<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Praxis Care</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004351</td>
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<td>Centre county:</td>
<td>Monaghan</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>Praxis Care</td>
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<tr>
<td>Provider Nominee:</td>
<td>Irene Sloan Ringland</td>
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<tr>
<td>Lead inspector:</td>
<td>Ciara McShane</td>
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<tr>
<td>Support inspector(s):</td>
<td>Caroline Vahey;</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 20 October 2015 10:30
To: 20 October 2015 18:30

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
The inspection took place over one day with two inspectors. It was in response to the provider’s application to register the centre for eight residents. This was the first inspection of the centre as a designated centre. It had previously been a unit within a designated centre however had been reconfigured.

The person in charge and the assistant director of nursing (person participating in management), nursing staff, care staff, a volunteer and a number of residents were all present on the day of inspection. The person in charge demonstrated oversight and knowledge of the centre and knew the residents well. Other staff spoken with were also found to be competent and knowledgeable.
The inspectors found for the most part the needs of residents were being met, however some areas required improvement to ensure compliance with the Regulations and residents were safe. The inspectors reviewed a sample of residents’ personal plans and saw that their needs had been assessed and care plans were in place. However, the care plans were not sufficiently detailed to ensure that all aspects of care were followed up therefore exposing the residents to risk as described in Outcome five and eleven. Medication management was found to be of moderate non compliance.

The inspectors saw that residents were linked with their community and that there were social goals outlined in their personal plans. However, not all social care goals were implemented as outlined in action plans. A number of the residents attended day service and the staff at the centre facilitated this ensuring residents attended. For those residents who did not attend a day service they were facilitated at the centre and engaged with staff to ensure development and stimulation.

There were systems in place to oversee health, safety and risk management. The centre had policies and procedures in line with this. The centre was equipped with appropriate fire fighting and detection equipment. The centre also had a risk register, however as outlined in Outcome 7 improvements regarding the management and identifying of risks was required.

The inspectors reviewed the centres records and documentation. For the most part the centre was in compliance with the Health Act 2007 as amended. However, a number of policies outlined in Schedule 5 were not entirely centre specific. In addition three policies as outlined in Schedule 5 were not yet developed.

These findings along with others are outlined in the body of the report and the action plan at the end.
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:
The inspectors found that residents’ rights and dignity was respected and they were consulted with how the centre was operated.

The centre had a complaints policy in place. The complaints policy outlined the role of the complaints person and the complaints process including the appeals process. Staff spoken with were aware of the policy and the handling of complaints. Residents stated in the questionnaires they would speak to a manager, or staff, if they had concerns. There was also an accessible version of the policy available to residents in a prominent place at the centre. The centre maintained a complaints log. At the time of the inspection there had been no recent complaints recorded in the complaints log.

Residents actively participated in the centre and assisted with household duties and, where appropriate, meal preparation. Residents also looked after their laundry in line with their abilities. Residents’ meetings were facilitated regarding formal consultation; however the inspectors were told that residents were consulted informally regarding choice on a daily basis. For example, for those residents who did not attend a day service they had choice regarding what time they got up at. Residents also chose what time they would have their meals at and chose their activities for the day, for example.

Residents had options to be by themselves should they wish. Each resident had their own bedroom which reflected their own personality and style preferences. They were assisted by staff to maintain their rooms. All residents, with the exception of one resident, had their own ensuite. Residents also had an intimate care plan completed within their personal plans. Residents had their own toiletries and their preferences
regarding same were respected.

There were no restrictions placed on visitors unless it had a negative impact on residents. There was space for residents to meet their visitors in private should they wish. The centre, at the time of inspection, did not have a visitor’s policy in place; this is outlined further in Outcome 18.

Staff were also seen to interact positively and respectfully with residents throughout the inspection.

**Judgment:**  
Compliant

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

**Theme:**  
Individualised Supports and Care

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

**Findings:**  
The inspectors found, for the most part, there were appropriate systems and policies in place to assist residents with their communication, however improvements were identified.

