<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-0004022</td>
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<tr>
<td>Centre county:</td>
<td>Dublin 7</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd.</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mary Reynolds</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sonia McCague (Day 3 only)</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>16</td>
</tr>
<tr>
<td>Number of vacancies 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 3 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
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<tbody>
<tr>
<td>29 September 2015 10:00</td>
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<tr>
<td>30 September 2015 10:00</td>
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<tr>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This was the first inspection of this designated centre and was announced and took place over three days, and formed part of the assessment of the application for registration by the provider. As part of the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors also received pre-inspection questionnaires from residents and relatives which gave written feedback both positive and negative of the service being provided at the centre. Feedback was mainly positive from
residents and relatives. However, the matters relayed to inspectors primarily related to staffing provision at the centre.

The designated centre is operated by the Daughters of Charity Disability Support Services Ltd and comprises two single detached bungalows within a campus setting, close to many local amenities. The bungalows were built in 1992 and have operated since then as a residential care centre. The centre provides full-time nurse led long term residential care for up to 17 residents with an intellectual disability. An accessible vehicle was available to this service and was used to facilitate resident transport requirements.

The nominated person on behalf of the provider was assessed in May 2015 as part of another registration process, and demonstrated satisfactory knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland. As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory.

Three outcomes were found to be in full compliance with Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013. The following areas were found to be substantially compliant with improvements required with regard to medication storage, one contract of care and arrangements to cover the absence of the person in charge.

The inspectors found that the designated centre was in contravention of the Health Act 2007, as amended with major noncompliances in a number of the regulations examined. The temperature of the hot water was too high and this was addressed on the day of the inspection. There were two major non-compliances relating to premises and staffing. Overall, the centre was not found to be resourced with sufficient and consistent staff to ensure the effective delivery of care and support for residents day and night to achieve their individual personal plans and fulfillment. The inspectors found that there were inadequate staff on duty to meet the assessed healthcare needs of the residents both day and night; staff nurses working at night represented in the statement of purpose as being part of the staffing complement of this designated centre were routinely being re-deployed elsewhere on site overnight and replaced by care staff. The findings of a staffing review conducted in August 2015 had not been evidenced or fully implemented to date. Improvements were also required relating to the provision of social care needs during the day and implementing individual assessed care to the residents living at the centre with complex care needs.

Moderate non-compliance with the Regulations was found in the following outcomes:
- residents rights, dignity and consultation
- social care needs and the completion of personal plans for all residents assessed interests, likes and aspirations
- premises particularly accessibility
- health and safety and risk management
- safeguarding and staff training
- general welfare and development
- healthcare
- statement of purpose not fully representative
- governance and management relating to staffing
- mealtimes and food service
- use of resources
- records and documentation including a policy, staff rosters and reports

The adverse findings relating to staffing were outlined to the chief executive officer as provider who attended the feedback meeting on the third day of the inspection. A written immediate action was given to the provider by inspectors relating to not ensuring that where nursing care is required, subject to the statement of purpose and assessed needs of residents, it is provided. The registered provider submitted a written undertaking that that a staff nurse will be on duty over a 24 hour period (day and night) and a needs assessment will be completed by the director of nursing. The inspectors confirmed and received staffing rosters on 9 November 2015 that a registered nurse was on duty and in place in each house overnight as a minimum.

Ten non-compliances were the responsibility of the person in charge and the remainder of 20 are for the provider to address. The actions outlined in the action plan can be found at the end of this report
Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:
Individualised Supports and Care

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

Findings:
There was a written complaints policy and procedure in place which was clearly outlined in the residents’ guide shown to the inspector. The person in charge was the local complaints officer. There had been no written complaints received according to the person in charge. Verbal complaints received included some issues about laundry and care of residents’ personal clothing which had been resolved satisfactorily according to the person in charge. Access to information and supports from independent advocacy services was not found to be promoted or facilitated further to records reviewed on this inspection.

The inspector observed staff engaging with residents mainly in a respectful manner, and the assessed care was implemented during the days observed by inspectors to a satisfactory standard. Some residents enjoyed planned activities during the day, for example, visiting the gym and sensory garden on site. However, much activity during the day was led by the routine and the resources of the service, not the resident and their support needs and wishes. For example, pictorial menus were in place at mealtimes. However, the available pictorial menus were not observed to be consistently used by residents and staff at mealtimes to facilitate resident choice.

Language used by staff in documentation and describing times when residents required support was not always found to be commensurate with adulthood. For example, at mealtimes when assistance was being provided, and in care planning documents when describing continence support needs. The culture, routines and practices observed during the inspection did not always consistently support and respect each residents independence, autonomy and privacy.
Staff provided appropriate support as required to residents with regard to their daily financial management, and management of their personal property. Further to a review of the records this aspect was well managed and transparent.

Residents had allocated personalised bedrooms which largely met their individual needs. One resident had requested a move to the other house and this had been facilitated and this choice respected. All rooms were decorated with soft furnishings, photographs, pictures and items of interest. However, improvements were required relating to the environment and premises which adversely affected day to day life of the residents, accessibility and dignity. For example, the doorways were not fully accessible to wheelchairs and relatives reported minor injuries to upper limbs on occasion. One relative reported ongoing difficulty with the door frame for a person using a wheelchair which in their opinion required widening. Inspectors noted that one bedroom door had a small peep-hole security device in place which allowed people outside her room to see inside. According to the nurse in charge this was not required for the resident and there was no rationale for the continued use which had potential to compromise the resident's right to privacy. At the time of feedback the inspectors were informed that this matter would be addressed as soon as possible, and the device removed as soon as possible.

