register and this will be checked by the PIC at the weekly health and safety walkabout. The provider Nominee and fire manager will ensure this is completed through audit.
The fire drill records did not indicate that all relevant evacuation scenarios had been simulated.

16. **Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
All simulated evacuation fire drills are now recorded. The PIC will audit the records following a simulated evacuation drill to ensure all are documented.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings, two residents had not been provided with suitable evacuation aids as required to assist their evacuation of the centre in a timely fashion

17. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
Since the inspection, the evacuation method for the two residents has been reviewed by the Service Logistics Officer and works completed to aid their timely and safe evacuation have been completed.

**Proposed Timescale:** 06/10/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that physical restraint was applied in accordance with national policy and evidence-based practice.

18. **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:**
A review of the service policy and the use of physical restraint will be reviewed by the Provider Nominee in conjunction with the service Chairperson of the Restrictive Practice Committee to ensure all applications of restraint are in line with national and evidence based practice.

**Proposed Timescale:** 01/12/2015  
**Theme:** Safe Services  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
It was not demonstrated that the on-going use of long-term segregation for a resident in an unsuitable environment was meeting the resident's challenging behaviour needs or that a more suitable living environment had been adequately explored and pursued.  

In addition, restrictive practice review processes and documentation required improvement.

**19. 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:**  
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.

**Proposed Timescale:**

**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:**  
The type of physical restraint recorded in the centre's restraint log did not always correspond with the information provided on the quarterly return (e.g. in relation to an entry made on 7.7.2015).

In addition, the quarterly return incorrectly categorised long-term segregation as environmental restraint.

**20. 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:**
The quarterly return for the July entries will be submitted as per quarterly notification returns on the 31/10/2015. The PIC will change the quarterly return to categorise long term segregation of a resident in place of environmental restraint.

**Proposed Timescale:** 31/10/2015

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**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:
Floor plans were to be submitted as part of the Statement of Purpose.

**21. 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:**
Floor plans have been submitted as part of the Statement of Purpose

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