From a sample of personal plans reviewed it was found that residents had a communication plan in place identifying their form and style of communication. Those that were reviewed were found to be effective and sufficiently detailed to assist with communicating with residents. Residents had access to wireless internet, radio and television. It was found that residents were not at all times assisted to their full capacity in terms of aids and assistive technology. For example, the inspectors found that one resident was highlighted as potentially benefiting from a computerised tablet to assist them with their communication. However, staff were concerned that it may be dropped and this option, of an alternative method of communicating, was not progressed.

The centre had a policy on communication, recently reviewed in March 2015. The policy identified areas such as communication assessments, communication through the key worker process in addition to the availability of communication tools for example. The policy did not outline resources such as a speech and language therapist should the need arise. This is further outlined in Outcome 18. Staff spoken with stated that access to a speech and language therapist was available in relation to dysphagia and other swallow difficulties. Staff spoken with were also familiar with residents’ communication abilities.
Judgment:
Substantially Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
The inspectors found that residents were supported to develop and maintain personal relationships and links with their community. However, inspectors found that the links residents made with their community were not at all times in line with their preferences as outlined in their personal plans.

The inspectors found from a review of residents’ personal plans and from speaking with staff that efforts were made with residents to maintain contact with family members. Family members were invited to residents’ reviews throughout the year, some of whom attended these. Residents were also supported to make phonecalls to family members and at key times of the year should residents request they were supported to send greeting cards.

Residents were supported to attend day services. These were not provided directly by the provider, however staff facilitated their attendance to same and links were maintained with the day service provider.

From a review of residents’ activity planners and from speaking with staff, and residents, it was evident that residents had links with their community. For example, on the day of inspection one resident, who was at home for the day, went to have their hair cut and then went out for lunch to a nearby hotel of their choosing.

Judgment:
Compliant

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

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

Findings:
There were systems and policies in place regarding the admissions, discharge and transfer of residents.

The inspectors reviewed a sample of residents’ contract of care which was in the form of four documents. The inspectors found that improvements had been made and it was clear what residents contributed towards and the breakdown of same. The contracts where possible were signed off by the residents and where this was not possible their representative signed them.

There were policies in place regarding admissions and transfers. The admissions policy was reviewed in April 2015. Further improvements were required to the policy to ensure that it was centre specific. The policy referenced providers outside of this jurisdiction. It also failed to outline the necessity to complete an assessment of needs no later than 28 days after admission to the centre. The referral agent, who is one sole provider, was also not outlined in the policy. This is further outlined in Outcome 18.

Judgment: Compliant

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

Theme: Effective Services

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

Findings:
The inspectors reviewed three personal plans during the inspection. Residents’ social, personal and health needs were assessed and recorded in individual resident’s personal
plan. For example, relationships, daily living skills, personal finances, mental health and physical wellbeing formed part of the assessment framework used within the personal plan.

Residents were involved in the assessment to identify their needs. This was evidenced in discussion with staff, and one resident, in relation to the creation of an accessible plan. All residents had a personal plan available in an accessible format.

Personal plans were reviewed a minimum annually or sooner if required, and changes to residents’ needs were reviewed and updated as evidenced in action plans and corresponding monthly review notes. There was an annual review of residents’ plans and residents’ families were invited to attend this review meeting. However, while residents had access to multidisciplinary support, it was not always evident from their personal plan if multidisciplinary support / recommendations formed part of the action plans. For example, one resident wore orthotic footwear however, it was not evident from their personal plan who had recommended this intervention.

Independence in life skills were promoted for residents within the centre. The person in charge outlined how residents were encouraged and enjoyed taking care of their own laundry and engaging in household tasks such as table setting and stacking the dishwasher. Some improvement was required in the documentation of independent life skills teaching. For example, skills being taught were not broken down into a task analysis format.