Free-standing screens available in two of the three shared twin rooms were not sufficient to ensure privacy and dignity when staff were providing care with residents, with gaps and see through material. The third twin room had a more robust free standing screen but this was not big enough to fully surround the bed space and the area of shared bedrooms and screening needs review. Access to a side table for personal belongings was not in place for all residents in twin rooms. Storage of assistive equipment such as hydraulic floor standing hoists were observed by inspectors to be inappropriately stored in residents accommodation under and over beds.

A visitor’s room was furnished in each house to allow for private visits when required and inspectors met with visitors in private during the inspection. The inspectors clarified with the person in charge arrangements in place for one resident with no named next of kin, as the director of nursing was named as contact and had signed the contract of care on behalf of the resident. Social workers were available and accessible to residents and relatives on a referral basis. Advocacy support was also confirmed as available on request. However, with regard to safeguarding reports submitted to the Authority there was no written evidence of referral or facilitating access to independent advocacy to support residents or relatives. However, further to the inspection the provider submitted a report to the Authority regarding this matter with rationale included.

Judgment:
Non Compliant - Moderate

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

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

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

Each resident has a written communication passport document in place. Sensory reviews took place and were fully documented in the residents’ records in order to inform care planning process. Full assessments were available as part of the admission and review process, many residents had their abilities and communication requirements clearly outlined as they had a detailed history with the service provider. Supports and assessments in place from speech and language professionals informed the personal plans and reviews of each resident where identified. However, as outlined in Outcome 1 of this report some language used was not commensurate with adult hood and staff require additional support and guidance with completing documentation in a more person centred manner.

The centre was part of the local campus and community and residents have access to radio, television, internet and information was available on local and national events.

Judgment: Compliant

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

Theme: Individualised Supports and Care

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

Findings:
Overall, residents were supported to develop and maintain personal relationships and families and friends were actively welcomed at the centre. The centre had an open door policy and families were encouraged to visit and spend time with their relative or friend. Contact with relatives in distant parts of the country was maintained with seasonal cards, annual party, and invitations to meet for coffee or an outing were facilitated.
Residents and staff referred to ongoing formal and informal communications from family members. Family members called in, and were also invited to take part more formally for reviews when required or requested. There was clear documentary evidence that some family members were fully involved in person centred meetings, and contacts with family members was recorded. In practice relatives were all invited be part of each individual annual personal care plan review. Many relatives attended and were active participants in the process, others requested the written minutes were sent to keep them up to date. Relatives confirmed to inspectors their knowledge of the process and invitation to attend.

Staff confirmed that they supported each resident to maintain and develop their relationships outside the immediate environment of the designated centre. Two residents went home regularly and supports were in place to facilitate this in a safe manner.

**Judgment:**
Compliant

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

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

**Theme:**
Effective Services

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

**Findings:**
Each resident and their family had been given a written agreement which details support, care and welfare of the resident. Details of service provision were clearly outlined and the service. A formal signed contract of care inclusive of fees payable was in place for most people living at the designated centre. However, one resident's contract was signed by the director of nursing and this practice needs review. Guidance relating to this practice submitted post inspection by the provider.

A written admissions policy was reviewed by the inspector which included the involvement of the person in charge, the resident and his/her next of kin. Referrals for admissions come via social workers to the person in charge, and an admissions committee also assess suitability for admissions within the criteria of the admissions policy.

**Judgment:**
**Outcome 05: Social Care Needs**

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

**Theme:**
Effective Services

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

**Findings:**

The Inspectors found that the wellbeing and welfare provided to the residents was adequate. However, some improvements were required with regard to provision of additional meaningful activity, and the planning and evaluating of this in the residents personal plan and documentation. The person in charge informed the inspector that some activities were in place, and residents were also supported by staff on campus in the 'skills' and horticulture departments by outreach staff. However, during the inspection, the inspectors observed that a small number of residents were engaged in repetitive activity during the day such as looking through catalogues and colouring. Improvements were required with regard to establishing and supporting residents with more meaningful activities and establishing short and long term goals in each personal plan.

Each resident's health, personal and social care and support needs were assessed and reviewed regularly. Each resident and their representative were involved in the writing up of their personal plans and some goals were documented. Residents' personal plans reviewed had clearly identified individual needs, choices and aspirations of each resident. Evaluations were completed and personal care plans were fully reviewed on a yearly basis, or more frequently should there be a change in personal health or circumstance.

There was no consistent meaningful narrative about social activities undertaken and how each resident reacted to individual experiences on a daily basis. Reviews could be further developed and documented and staff require additional training and guidance on goal setting with residents. Examples of written goals reviewed were limited and related to one off experiences and one resident's records reviewed had one long term goal only in place, with no plans to review the personal plan. Inspectors also observed that whilst basic care was delivered the time for quality activity was dependent on the staff roster and availability of staff. Feedback received and reviewed in some pre-inspection questionnaires from relatives also confirmed staffing as an area which required
improvement, and this is also referenced in Outcome 17 of this report.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Safe and suitable premises**

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

**Theme:**
Effective Services

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

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

**Findings:**

Overall the design and layout of the premises was found to be suitable for the its’ stated purpose. However, improvements were required to fully meet the legislative requirements, accessibility and the requirements of Schedule 6. At the time of this inspection 17 people were accommodated in the two houses, with one empty bed. The provider has requested registration for 18 people. The single and twin bedrooms outlined in the plans and the statement of purpose required review. The day and dining space in one house was not suitable or sufficient to meet the needs of all 9 residents living in this house. The observations made by inspectors of mealtimes, and the use of the day space would indicate that in this house further day space was necessary to allow for each residents social participation in the house and to fully enable access to kitchen and dining space.