Improvements were required both in the documentation of action plans and the implementation of action plans across a significant number of assessed needs within the centre.

Health plans did not outline the specific interventions with timeframes required to fully support residents’ assessed needs. For example, one resident had a diagnosis of hypothyroidism, however the health action plan did not outline the signs and symptoms which staff should observe for, which may indicate deterioration in the resident’s condition. In addition, medication and blood monitoring, which were required to support the treatment of this condition, were actioned in a separate medication action plan, however, no reference was made to the hypothyroidism health action plan. In some instances health action plans made reference to other documentation, this supplementary documentation was not contained within the personal plan and it was unclear where or how staff access this information. For example, one resident had a diagnosis of diabetes and the action plan made reference to a diabetes management plan. The action plan did not outline how or where staff could access this information. Not all healthcare interventions were implemented. This is further discussed in Outcome 11.

Social care goals were developed for residents and action plans outlined the intervention and timeframes to achieving goals. As outlined in Outcome 2, not all social care goals were implemented as outlined in the action plans. For example, one resident’s goal was to go to the library every second month however this resident had not been to the library in almost six months. In addition this resident had a goal to go personal shopping every second month with one to one staff support. While this had taken place three
times in a one month period, prior to this date this goal had not been actioned for six months.

**Judgment:**
Non Compliant - Moderate

### Outcome 06: Safe and suitable premises

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

**Theme:**
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found the premises were safe and suitable to meet the needs of the residents at the time of the inspection.

The centre was a purpose built bungalow and had capacity for eight residents. Each resident had their own bedroom which was decorated to reflect the personality and preferences of each resident. Seven of the eight bedrooms had an ensuite while the other resident had access to a main bathroom which was equipped with both a shower and a bath. The centre had two large lounge rooms; residents had a preference for one which was used more often. The other lounge room was also used at times. The centre had a large kitchen which was equipped to meet the needs of residents. There was also a dining area with a sufficient amount of seating. A utility room was in place with facilities to launder residents’ clothes; chemicals were also stored here in a locked press. The backyard was complete with garden furniture for residents to avail off.

The centre was found to be accessible. For example, there were handrails and a ramp at the front door in addition to grab rails in bathrooms. The inspectors saw a wheelchair user navigate with ease throughout the centre.

The inspector reviewed the service documentation for the hoists and found they were within their service period. The person in charge had contact an external provider to service the profiling beds, which were serviced September 2014. At the time of inspection the profiling beds were found to be in working order.

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

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

**Theme:**
Effective Services

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

**Findings:**
Systems were in place to manage health, safety and risk management with some areas for improvements identified in order to comply with the Regulations.

Systems to manage fire at the centre were in place. The centre had a suitable evacuation plan which staff and residents spoken with were aware of. This plan was also visible in the centre and there was a clearly marked assembly point should the need to evacuate arise. Evacuation routes were also clear of clutter. There was adequate emergency lighting in place as too there were fire extinguishers, fire doors, fire blankets, break glass units and a fire detection system in place. The fire equipment and systems were all within their service period. There was also one emergency sleigh to transport a number of residents should the need arise. A personal emergency evacuation plan (PEEP) was developed for each resident with clear detail outlining the residents abilities. From a review of the PEEPs the inspector found that two residents, both of whom lived in the same compartment, required the use of the sleigh. The inspector found that this had not been identified as a potential risk nor had a drill, relating to this, been completed. Residents had participated in fire drills as seen from the fire drill log. The inspector reviewed these and found that a resident had refused to leave the centre during a drill. The resident who refused to leave had not been identified nor was the learning from this drill identified. The inspector did see that debriefing post incident had occurred but learning was not outlined.

There were adequate systems in place to prevent infection. Colour coded chopping boards were in place, sufficient hand-washing facilities were available including appropriate signage. There was also a separate hand washing sink in the kitchen. Mops were stored separately and were also colour coded. Chemicals were locked away in a press therefore minimising any adverse effects. Residents had their own laundry baskets one for clean clothes and one for dirty clothes.

A risk register was found to be in place, elements of which had been reviewed 01 October 2015. Although risks had been identified the risk activity had been categorised as the risk and the actual risk was therefore not recorded. From a review of staff training records the inspector found that a number of staff were scheduled to attend risk management training in December 2015. Individual risks for residents had not all times been identified and at times where risks had been identified such as poor skin integrity care plans were not in place to support same.
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):
No actions were required from the previous inspection.

Findings:
The inspector found for the most part there were policies and procedures in place to safeguard and protect residents.

Staff at the centre had received training in the protection of vulnerable adults. Staff spoken with were aware of who the designated officer was in addition to being knowledgeable regarding indicator, type and response to abuse should it occur. Residents stated in questionnaires they felt safe and would speak with a staff member if they were worried or had concerns. The centre had a policy on safeguarding residents and also had the revised national policy on safeguarding vulnerable adults.

From a review of incidents and accidents, and from speaking with staff, it was apparent that a small number of residents had at times behaviour that challenged. The inspectors found in the personal plan for one resident guidance regarding their behavioural support. However, it failed to identify all components of a formal behaviour support plan including reactive strategies or the function of the behaviour. It had also not been developed or signed off in conjunction with a behavioural support therapist or a psychologist.

Judgment:
Substantially Compliant

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:
At the time of inspecting the inspectors found that the provider had notified the Authority in accordance with the requirements of the Regulations.

The provider was also aware of their responsibility to do so under the Health Act 2007 as amended.

Judgment:
Compliant

Outcome 10. General Welfare and Development
*Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

Theme:
Health and Development

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

Findings:
The centre did not have a policy on access to education, training and development for residents. This is further actioned in Outcome 18.

Four residents attended a day service external to the centre. There were a range of activities both internal and external to the centre, for example, trips to the hairdresser or beautician; lunch out, reflexology and music sessions. There was a weekly meeting with residents to plan activities for the upcoming week and planned activities were displayed in pictorial format in individual residents’ bedrooms and on a notice-board in the centre.

Training in the form of independent self help skills was promoted for residents in the centre. As discussed in Outcome 5, some improvement was required in the documentation of independent life skills training.

Judgment:
Compliant
### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

**Findings:**
Residents had access to allied healthcare professional such as the general practitioner, physiotherapist, occupational therapy and speech and language therapist. A chiropodist attended the centre every six weeks and residents could avail of services from a reflexologist in the centre if they so wished. On the evening of the inspection the reflexologist arrived to treat a number of residents. Residents did not have access to a psychologist or a behaviour support specialist as discussed in Outcome 8.

One resident was prescribed medication for a mood disorder which required blood testing every three months to monitor potential toxic side effects. However, on review of the resident's personal plan and in discussion with the person in charge, it was evident the resident had not had serum medication levels tested in twelve months. There was no action plan within the resident's personal plan to guide staff in the safe management of this therapy and staff were unclear on the frequency of blood monitoring requirements. In addition this resident was prescribed a number of medications to treat mental health difficulties, however he/she did not have access to a psychiatrist.

Residents had access to a choice of meals and a visual meal planner was displayed in the dining area, appropriate to residents’ communication needs. The inspectors spoke to one resident who said he/she was happy with the food available in the centre. Residents were encouraged to make healthy living choices, for example, one resident with complex nutritional needs had a plan in place to support these needs.

**Judgment:**
Non Compliant - Major

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### Outcome 12. Medication Management

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

**Theme:**
Health and Development

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

No actions were required from the previous inspection.
Findings:
The centre had a medication policy and written procedures were reflected in practice within the centre. The practice of medication management was discussed with the person in charge.