Both houses are bright, hygienic, light and decorated and maintained to a good standard. The centre is located adjacent to an outdoor sensory garden on the campus. Residents in both houses also could access a shared garden space through the doors from both dining spaces and sun room. However, the doorways were not easily or independently accessible to all residents. Building works were ongoing adjacent in the nearby premises behind the centre, and this activity overlooked the gardens. The garden areas had not been screened from a privacy perspective and during the inspection no residents were observed using the garden and seating areas provided.

The dependency of residents has increased in recent years, and additional space was now required to facilitate assistive equipment and provide the assessed care and supports necessary. The majority of residents are wheel-chair users on a full or part time basis. Additional spatial requirements related to moving around this house were identified. For example, three residents in wheelchairs could not access the dining room table at meal times in one of the houses.
The application to register and statement of purpose request that 9 people are currently accommodated in one house and 8 in the second house. Therefore, in line with the findings of Outcome 17 of this report occupancy in both houses will be a lesser number in each in line with resident dependencies, and accessibility requirements. A further assessment of communal day space requirements completed by a qualified professional is required to ensure that residents have the required accessibility and space for their activities. Storage of assistive equipment such as sit to stand hoist and hydraulic hoist was inappropriately placed in residents rooms.

Each of the two bungalows had both single and twin bedrooms with hand-washing facilities in each room and a fully equipped assisted bathroom and shower in each house. Portable screening was available in each shared room which could be used to maintain privacy and dignity, and all bedrooms had blinds and curtains in place. However, as outlined in Outcome 1 the current arrangements were inadequate and required improvement. The bedrooms were generally of adequate size with adequate wardrobe and storage space.

Each house also had a quiet/visitors room where private meetings and visits took place, a kitchen area, a utility room and a clinical room/office. A shower 'wet' room and separate fully equipped bath room was in place, with a jacuzzi type assisted bath in place. Two separate toilets (one assisted) were in place, all with privacy locks in place. The standard of hygiene, maintenance and provision of equipment in place was good and housekeeping staff were employed to maintain this to a good level.

**Judgment:**
Non Compliant - Major

<table>
<thead>
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<th>Outcome 07: Health and Safety and Risk Management</th>
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<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
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**Theme:**
Effective Services

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

**Findings:**
Overall the provider had measures in place to ensure that the health and safety of residents, visitors and staff is promoted and protected. However, some improvement was required in the following areas hot water supply and accessibility and storage of chemicals in the open sluice room. The temperature recording in the hot tap of a residents bedroom was 56.1 degrees centigrade on the day of the inspection. Evidence was provided to inspectors following this inspection that the hot water temperatures had been fully addressed and are routinely checked by maintenance staff.

A written safety statement was in place and reviewed by the inspector, and found to be
adequate. The inspectors reviewed the centre's risk register which was centre specific and detailed risks to ensure that all identified risks were minimised. The risks associated with storage of an oxygen cylinder in the clinical room was not found to be documented on the risk register shown to inspectors. The inspectors saw that the controls outlined in the risk register were used in practice and referred to by staff during the course of the inspection. Specific risk assessments to support residents were also in place. Staff who spoke with inspectors had a good understanding of risk management and some staff had completed training and support in completing risk assessments to a good standard.

There were safe systems in place to mitigate risk of fire. The centre had fire extinguishers in place, at the time of inspection they were within service. There was a monitored fire alarm with a fire panel at the front door of the house and weekly checks were completed on such equipment. Inspectors noted that all houses had a break glass facility in place, key/swipe operated door exits are in place in the communal spaces. One key was available on the corridor, and staff held a key to facilitate exit and evacuation. Staff knowledge was clear in relation to actions to take in case of fire or any emergency took place. For example, the fire alarm sounded at the time of inspection from another house on the campus and residents recognised this as the fire alarm, all actions were in line with procedures and residents were reassured by calm approach of staff.

All staff had completed fire safety training as per records reviewed by the inspector, with fire drills taking place day and night. Staff interviewed by the inspectors and could clearly outline the correct measures to take should an evacuation be necessary. Each resident had a personal emergency egress plan which had been recently reviewed. The centre had a written emergency plan in place and arrangements in the instance of a full evacuation. There was a campus wide plan to facilitate any evacuation as a result of an emergency and a clinical nurse manager co-ordinates management of the campus overnight. A communication pager system operated over 24 hours if any staff member required additional assistance or was working alone at any time of the day and requires assistance. However, whilst measures to mitigate these risks associated with lone working at night were in place to support staff and residents, this information did not form part of the risk register records. For example, one resident was identified in her evacuation plan as requiring four people to evacuate if in bed at night. Residents living in the house had also been assessed as requiring a minimum of two people to evacuate. Staffing availability on site was reviewed in line with Outcome 17 and overall staffing and the provider was asked to review the dependencies, mobility and evacuation requirements in line with documented assessed needs of each resident.