Safe arrangements were in place in relation to the ordering, storing and administration of medication and in line with current guidelines and legislation. However, improvements were required in relation to prescription records maintained within the centre. Medications prescribed were transcribed by two staff onto a prescription medication record, however this record was not signed by the prescribing doctor and was not in line with guidance issued by An Bord Altranais agus Cnaimhseachais na hEireann. One resident was prescribed a controlled medication and safe handling, storage, documentation and administration practices were also in place.

There were suitable arrangements in place for the disposal of unused or out of date medication with documentation completed by staff and signed by the receiving pharmacist.

While there were no residents in the centre self medicating, all residents have had a medication assessment completed in order to assess levels of competencies in relation to this.

Medications were supplied to the centre by a pharmacy in a nearby town. The pharmacist delivered the medications weekly to the centre. The pharmacist had met all the residents within the centre.

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):
No actions were required from the previous inspection.

Findings:
The statement of purpose reviewed by the inspectors was last reviewed 29 July 2015. It was found to comply with the requirements of the Regulations for the most part.

An area for improvement was identified; the organisational structure did not outline the
organisational details for the designated centre.

**Judgment:**
Substantially Compliant

### Outcome 14: Governance and Management

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The inspector found there were management systems in place with effective arrangements for governance and management.

The person in charge was found to be a competent person with significant experience in health care and was a registered nurse. They were the person in charge for two centres, however the inspectors found they had sufficient oversight and knowledge of the centre and were regularly present at the centre. The person in charge was supported and reported to a person participating in management, an assistant director of nursing, who was present throughout the inspection. They too were knowledgeable of the Regulations and the operations at the centre including the residents. It was evident from interactions with residents they knew the person in charge well and the assistant director of nursing.

There were four team leaders positions at the centre, all of which were nursing posts. On the day of inspection one of these posts was vacant and the centre was actively trying to recruit for it. A team of support workers were also employed at the centre and were supported in their role by the team leaders. Staff spoken with on the day of inspection were found to know the residents and their needs. Staff, at all levels, attended supervision and were appraised annually. New employees went through a probation period and underwent regular reviews prior to completing their probation.

The person in charge attended monthly management meetings, the most recent of which was in September 2015. The inspector reviewed the minutes for these. Team meetings also occurred regularly, the last of which was held in September 2015.

Six-monthly unannounced visits were completed, the most recent was in July 2015. An annual review was also completed, however further detail was required to ensure the
The review was linked to a schedule of audits and all quality indicators were assessed. The review consulted with residents and their representatives. The inspectors found that audits were completed for areas such as medication and residents’ finances.

**Judgment:**
Compliant

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

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Arrangements were in place if the person in charge was absent for a period of 28 days or more. There was an awareness of their responsibility under the Health Act 2007 as amended to notify the Authority of any such absence.

**Judgment:**
Compliant

### Outcome 16: Use of Resources

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

**Theme:**
Use of Resources

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

**Findings:**
The inspectors, from a review of staff rosters and residents’ needs and wishes, found at the time of inspecting, that they were sufficiently resourced in line with their statement of purpose.

The centre did have a team leader vacancy which they were actively trying to recruit for, however these vacant hours were being covered at the time of inspecting.
The centre had an accessible form of transport. At the time of inspection this was being used by another centre due to competing needs. However, staff were indemnified to take residents in their vehicle. In addition, for those that required accessible transport, staff made arrangements with a local taxi company.

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

**Findings:**
The centre had an appropriate mix of skilled staff to meet the needs of residents. There were four team leaders employed at the centre, all of whom were all registered nurses. The person in charge was also a registered nurse. The inspectors reviewed the registration details for the nurses and found they were valid. The care workers were also found to be appropriately qualified; a number had a degree in social studies while others had Fetac qualifications. At the time of inspection there was also a volunteer working at the centre Monday to Friday who was supported by the staff. They were involved in tasks that were not linked to direct care.