Each resident had a moving and handling assessment completed and detailed in their records to inform and guide staff in supporting this aspect of their assessed care. Infection prevention and control practices were generally found to be good, with a suitably equipped sluice room in place. However, the door was observed on a number of occasions to be left open and cleaning materials were not appropriately stored. Household staff maintained a good standard of hygiene in the laundry and bathroom and shower rooms. Waste disposal was in line with best practice and staff were observed using disinfectant hand gels on entering and leaving the centre. The inspectors recommend that the practice of leaving each resident’s labelled wash sponge in the bathroom is discontinued as this system of storage is not person centred, and there is an associated risk of cross-infection.
**Judgment:**
Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

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

**Findings:**
The inspectors found that there were adequate measures in place to protect residents from abuse and keep them safe. However, some improvements were required with regard to record keeping and provision of staff training to four staff members working at the centre who did not have a record of receiving their safeguarding updates. There was evidence that restrictive practices had been reviewed in accordance with the policy.

There had been two statutory reports made to the Authority in line with legislative requirements prior to this inspection. Some improvements were required with regard to training and safeguarding residents during the preliminary process. The outcome of the preliminary review was that a protective measures included moving a staff member.

The majority of staff working at the centre had attended and received training in safeguarding vulnerable adults and were knowledgeable on what constituted abuse and were clear on the local reporting procedures. However, it was found that some staff working at night in the centre or on a temporary basis did not have their training and refresher updates accounted for in the training records. Some improvements were required with regard to ensuring all staff were fully aware of the most recent policy guiding practice known as the “service user welfare and protection policy”.

The records and files relating to one of the safeguarding reports were reviewed by inspectors for completeness of the response. Overall, the resident was found to be safeguarded further to the initial report, however, there were improvements required relating to the record keeping and methodology of the review which took place. The records reviewed by inspectors of how the findings determined the conclusion and final outcome were incomplete. Staffing requirements were evidenced as being fully reviewed as part of this report and records of staff rosters not included as required in the file. There was a current investigation in process further, the outcome and records will be
reviewed as a follow up to this inspection at a future date. The inspectors were satisfied that all residents were suitably safeguarded during this current process and improvements had been made by the provider.

The feedback from relatives and friends who advocated on behalf of residents was listened to and acted upon, further to the findings of Outcome 1. However, the findings in Outcome 1 of this report relating to privacy and dignity required additional oversight by the provider to fully protect the residents rights and property. Many of the residents living at the service had limited verbal interaction with the inspector. Observation of residents during the inspection confirmed that residents were comfortable in their home and that appropriate safe supports were in place.

Personal and intimate care plans were found to be in place and provided guidance to staff; ensuring a consistency in the personal care provided to residents. Generally it was found these plans focused very much on supporting residents to be as independent as possible in this area. Residents with higher support needs had plans which respected their individual dignity and privacy. However, some aspects of the written plans required improvements to fully support care provision particularly for care provided at night. This aspect of is reviewed under Outcome 18 of this report.

Quarterly reports on any form of restraint used were accurate and involved detailed risk assessment and communication with relatives. Inspectors found that some residents used bed rails and their use had been considered as part of each resident’s multi-disciplinary team (MDT) reviews. Physical restraints described by the provider such as the use of the door swipes did not restrict residents. A review of the policy on restraint found that alternative measures trialled before the use of any form of restraint were fully documented prior to the use of any restrictive practice. The inspectors acknowledged the comprehensive nature of the multi-disciplinary approach employed. The person in charge confirmed restrictive practices were used within the centre, and that there was a policy of moving towards a restrictive free environment within the broader service. Residents were also involved in the creation of comprehensive positive behavioural support plans (as required).

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.
Findings:
A record of all incidents and accidents occurring in the designated centre was maintained by the person in charge and where required notified to the Authority. The inspectors discussed with the person in charge an incident where a resident had been identified as having skin breakdown and the measures to mitigate risks associated were included in the nursing care plan. The incident was notified appropriately further to the inspection and in line with requirements.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Residents were observed to be supported to develop their own personal interests, including art, gardening, massage treatments and bowling. Some residents attended theatre and shows with staff support.

The person in charge supported residents to retain control over their activities and make choices, relating to spending their own monies in line with their likes and dislikes. The person in charge told inspectors that a resident with cognitive difficulties enjoyed hand massage and one to one time with staff. However, further development and improvements were necessary to access experiences external to the centre.

The inspectors found that the age profile of the residents in the houses varied. Some residents lived at the centre but also spent nights at home with family members. Most residents had not been in substantive full or part time employment during their life and had lived on the campus since childhood or younger years.

Residents' opportunities for new experiences, social participation and skill maintenance and enhancement did not always form a key part of residents' personal plans. Improvements were required as identified in Outcome 5 of this report. Personal plans in place required development in relation to aspects of goal setting and planning activity. For example, there were no plans for breaks or holidays, and short term goals were mainly campus based. Further development and access to the community external to the centre was required for some residents. Some residents had established links with day services, and family and social networks which were positively maintained and
developed.

Resident’s personal plans identified some opportunities for residents to develop their skills and maintain and develop their levels of independence, appropriate to the assessed needs and requests of residents. Opportunities for involvement in cooking at the centre were limited as most meals were prepared in a central kitchen and came to the centre in a heated system. All residents required some level of supervision with using the kitchen, making drinks and getting snacks. However, the environment did not fully enable residents to access the kitchen areas in both houses due to accessibility issues for wheelchair users and those with mobility difficulties.

**Judgment:**
Non Compliant - Moderate

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

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

**Findings:**
Overall the inspectors found that residents were supported on an individual basis to achieve, maintain and enjoy good health outcomes. The residents had full access to medical services, and could access a doctor on call service if required overnight. Residents were fully supported to maintain their medication and health care plans, by the multi-disciplinary team. For example, good oversight of residents with a diagnosis of epilepsy was in place and access to the outreach services on a nearby campus facilitated improved quality of life outcomes for many residents with reduced seizure activity.

The standard of health care plans was found to be good overall and in line with legislative requirements. The inspector reviewed a number of residents' health care plans, records and documentation and found that residents were facilitated to access to allied health professionals. Residents with complex assessed needs had assessment and reviews through a multi-disciplinary approach. The inspector noted residents had local access and referral to psychology, psychiatry, social work, occupational therapy, dietician and speech and language on site. Residents could also access chiropody, ophthalmology, and dental services. Significant health care issues had been comprehensively provided for. However, as outlined in Outcomes 1 and 18 of this report, some aspects of documentation about assessed nursing care needs were not clearly outlined and communicated to inform and guide staff. For example, continence needs and pressure area care.
Pain management and health care interventions and maintaining an active lifestyle in accordance with the needs and wishes of the specific resident were promoted. For example, care plans were in place to monitor residents who experienced seizures and the appropriate health care supports were in place and well documented. Communication between residents attending day services was maintained and informed personal plans. One resident had a specialised feeding tube placed directly from the abdomen to the stomach in order to provide daily nutrition. The person in charge confirmed that staff had been updated with the procedures around care of the feeding tube, administration of medication and maintenance of the tube. However, inspectors reviewed the policy dated 2010 and found that practices relating to the use of syringes and sterilisation procedures were not fully in line with evidenced based practice.

The inspector reviewed the menu and the food was seen to be varied and nutritious and supplied from a central kitchen on another campus. Mealtimes including lunch times, dinner and snacks were observed and the meals service included hot and cold options. Inspectors were informed that residents were fully involved in choosing their meals from a four week rolling menu at the centre. The pictorial menu was available and assisted residents with making their choices, when available. Meals are provided in a heated trolley, and temperature checked by staff prior to serving. However, the temperature probe in one of the houses was overdue for re-calibration and required review. Arrangements for residents to make make food or have other options were limited and this area requires development to enhance current choices.

Staff were observed providing support to residents at mealtimes. However, the manner in how independent dining was promoted requires review and further supervision to ensure a high standard is maintained. There was significant variation in the standard of support at mealtimes observed including good examples where staff sat with residents and offered discreet encouragement. Examples of poor practice were also observed by inspectors where staff approached residents away from their eye-level and behind them whilst sitting at the table. Tables were not always set up correctly, pictorial menus not consistently used to facilitate choices, and at times there was insufficient numbers of staff to ensure all residents could enjoy their meal together in a sociable environment. Three residents in one house could not access the main dining table due to their individual seating requirements, and no alternative surface had been sourced to date, so they dined in the same room but separately.

Improvements were required with regard to supports and development of life skills and participating actively in mealtime experience as a social occasion.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

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

**Findings:**
Overall the inspector found that the requirements relating to medication management systems were safe. Each resident was fully protected by the centre's policies and procedures for medication management. All prescribing and administration practices were in line with best practice guidelines and legislation and systems were in place for reviewing and monitoring safe medication practices. Staff responsible for administering medication were all registered nurses. The inspectors observed staff administering medication in a person centred way, in line with individual care plans and resident preferences for taking their medication. Practices observed by inspectors were found to be safe and in line with Bord Altranais agus Cnáimhseachais na hÉireann safe medication administration practices.

Audits of medication management took place by the pharmacy department. A weekly audit also took place by night staff and this audit included the cross-checking of the amount of medication stored with the amount recorded as administered. Medication which requires special storage and documentation was maintained in line with policy, and all other medication was found to be appropriately stored. However, a lock for the medication fridge in one house was not in place. The inspectors would request that a review of the current local practice of storing the red box for medication which had additional storage requirements in the trolley be reviewed.

Local policies and procedures were also in place pertinent to the designated centre such as the medication ordering protocol and the weekly collection, and return of prescription medication. The written medication management policy dated 26 January 2015 informed and guided practice.

The inspector found that each resident's medication was reviewed regularly by the prescriber. Evidence of staff nurses' most recent completion of medication management updates was not in place for all staff engaged in medication management.

**Judgment:**
Substantially Compliant

**Outcome 13: Statement of Purpose**
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The updated statement of purpose was provided to the Authority prior to the inspection which met many of the requirements of Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013. However, revised details of the premises, and current accurate staffing arrangements were not clearly reflected in this document and required improvement.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The provider has established a management structure and the roles of all managers and staff were clearly set out and understood. The structures included supports for the person in charge to assist her in delivering a good quality service. These supports included regular meetings with the provider and clinical nurse manager (CNM) 3 linked with the centre. The provider nominee had submitted all the required information for registration purposes including planning compliance. Information required for the newly appointed CNM3 was also submitted as part of this registration.

An assessment of fitness of the the person in charge was completed and she was interviewed following the inspection on 30 October 2015. She confirmed information submitted as part of the registration application. She has worked in this service for 23 years as staff nurse and clinical nurse manager. She was a qualified intellectual disability nurse and had completed post graduate management qualification.