From a review of staff training the inspectors found that staff training was up-to-date for the most part. Where staff were due refresher, the person in charge had booked them for training which was pending. The inspectors found that staff knowledge regarding high alert medication was insufficient as outlined in Outcome 11 and further training was required. The inspectors also found that staff were not at all times appropriately supervised in relation to meeting the healthcare needs of residents. As outlined in Outcome 11 a resident did not undergo blood monitoring for a high risk medication as appropriate.

Staff members spoken demonstrated competence in areas such as fire safety, safeguarding and risk. The person in charge supported the team leaders while the team leaders had oversight for the team of care workers. Staff attended frequent supervision and were appraised annually; this was also evidenced in staff files.
From a review of a sample of staff files the inspectors found that the centre was in compliance with Schedule 2.

Judgment:
Substantially Compliant

**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

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

**Findings:**
From a review of the centre’s documentation, in line with the requirements of the records listed in Part 6 of the Health Act 2007 as amended, the inspectors found improvements were required.

The inspector reviewed the centre’s policies and procedures and found that not all were in place. The centre did not have a policy on visitors, access to education, training and development or provision of information to residents.

The inspectors also found that a number of policies were not completed in line with the specificities the centre. For example, as outlined in Outcome 2 the communication policy did not identify the role of a speech and language for communication deficits for adults, however it did not outline the role of a speech and language therapy for children. The centre provided a service to adults. The admissions policy failed to identify the requirements of assessing residents’ needs post admission as per the Regulations. It also made reference to external providers outside of their jurisdiction. The policy and procedure on missing persons was also found not to be centre specific as it outlined procedures for young persons under 18 years of age and children. It too referenced external agencies outside of the centres jurisdiction.

The inspector found that the documentation outlined in Schedule 3 was maintained in the centre. The inspectors reviewed the directory of residents and found for residents who spent time in hospital, their departure and return date, had been updated in the directory.
The centre had adequate insurance which outlined insurance for injury against residents as well as insurance for other risks in the centre including damage to property. The residents’ guide was available in two formats one which was text heavy and detailed and a second that was more accessible to residents and complete with pictures.

**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:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Praxis Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004351</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>20 October 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 November 2015</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not at all times supported to use assistive technology as outlined in the body of the report.

1. Action Required:
Under Regulation 10 (3) (c) you are required to: Ensure that where required residents

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
are supported to use assistive technology and aids and appliances.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure residents are at all times supported to use assistive technology and aids and appliances as appropriate. Where a service user is assessed suitable for use of assistive technology, the Person in charge will ensure that this is acquired.

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

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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:**
The involvement of multidisciplinary support was not evident in all residents' plans.

2. **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 Registered Provider will review all residents plans to ensure Multidisciplinary input is clearly documented and ensure all multidisciplinary support and recommendations form part of the action plan. The Person in charge will ensure MDT input where this is required.

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

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**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
- Health action plans did not outline specific interventions with timeframes to meet assessed needs of residents. Supplementary documentation to guide staff in implementing care was not consistently referenced in health action plans.

- Independent teaching skills were not documented in a task analysis format.

- Social care goals were not consistently implemented.

3. **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 Registered Provider will ensure all health needs of residents are met with clearly defined timelines specified and any supplementary documentation for staff guidance will be clearly referenced. The person in charge will ensure close supervision of Keyworking staff to ensure that all needs are met and SMART outcomes set.

The Registered Provider will ensure that the Person In Charge will implement task analysis where necessary to promote independent teaching skills. The person in charge and Keyworkers will continue to assess each individual and where there is an identified opportunity for promoting independent teaching skills, task analysis will be implemented.

The Registered Provider and the Person In Charge will ensure all goals are consistently implemented and reviewed. The Person in charge will review residents outcomes with keyworkers in monthly supervision sessions.

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

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

**Theme:** Effective Services

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

Improvements regarding the management or risk, as outlined in the body of the report were required.

All risks had also not been identified.