There had been a six monthly review of the quality and safety of the service carried out by the nominee provider, and quality manager. The findings and recommendations of a
staffing review of the service completed during 2015 had not yet been fully implemented. The inspectors acknowledge that the provider had undertaken a review of staffing, and the outcomes of this review was shown to the inspectors. The person in charge confirmed that day staffing had increased and three staff were allocated to each of the two houses and she worked between both houses supervising care. Further to a recent safeguarding report additional supervision and visits by the clinical nurse manager 3 on duty had been put in place to supervise staff and support residents. An increase in the daily number of visits to the centre was occurring. However, this measure was not found to be fully effective as no written report other than a record of having made the visits was in place to monitor and evaluate care practices.

The adverse findings relating to staffing were outlined to the chief executive officer as provider at the feedback meeting on the third day of the inspection. An immediate action was given to the provider relating to not ensuring that where nursing care is required, subject to the statement of purpose and assessed needs of residents, it is provided. The registered provider completed a written undertaking that a staff nurse will be on duty over a 24 hour period (day and night) and a needs assessment will be completed by the director of nursing. The inspectors confirmed and received staffing rosters on 9 November 2015 that a registered nurse was on duty and in place in each house overnight as a minimum.

Ten non-compliances were the responsibility of the person in charge and the remaining 20 are for the provider to address.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge

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

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge had not been absent for a prolonged period since commencement of regulation and there was no requirement to notify the Authority of any such absence. However, the clinical nurse manager who was the person nominated to work in the absence of the person in charge had been on extended leave for the last five months and the deputy role was not adequately covered at the time of the inspection. The inspectors were informed that a recruitment process was ongoing to cover the role on a temporary basis.
The provider was aware of the requirement to notify the Authority in the event of her absence of more than 28 days.

**Judgment:**
Substantially Compliant

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### Outcome 16: Use of Resources

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

**Theme:**
Use of Resources

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

**Findings:**
The inspectors found that sufficient resources were not always provided to meet the needs of residents to ensure the effective delivery of care and support in accordance with the statement of purpose.

Staffing levels were not judged to be adequate to support residents to achieve their individual personal plans and to meet their assessed support needs at all times. Flexibility could not be consistently demonstrated within the staffing roster to meet specific needs of residents. Staffing at night was not adequate.

**Judgment:**
Non Compliant - Moderate

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### Outcome 17: Workforce

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

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.
**Findings:**
The provider had undertaken a staffing review during August 2015, and acknowledges that recruitment was ongoing at the time of the inspection. However, the skill mix and staffing in place did not fully reflect the statement of purpose and the staffing rosters shown to inspectors. For example, nursing staff identified on the roster for this designated centre did not consistently work in the two houses and were often allocated to other designated centres on campus and replaced with care staff, and supplemented with on call staff. The nature of each residents assessed dependency both social and nursing was not being met on a 24 hour basis by the provider at all times.

The inspectors confirmed with the person in charge the actual and planned staff rosters in place to provide for a full time nurse led service. Residents received interventions and support from all staff in a respectful, timely and safe manner. However, inspectors reviewed four mealtimes in the designated centre and found there was not always sufficient staff on duty to provide appropriate supports. The staffing in place was not always consistently found to be guided by activities and outings planned for by residents. Feedback from relatives also confirmed dissatisfaction with staffing and confirmed that there are times when staff are busy. A number of written feedback questionnaires received by the Authority noted that at times there were insufficient staff available.

Staffing levels included the person in charge, who worked full time, nursing and care assistant staff. Each house had a member of household staff responsible for hygiene and food service, on the second day of the inspection the household staff was on unanticipated sick leave and there was no replacement allocated. One allocated staff nurse at night between the two houses and two care staff; the two houses were also supported by staff known as "runners" co-ordinated by the clinical nurse manager 2 on duty at night. Residents with high levels of assessed dependency and residents with complex medical and nursing needs lived at both houses.

Staff confirmed to inspectors that the 'basic' daily care needs were met from current staffing provision. However taking residents out or spending more one to one time with residents was not always possible each day, and this was dependent on the availability of staff. For example, a theatre trip had taken place recently and the person in charge told the inspectors that some staff also attended in their own time to facilitate this type of event for residents.

The inspectors reviewed staff training records and saw evidence that staff employed in both houses had mandatory training in place including fire safety, moving and handling and risk management training and those spoken with had a good knowledge of procedures to follow. As referred to in Outcome 8 not all staff working at the centre had received their safeguarding vulnerable adults update. Overall, staff were found to be up to date with clinical training. Staff interviewed by the inspector confirmed that they were satisfied with the management support and training provided which enabled them to provide a good standard of care.

The recruitment process was found to be robust. Three staff files were reviewed prior to this inspection on 10 August 2015. All documents outlined in schedule 2 of the regulations were available in each of the files reviewed. There were no volunteers
identified as working in the centre. The inspectors confirmed that vetting procedures were in place for people engaged to undertake services, for example, massage and relaxation with residents at the centre.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Residents and Adults) with Disabilities) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Records reviewed were generally maintained to a required standard and clinical documentation was clear and easy to read and informed practice. Some improvements were required relating to the Schedules 3 and 4 as outlined in Outcomes 5 and 8 of this report.

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

The centre had all of the written operational policies as outlined in schedule five available for review. Further to a review of the gastrostomy policy the inspectors found it required a minor review relating to the use of single use syringes, and a review had not taken place since 2010.

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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004022</td>
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<tr>
<td>Date of Inspection:</td>
<td>29 September 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 December 2015</td>
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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:
Language and communications were not consistently commensurate with adulthood and did not fully respect the dignity of each resident.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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) The PIC will ensure that all documentation in the designated centre is reviewed and that language is commensurate with adulthood.
b) The Pic will highlight at a unit meeting that staff use appropriate language to reflect adulthood of residents
c) A member of the training department is providing 1:1 support to staff to review personal plans and ensure goals are written in a SMART format

Proposed Timescale: a) 30/11/15  b) 20/11/15  c) 28/02/16

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**Proposed Timescale:** 28/02/2016  
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of any referral to independent advocacy services documented to support residents and relatives.

**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:**

a) The PIC will ensure that there is literature and posters in the designated centre regarding how to access Independent Advocacy Services.
b) The Chairperson of the Advocacy Steering Group will meet with the residents to explore what additional support they would like in relation to Advocacy.
c) The PIC will write to all families advising them of the Advocacy Services and how to access same on behalf of their family member.
d) Residents will continue to attend local Advocacy group with the support of staff

**Proposed Timescale:** 31/12/2015  
**Theme:** Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Space in the three twin rooms was inadequate to ensure each resident had access to their personal property and possessions beside their beds.
3. **Action Required:**
Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

**Please state the actions you have taken or are planning to take:**
a) A side table/locker will be installed for any residents who would like one beside their bed
b) Bedroom screens in two shared bedrooms have been replaced
c) Review of existing screens to be carried out by the PIC and alternative options to be explored with a view to replacing them

**Proposed Timescale:** 28/02/2016

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

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One contract of care was not signed by the resident or their representative.

4. **Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
Contract of care for one resident have been resent to their key support person/family for signing - Social Worker has followed up to ask for contract to be signed and returned..

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

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents personal plans required development to ensure that meaningful activities are included appropriate to her interests and evaluated as part of each review.

5. **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:

a) The PIC will ensure that all personal plans are reviewed and will be reflective of the needs and wishes of each resident

b) A member of the education dept. will provide training for staff in care planning and person centred planning

Proposed Timescale: 28/02/2016

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The needs and numbers of residents each house can accommodate requires professional assessment to review spatial requirements.

6. **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:

a) The number of residents accommodated in the designated centre will be reduced to 17.

b) The Occupational Therapist will carry out an assessment to review the spatial requirements of the residents in each house. The Pic has forwarded a referral to O.T. on 16/11/15

Proposed Timescale: 31/01/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Accessibility to premises to promote independence was not assessed including the bedrooms, day space, kitchen and garden. These required review and action to support and promote the independence of residents.

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

Please state the actions you have taken or are planning to take:
The Assistive Technology team will carry out a review to assess the accessibility of the premises to promote independence including bedrooms, day space, kitchen and garden.
The PIC has forwarded a referral to Assistive Technology Team on 16/11/15

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<td><strong>Theme:</strong> Effective Services</td>
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<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
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<tr>
<td>A review of storage requirement in both houses in line with requirements of Schedule 6 is required.</td>
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<td>8. Action Required:</td>
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<td>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.</td>
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<td>Please state the actions you have taken or are planning to take:</td>
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<tr>
<td>a) The Service Engineer, PIC and CNM3 to carry out a review of storage requirements in both houses and make recommendations to maximise any available space.</td>
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<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
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<tr>
<td>Assessment and review of accessibility with reference to the statement of purpose was not evidenced by any review or action to address any matters arising.</td>
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<td>Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.</td>
<td>Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.</td>
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<td>Please state the actions you have taken or are planning to take:</td>
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<tr>
<td>The Occupational Therapist to carry out an assessment regarding accessibility for residents within the designated centre. The Statement of Purpose and Function will be amended to reflect any changes or alterations required in the premises.</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td><strong>Proposed Timescale:</strong> 31/01/2016</td>
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<td>The Registered Provider is failing to comply with a regulatory requirement in</td>
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the following respect:
The risk register did not contain details of measures in place to mitigate risks associated with lone working at night and the storage of oxygen cylinder.

10. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
a) The risk register has been updated to include measures in place to support Lone Workers on night duty.
b) Guidelines will be put in place in relation to storage/transportation of oxygen cylinder within the centre.

(a) 15/12/2015 (b) 31/12/15

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The doors to the sluice rooms were left open with chemical products not securely locked away.

11. Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
a) PIC to ensure that all staff are aware of the need to keep the sluice room door closed at all times and chemical products locked away in allocated storage area.

Proposed Timescale: 15/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff working at the centre did not have up to date training in adult safeguarding on their staff training records.
12. **Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
One staff attended refresher safeguarding training on the 13/10/15. All staff have completed training.

**Proposed Timescale:** 13/10/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The process of managing and documenting the preliminary enquiry for a safeguarding report was not found to be robust.

13. **Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
If an allegation of abuse is made against a staff member they may be either removed from the designated centre and transferred under supervision, or put off work on protective leave with full pay, without prejudice and accordance with service policy and trust in care policy, pending the outcome of the preliminary investigation process

**Proposed Timescale:** 15/12/2015

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Access to opportunities to participate in activities external to the centre were limited such as for education, training and employment.

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

**Please state the actions you have taken or are planning to take:**
a) The PIC will ensure that opportunities for education, training and employment will be
explored with each resident when assisting them to develop their personal plan
b) Staff will be provided with training to assist service users in developing personal plans by a member of the training department

**Proposed Timescale:** 31/03/2016

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The standard of mealtime assistance was variable and not consistently offering choice and independence to residents.

**15. Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
a) Written guidelines have been developed to ensure that all staff are aware of the appropriate way to support residents at mealtimes
b) The PIC has reviewed staff break times to ensure sufficient number of staff are available to support residents at mealtimes.