**4. Action Required:**

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

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

The Person in Charge will review all risks and ensure that identified risks are fully risk assessed and that necessary care plans are in place. The Person in charge / Keyworker will review all service user risks in line with care plans at least 6 monthly or sooner if such risks are not mitigated.

A business continuity plan is available in the designated centre which outlines systems for responding to emergencies.

The risk register will be reviewed to ensure all risks are clearly documented on a monthly basis by Person in Charge who will continue, with the care team, to be vigilant of any further risks and ensure that these are incorporated within the risk register.
### Proposed Timescale: 30/11/2015

**Theme:** Effective Services

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

An evacuation drill was required for two residents who lived in the same compartment. It was documented both required use of a sleigh in the event of a fire, of which there was only one.

5. **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:**

The person in charge will ensure that personal emergency evacuation plans are amended to clearly guide staff in the event of an evacuation situation.

### Proposed Timescale: 13/11/2015

#### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

The behavioural support plan on place for one resident was not in line with evidence based practice.

6. **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 Registered Provider will ensure the behavioural support plan for one resident is reviewed by a behaviour specialist as a matter of urgency.

The Registered Provider will ensure all behaviour support plans are in place and in line with evidence based best practice as required for residents.

### Proposed Timescale: 11/11/2015

#### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in**
One resident had not had blood monitoring in one year in relation to a prescribed medication. Best practice guidelines indicate blood monitoring for this medication should be carried out every three months.

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

Please state the actions you have taken or are planning to take: 
The person in charge will ensure that all future blood monitoring will take place within recommended best practice timeframes of 3 monthly as a minimum. This will be set as an outcome which will be reviewed on a monthly basis.

Blood Monitoring in respect of one resident was completed on the 20.10.15.

Proposed Timescale: 13/11/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect: 
Residents did not have access to a psychiatrist, psychologist or a behaviour therapist appropriate to their assessed needs.

8. 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 Person in Charge will ensure that where necessary, residents will be referred to all allied health care professionals appropriate to their assessed need. This will be identified through supervision sessions with keyworkers and be reviewed at service users annual review.

Proposed Timescale: 13/11/2015

Outcome 12. Medication Management
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect: 
The policy and procedure is not in line with guidance issued by An Bord Altranais agus Cnaimhseachais na hEireann. Transcribed medications are not signed by a medical practitioner on the medication prescription record.
9. **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 Registered Provider will ensure that policy is amended to reflect guidance issued by An Bord Altranais agus Cnaimhseachais na hEireann.

The Person in charge will make necessary arrangements to ensure that transcribed medication is signed by a medical practitioner on the medication prescription record.

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

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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:**
All elements of Schedule one were not outlined specific to the centre.

10. **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 Person in charge will amend to Statement of Purpose ensuring it contains 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.

**Proposed Timescale:** 13/11/2015

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff required further training regarding medication management in particular relating to high alert medications.
11. **Action Required:** Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
Person in charge will arrange medication management update training in particular relating to high alert medications.

**Proposed Timescale:** 30/12/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
As outlined in Outcome 17 the inspectors found that at all times staff were not appropriately supervised.

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

**Please state the actions you have taken or are planning to take:**
The Person in charge will ensure that all staff receives the necessary supervision in carrying out their role to ensure the needs of residents are met at all times and all issues actions are completed as appropriate.

**Proposed Timescale:** 13/11/2015

**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 requirements of schedule 5 were not complete.

13. **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 Registered Provider will ensure that where policies are not in place they will be devised in accordance with Schedule 5, the following policies will be devised by The quality and governance team of Praxis Care
Visitors Policy
-Access to Education, Training and Development
Provision of Information on Residents.

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

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As outlined in Outcome 18 a number of the policies required a review to ensure they were specific to the designated centre.

14. **Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure necessary amendments are made to the following policies as outlined in the body of the report and as per schedule 5 by Praxis Care Quality and Governance team:

- Communication Policy
- Admission Policy
- Missing Persons Policy

**Proposed Timescale:** 01/12/2015