**Proposed Timescale:** 15/12/2015

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Temperature probe required re-calibration to ensure safe food service.

**16. Action Required:**
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
Temperature probe has been recalibrated to ensure safe food service

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

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17. **Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
a) If residents wish to have an alternative meal to the one that is on offer in the daily menu, this will be facilitated and residents will be assisted to prepare same if they so wish.

**Proposed Timescale:** 15/12/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Mealtimes and each resident's access to suitable dining tables require review.

18. **Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

**Proposed Timescale:**

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The storage of MDA's in the red box was not in line with legislative requirement as the box was mobile from the trolley and not 'fixed'.

19. **Action Required:**
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
The MDA drug in use in the designated centre is stored in a locked box within a locked press.

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

<table>
<thead>
<tr>
<th>Outcome 13: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> Details of the premises, and current accurate staffing arrangements were not clearly reflected in the statement of purpose.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> 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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Statement of Purpose to be revised to reflect accurate details of the premises and current staffing arrangements</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 31/01/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 14: Governance and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The provider has not put in place effective systems to monitor the quality and safety of care on a consistent basis.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> a) CNM3 will continue to visit the designated centre on a daily basis and will keep a written record of any intervention they need to make regarding care practices and discuss with PIC</td>
</tr>
</tbody>
</table>

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

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements for the absence of the person in charge was not be satisfactory.

22. **Action Required:**
Under Regulation 33 (2) (c) you are required to: Give notice in writing to the Chief Inspector of the name, address and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge.

Please state the actions you have taken or are planning to take:
A CNM1 has been appointed and commenced on the 16/11/15. He will assume the role of PPIM in the absence of the PIC

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

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**Outcome 16: Use of Resources**

**Theme:** Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing resources were insufficient.

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

Please state the actions you have taken or are planning to take:
The designated centre has an approved staff complement which is agreed as part of the service level agreement signed with the HSE annually. An annual needs assessment to be carried out by CNM3. This to be updated more frequently if the needs/identified risks for the residents change. A review of staffing to be carried out annually by the Service Manager, Director of Nursing, Director of HR and CNME using information obtained from the needs assessments of residents in the designated centre to inform staffing requirements. Any requirement to increase the staff complement as a result of the annual review will be submitted to the HSE for approval of funding.

Vacant posts in the designated centre as outlined in action for outcome 17 will be filled through an active recruitment process and will result in sufficient staff being available to ensure residents have access to increased outings and activities. The weekly roster will be planned in a flexible manner to ensure sufficient staff
resources are available to enable residents to access activities and outings as per their personal plan. There will be a monthly audit of activities and outings for each resident, carried out by their keyworker to ensure the residents social needs are met according to their personal plan.

**Proposed Timescale:** 31/03/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider has not ensured that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided. This was subject to an immediate action plan.

24. **Action Required:**
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

**Please state the actions you have taken or are planning to take:**
The Director of Nursing and CNM3 are carrying out a review of nursing supports required in the designated centre over a 24 hour period. The following areas were included in the review process:
- Lone workers risk assessment updated and included in the risk register
- Risk assessment on care staff working without the presence of a nurse was completed and included in the risk register
- Review of external assessors report on staffing levels within the Ardelle group in 2013.
- Assessments of need for all residents that were completed in 2013 were repeated in October 2015.
- Day & night reports & nursing notes over 3 month period reviewed to identify the quantity of direct nursing intervention that was required
- Night time incident /accident reports reviewed.
- Available supports at night reviewed
- Meeting with Nominee Provider, PIC, PPIM, Night Managers, CNM3, Director of Nursing & external consultant to discuss findings of updated service users assessment of needs and staffing levels held on 26th November 2015
- Report on the review process to be sent to Nominee Provider by 31st January following validation of the findings and recommendations by an external consultant.
- Statement of purpose and function to be amended to reflect the changes recommended in the review report
**Proposed Timescale:** 31/01/2016  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staffing rosters were not fully maintained showing staff on duty particularly at night.

25. **Action Required:**  
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**  
Staff rosters have been amended to ensure that all staff working in the centre, including night staff are accurately reflected on the weekly roster.  
Meeting held with night managers on 09/11/15 and completing staff rosters accurately was highlighted.

**Proposed Timescale:** 09/11/2015

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
A policy around gastrostomy care required review.

26. **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:**  
Policy on gastrostomy care will be reviewed by the service policies and procedures working group.

**Proposed Timescale:** 28/02/2016

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**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Records reviewed relating to an allegation of abuse reported were incomplete.

27. **Action Required:**  
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in
Please state the actions you have taken or are planning to take:
A copy of Staff rosters will be included in the file containing the records of any allegation of abuse

**Proposed Timescale:** 15/12/2015  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Staffing rosters in line with Schedule 4 requirements were not fully maintained.

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

Please state the actions you have taken or are planning to take:  
PIC will ensure that names of staff working on night duty are recorded on the weekly roster for the designated centre.

**Proposed Timescale:** 03/11/2015  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Records relating to staffing roster of accountable staff in charge at the designated centre and supervising the residents were not maintained further to incidents notified to the Authority.

**29. Action Required:**  
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:  
A copy of staff roster will be maintained in relation to incidents notified to the authority.

**Proposed Timescale:** 15/12/2015  
**Theme:** Use of Information
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records and nursing care plans relating to continence and pressure area care were not specific or clearly informing practice.

30. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

Proposed Timescale: