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

**Centre ID:**  
OSV-0005157

**Centre county:**  
Tipperary

**Type of centre:**  
Health Act 2004 Section 38 Arrangement

**Registered provider:**  
Daughters of Charity Disability Support Services Ltd

**Provider Nominee:**  
Breda Noonan

**Lead inspector:**  
Julie Hennessy

**Support inspector(s):**  
Noelle Neville

**Type of inspection**  
Unannounced

**Number of residents on the date of inspection:**  
5

**Number of vacancies on the date of inspection:**  
0
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 20 January 2016 09:00
To: 20 January 2016 16:30

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>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Communication</td>
</tr>
<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 10. General Welfare and Development</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
<tr>
<td>Outcome 18: Records and documentation</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This was the second inspection of this designated centre, run by the Daughters of Charity Disability Support Services Limited. This inspection was in response to notices of proposal to refuse and cancel registration of the centre that were issued by the Health Information and Quality Authority (HIQA) to the Daughters of Charity in response to an application by the provider to register the centre. This inspection followed up on non-compliances from the previous inspection and also considered a submission by the provider in relation to the notices of proposal to refuse and cancel registration of the centre.

This centre comprises a single two-storey house in a small village. The centre was clean, warm, homely and well-maintained with a pleasant private garden to the rear. The residents who resided in the centre were generally of an older age group and some residents had restricted mobility.
As part of the inspection, inspectors met with residents and staff members who were in the centre on the day of inspection. Residents told inspectors that they were happy and liked where they were living. Some residents were retired and were supported to pursue interests of their choice. Other residents were semi-retired and attended a day service on a part-time basis. Residents outlined how they were supported to be part of the local community. Relationships with family and friends were encouraged and facilitated.

There was evidence of improvement across all outcomes since the previous inspection, when inspectors had found a high level of non-compliance with a total of 10 of 18 outcomes at the level of major non-compliance. At the previous inspection, it was identified that the use of the centre to provide a day service for a resident from another centre had resulted in peer-to-peer abuse of residents living in this centre. At this inspection, it was found that this failing had been fully resolved as the practice had since ceased. Since the previous inspection, additional supports had been provided to the person in charge and staff in order to ensure that residents' needs were being met. These supports included staff training, management support and other input into key areas.

However, at this inspection three outcomes remained at the level of major non-compliance:

Under Outcome 6: Safe and suitable premises, failings identified at the previous inspection relating to accessibility of the centre remained, in particular in relation to residents being able to safely access upstairs bedrooms. While this finding is unchanged, the provider has progressed this issue. In a representation to HIQA the provider confirmed that plans to build an extension and create two new downstairs bedrooms had been submitted to the Health Service Executive (HSE). The provider nominee has confirmed that funding for these plans has been approved. However, the final time-bound plans have yet to be submitted to HIQA.

Under Outcome 11: Healthcare needs, it was not demonstrated that multidisciplinary team input was readily available. A number of residents had been identified as requiring occupational therapy assessment to ensure their comfort and safety on the stairs or to reduce the risk of falls. Some assessments were outstanding since the previous inspection and a while another assessment was requested more recently in September 2015, it was now required as indicated by a number of recent falls.

Under Outcome 14: Governance and management, it was identified at the previous inspection that the person in charge managed four designated centres across a wide geographical spread and this arrangement did not ensure the effective governance, operational management and administration of the designated centres concerned. The provider in a submission to HIQA, outlined that the area of responsibility for the person in charge would be reduced to two centres. While additional supports have been provided to the person in charge, at the time of the inspection this change had not yet occurred.
A number of other key areas still required improvement. Inspectors found that multidisciplinary input was required for personal planning reviews and behaviour support plans for residents. Improvement was required in order to support residents to communicate, with respect to risk management, the assessment of residents' training and personal development wishes and abilities, healthcare planning and ensuring consistent delivery of care and support to residents.

Inspection findings including non-compliances are discussed in the body of the report and in the action plan at the end of the 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
At the previous inspection, it was found that the provider failed to demonstrate that residents' participate in a meaningful way in the organisation of the designated centre. It was not clearly demonstrated whether residents were consulted in relation to the use of their home to provide a day service for another resident.

At this inspection, inspectors spoke with residents and reviewed minutes from residents’ meetings. Residents told inspectors that they were happy living in their home and that they could raise and discuss any issues of their choice. The issue relating to the use of their home as a day service for another resident has been resolved since the previous inspection and this practice has since ceased.

At the previous inspection, some information management practices did not respect residents’ privacy and confidentiality in relation to their personal information. For example, person information was visible on a communication board in the kitchen. At this inspection, while this information had been removed from the communication board, a review of minutes from residents’ meetings revealed that personal information was being discussed at residents’ meetings, such as the taking of blood tests.

At the previous inspection, staff described how residents were called into the office to receive their medications and this practice was also outlined in a resident’s behaviour support plan.
Inspectors found that this practice was not person-centred. At this inspection it was found that this practice has since ceased.

**Judgment:**
Substantially Compliant

---

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
An inspector reviewed the communication needs of residents in this centre including residents with a hearing impairment and residents who did not communicate verbally. Where residents had been reviewed by a speech and language therapist (SLT) and recommendations made, the inspector found that those recommendations were not always implemented. For example, the SLT had made specific recommendations in relation to using a communication book and a sequence picture timetable board. The inspector spoke with staff who said that they were not implementing those recommendations and saw the recommendations as being more applicable to staff unfamiliar with residents. This was discussed with the person in charge on the day of the inspection.

**Judgment:**
Non Compliant - Moderate

---

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
On the previous inspection, there was evidence of peer-to-peer assault in the centre.

Since the previous inspection, the provider nominee had ensured that arrangements had been put in place to remove the risk of this happening and that the issue had been resolved.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
At the previous inspection, it was found that a comprehensive assessment of residents’ health, personal and social care needs, abilities and wishes had not been completed.

At this inspection, it was found that improvement had been made in this area. Residents’ health needs had been assessed. Personal development skills were being identified as goals in residents’ personal plans. However, further improvement was required in relation to ensuring that each resident had a comprehensive assessment of their social and personal development needs, which in turn informed personal goals. While there was a comprehensive assessment in place for one resident’s training and personal development needs, this was not in place for all residents. This will be further discussed under Outcome 10.

At the previous inspection, it was found that goals were not based on an assessment of residents’ needs. As a result, there were no planned goals to address some identifiable needs. In addition, the supports required to meet goals were not specified.

At this inspection, it was found that progress had been made in this area. Long-term goals had been considered. It was clear how such goals contributed to residents’ quality of life. The process for developing goals involved both residential and day services.
However, further improvement was required as the supports required to meet goals were still not specified.

At the previous inspection, it was found that the review of the personal plan was not multidisciplinary, as required by the regulations. In addition, where multidisciplinary (MDT) input had been sought, there was no link between MDT meetings and the residents’ personal plans and the care and support that was delivered to them.

Since the previous inspection, MDT meetings had been held for three of five residents. This meant that MDT meetings were outstanding for two residents. In addition, due to the lack of dedicated psychology support in the service, psychology input into the MDT review or personal plan was not available where required. This will also be discussed in the context of behaviour support under Outcome 8. It is acknowledged that the service has been making concerted efforts to recruit a psychologist and recruitment is actively underway.

At the previous inspection, it was not always clear if the identified healthcare need had been followed up following discharge from hospital. In addition a plan of care for the identified healthcare need had not been created following discharge from hospital. There was no written or coordinated plan in place in relation to a resident as they were being cared for in two separate locations. At this inspection, it was found that these specific gaps had been addressed. Healthcare plans are further discussed under Outcome 11.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
In this centre, there are two bedrooms upstairs. At the previous inspection, it was identified that there were difficulties with accessing the two upstairs bedrooms at times and this was identified as a major non-compliance.
At this inspection, inspectors observed that residents managed the stairs with little difficulty on the day of inspection with the aid of handrails on both sides of the staircase. However, an occupational therapy assessment from October 2014 documented that the stairs presented a problem intermittently for residents due to healthcare issues. In addition, inspectors saw that upstairs rooms were accessed frequently which increased the likelihood of falls during certain times of illness. Alternatively, residents would be restricted from going freely to their rooms during these times. While this finding is unchanged, the provider has progressed this issue. In a representation to HIQA, the provider confirmed that plans to build an extension and create two new downstairs bedrooms had been submitted to the Health Service Executive (HSE). The provider nominee confirmed that funding for these plans had been approved. The final time-bound plans have yet to be submitted to HIQA.

At the previous inspection, inspectors found that there was an accessible shower room downstairs that was used by all residents. This was because the other facilities comprising a downstairs bathroom and upstairs shower room were not accessible. However, the use of one shower by a number of residents in any one morning presented difficulties for any resident at risk of falls, as it made it difficult to keep the bathroom floor dry and presented a slip hazard. This was a new finding at this inspection.

At the previous inspection, it was also identified that there were some accessibility issues for residents who used walking aids to get into the kitchen. The kitchen was long and narrow and at the previous inspection, it had been observed that when people were sitting at the kitchen table it was difficult to move the walking aid. This finding was unchanged.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
At the previous inspection, it was found that the risk management system was not sufficiently robust as staff did not understand how to complete a risk assessment. At this inspection, some improvement had been made. Risk assessments had been reviewed and updated since the previous inspection and input from a manual handling instructor had been sought in relation to 'people moving and handling' risk assessments. In
addition, risk assessments were now being discussed at staff team meetings. However, failings were again identified in a sample of risk assessments reviewed. The measures in place to control risks were not always up-to-date. For example, risk assessments referenced a stairlift to manage the risk of falls on the stairs for those accessing upstairs bedrooms. However, the installation of a stairlift was no longer a consideration in this centre. Falls risk assessments underestimated the risk of falls. The initial risk rating in some risk assessments did not reflect other information arising from falls assessments. Occupational therapy reviews in relation to the safety of residents on the stairs and in their bedrooms, categorised as a priority, were outstanding. One review had been outstanding since 15 May 2015 (8 months previously).

At the previous inspection, it was found that the risk management policy did not meet the requirements of the regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. Since the previous inspection, the policy had been updated to meet the requirements of the regulations.

At the previous inspection, it was found that while each resident had an individual evacuation plan which outlined the help that residents would need in the event of an evacuation, this document was unsigned and undated and it was unclear if the information contained in it was valid. At this inspection, while this document was now signed and dated, a further gap was identified in that residents’ names had been removed from the evacuation plan. As a result, it could not be demonstrated that staff would know what support each individual resident would require in the event of an emergency.

At the previous inspection, fire drill records did not demonstrate that staff knew how to safely evacuate residents in the event of a fire as a night-time drill had not been completed within the previous six months, in accordance with the organisation’s policy. Since the previous inspection, a night-time drill had been completed and demonstrated that residents could be evacuated in a timely manner.

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

Findings:
At the previous inspection, inspectors found an absence of evidence in behaviour support plans that every effort had been made to identify the cause of residents' behaviour. Also, multidisciplinary input into behaviour support plans viewed in the centre was limited. Behaviour support plans for residents with behaviour that challenges did not provide adequate guidance for staff. There was no link between the residents' risk assessments relating to responsive behaviours and the behaviour support plan and risk assessments were inadequate. Also, there was insufficient review of strategies through the personal plan.

At this inspection, inspectors found that improvement had been made with respect to the management of responsive behaviours. For example, where there was a change in a resident's behaviours, staff had taken the initiative to commence recording such changes. This allowed for trends to be captured and for triggers to be identified. Such practices and solutions were then discussed by the multidisciplinary team. Also, the person in charge outlined that the multidisciplinary team had reviewed behaviour support plans in place. However, further improvements were required in some areas. There was no input from a suitably qualified and experienced professional into residents' behaviour support plans. As a result, behaviour support plans did not adequately outline how to support residents with responsive behaviours. Management strategies did not address all known triggers, such as staff unfamiliar to a resident working in the centre, the need for 1:1 support to be provided or a dislike of loud noises. Steps to be taken by staff following an incident were not detailed, such as a recording of incidents or how to support a resident following an incident. There did not appear to be a link between the residents' risk assessments relating to responsive behaviour and the behaviour support plan. Risk assessments had not been updated to reflect recent incidents.

At the previous inspection, inspectors found that staff training records indicated that mandatory training in relation to responsive behaviour was not up-to-date for all staff. At this inspection, training records indicated that mandatory training in relation to behaviour that challenges was now up-to-date for all staff.

At the previous inspection, inspectors found that the arrangement in place whereby the centre was being used to provide a day service for a resident not residing in the centre had resulted in the peer-to-peer abusive practices against residents living in the centre. In addition, the organisation's policy to protect residents from financial abuse was not being followed in that all entries were not double-signed. Since the previous inspection, the practice whereby the centre was being used to provide a day service for a resident not residing in the centre had ceased and there were no further incidents of peer-to-peer abuse. A sample of day-to-day financial records indicated that recording was in line with the organisation's policy.

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

Theme:
Safe Services

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

Findings:
At the previous inspection, it was found that not all incidents of peer-on-peer abuse had been notified to HIQA, as required by the regulations. Since the previous inspection, all incidents had been reported to HIQA as required.

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

Findings:
At the previous inspection, it was found that not all residents had had a formal assessment of their training, educational and personal development goals.

There were a number of proposed actions to address this failings both in the provider's action plan submitted following the previous inspection and in the provider's representation to HIQA. While progress had been made in this area, the actions had not been implemented in full.

The provider's action plan outlined that staff between the centre and day service would meet to develop a plan for each individual service user’s education and training needs. In addition, there would be a separate, and designated, section in each care plan to ensure appropriate assessment of education, training and development needs of each service user. Out of each assessment, short, medium and long term goals would be developed with the resident to ensure that residents are afforded every opportunity
available to them around education, training and employment. From a review of personal plans, it was not demonstrated that this action had been fully implemented. Some residents had identified skills development goals, but only one resident had an assessment of their abilities or wishes underpinning such goals.

The provider in a representation to HIQA had stated that staff training would be delivered to support the development of suitable education programs for each resident. The person in charge told inspectors that she had delivered training to the staff team in relation to meaningful activities for residents. It was not clearly demonstrated that this training would be sufficient to support the development of suitable education programs for each resident, as outlined in the provider’s representation.

Judgment:
Substantially Compliant

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

Findings:
At the pervious inspection, it was found that while healthcare records indicated that residents had healthcare needs, these needs were not always written in a plan to direct care. This raised the risk of inconsistent delivery of care to residents. In addition, while there was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required, the recording and follow up care planning required improvement.

At this inspection, inspectors found that improvements had been made. An inspector reviewed a sample of healthcare records and found that some care plans clearly directed the care to be given to residents, for example healthy eating plans were very clear.

However, it was not demonstrated that multidisciplinary team input was always facilitated, based on residents’ needs. In addition, an inspector found that where recommendations had been made by allied health professionals, these recommendations were not always documented in a plan of care and a delay was noted in following up on a recommendation. For example, a speech and language therapist (SLT) had recommended an onward referral to an occupational therapist (OT) on 15 May 2015 but this referral was not made until 6 September 2015. The referral was required in order to ensure the comfort and safety of residents while using the stairs. An OT assessment was
outstanding for two other residents. One assessment was also regarding resident's safety and comfort on the stairs. Another OT assessment was outstanding since 28 September 2015 even though there had been repeated falls in a two month period. All three residents had been assessed as a priority for an OT assessment. Staff told an inspector that an environmental assessment of this house by an OT was also outstanding.

Also, where the SLT recommendations were not incorporated into a plan of care staff were aware of the recommendations to be followed and the rationale behind the recommendations. This failing indicates the need to increase staff understanding of how to use care plans and their importance in ensuring consistency in delivering care. This would be particularly relevant in the event of any staff changes, for example as a result of new or agency staff.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

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

**Findings:**
At the previous inspection, it was identified that while medication prescription records contained the signature of the nurse who transcribed the record, additional controls such as an independent verification were not implemented to safeguard this practice.

At this inspection, an inspector reviewed a sample of medication prescription records and found that they now contained the signature of the nurse who transcribed the record and additional controls such as an independent verification were now in place.

**Judgment:**
Compliant
### Outcome 13: Statement of Purpose

**Theme:**
Leadership, Governance and Management

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

**Findings:**
At the previous inspection, it was found that the Statement of Purpose did not meet the requirements set out by Schedule 1 of the regulations. Since the previous inspection, a revised Statement of Purpose had been submitted to HIQA. However, while some aspects had been rectified in the revised version, the Statement of Purpose still did not meet the requirements set out by Schedule 1 of the regulations.

For example, the specific care needs and services to be provided by the centre to meet those care needs were not clearly set out, including nursing support. The arrangements for residents to access employment were not outlined. In addition, the number, age range and gender of the residents for whom it is intended that accommodation should be provided was not acceptable. The admissions criteria was not sufficiently detailed. Separate facilities for day care were not adequately outlined. This was discussed again with the person in charge during the inspection.

**Judgment:**
Non Compliant - Moderate

### Outcome 14: Governance and Management

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
At the previous inspection, a number of failings were identified in relation to governance and management of the centre.

At the previous inspection, it was found that the person in charge managed four designated centres and this arrangement did not ensure the effective governance, operational management and administration of the designated centres concerned. The provider, in a submission to HIQA, outlined that the area of responsibility for the person in charge would be reduced to two centres. At the time of the inspection, this change had not yet occurred. Additional supports had however been provided to the person in charge in the form of part-time nursing support. The person in charge, however, told the inspector that this nursing support was currently being allocated to another centre, due to current higher needs in that centre. Notwithstanding the overall improvements in this centre since the previous inspection, the number of failings at the level of moderate non-compliance indicates that this arrangement has not yet been satisfactorily addressed. This is evidenced in particular by ongoing gaps in risk management and healthcare planning, which is further compounded by outstanding allied health support in the form of occupational therapy assessments and psychology input into behaviour support plans.

At the previous inspection, it was found that while an unannounced visit to the designated centre had been completed, it was not demonstrated such visits contributed satisfactorily to improving the quality and safety of care delivered in the centre. Since the previous inspection, an unannounced visit had taken place over a two-day period (on 12 and 13 January 2016). Outstanding key areas were also identified in this visit and what action will be taken was included. For example, in relation to the need to complete a robust assessment of residents' training and developmental needs, it was identified that the service is completing an assessment tool to support such an assessment. In addition, it was specified that staffing needs would be assessed through individual MDT meetings and be based on the increasing needs of residents in this centre. An inspector reviewed MDT minutes and found that staffing requirements were being considered and identified during such MDT reviews.

At the previous inspection, it was found that while an annual review of the centre had been completed, it was not demonstrated that the annual review contributed satisfactorily to improving the quality and safety of care delivered in the centre. In addition, the annual review of the quality and safety of care and support in the designated centre did not provide for consultation with residents and their representatives. A copy of the annual review of the quality and safety of care and support in the designated centre had not been made available to residents. Since the previous inspection, consultation with family members had taken place in order to elicit their views and experiences of the service. Also, a copy of the annual review will made available to all families and service user representatives by the person in charge.

At the previous inspection, it was found that the deputising arrangements in the event of the absence of the person in charge for 28 days or more had not been formalised. This has since been addressed and there is a nominated person to deputise in the absence of the person in charge.
At the previous inspection, it was found that the house manager was part-time in this centre (17.5 hours per week) with no allocated supernumerary hours and it was not demonstrated that this arrangement was satisfactory to meet the residents' needs. Since the previous inspection, the person in charge confirmed that additional support has been provided to the centre to allow supernumerary hours for the house manager.

At the previous inspection, it was not demonstrated that the arrangements and supports in place for the provider nominee to govern this centre and 14 other centres in this service were adequate to ensure that the service provided was appropriate to the residents' needs, that it was safe, consistent and effectively monitored. Since the previous inspection, additional supervisory and management arrangements have been put in place. Weekly meetings between the provider nominee, persons in charge and clinical nurse manager (CNM3) have commenced. The person in charge has said that, although this is a recent development, she has found it very beneficial as a support. The person in charge also outlined that she has the support of a CNM3 if required.

The provider in a submission to HIQA outlined other changes to the supports being provided to the provider nominee at service-level, including weekly meetings between the provider nominee and executive team and weekly meetings between the provider nominee and other managers as required to progress alternation and building plans. Evidence of these changes was not available in the centre and the inspector has requested this information from the provider nominee.

**Judgment:**
Non Compliant - Major

---

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

**Findings:**
At the previous inspection, it was not demonstrated that staff had the required skills and qualifications to meet the needs of residents. Overall, while improvement was demonstrated across relevant outcomes, staff required further support to ensure that residents' needs were met.
As previously identified under Outcome 14, an additional staff nurse had been made available to the centre on a part-time basis. However, the person in charge told an inspector that this nursing support was currently being allocated to another centre, due to current higher needs in that centre.

Additional supports for residents in the form of volunteers had been identified through the MDT process and MDT minutes indicated that the person in charge would source any volunteers.

Training in relation to risk assessment and behaviours that may challenge had been delivered to all staff since the previous inspection. However, as previously identified under Outcomes 7, 8 and 11, a greater understanding of the purpose and use of risk assessments, behaviour support plans and care plans in supporting residents was still required.

Training for staff in relation to supporting residents' mealtimes and preventing choking was outstanding for half (three of six) staff who had never been trained. The needs of residents at this centre had identified that there was a risk of choking.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

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

**Findings:**
At the previous inspection, inspectors found that the admissions policy did not take account of the need to protect residents from abuse by their peers. Since the previous inspection, the admissions policy had been revised and now took account of the need to protect residents from this abuse.
At the previous inspection, inspectors found that there was a residents’ guide available in the centre but it did not include the terms and conditions relating to residency. At this inspection, this failing was unchanged and the residents' guide still did not include the terms and conditions relating to residency.

At the previous inspection, inspectors found that in some healthcare files reviews of residents’ healthcare needs by consultant specialists were filed in plastic pockets at the back of the healthcare record and could not be seen. This system did not adequately ensure that relevant healthcare information was available to plan care for residents.

At this inspection, while the specific failing from the previous inspection had been addressed, an inspector found that residents' information overall was disjointed, repetitive and difficult to retrieve. Measures in place to control risks were contained in care plans instead of risk assessments. Information relevant to the delivery of care was contained in a number of places such as residents’ meeting minutes and risk assessments. Information in risk assessments for behaviour that challenges did not inform behaviour support plans. Information contained in falls risk assessments did not inform the risk level of the subsequent risk assessment completed for falls. There were more than 20 healthcare plans in place, some of which were repetitive and made information unwieldy and difficult to retrieve. For example, in one resident's file, there were three care plans that related to the supports the resident required during mealtimes. In addition, the assessment template in use emphasised the assessment of healthcare needs over social, personal development and educational and training needs. As previously mentioned, it was not demonstrated to inspectors that staff used or understand how to use healthcare plans when they are actually needed and an inspector found that this problem was exacerbated by the excessive volume of healthcare plans on file for each resident, many of which were not required. The retention of information in this format carried with it potential risks of staff missing key information and also did not promote the delivery of care in a safe consistent manner. This was discussed in detail with the person in charge during the inspection and has been previously discussed with the provider nominee of the service.

Judgment:
Non Compliant - Moderate
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005157</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>20 January 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 February 2016</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 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:

Some information management practices did not respect residents’ privacy and confidentiality in relation to their personal information.
1. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
All information relating to any individual service user will be discussed confidentially with the individual service user and stored in their file.

**Proposed Timescale:** 20/02/2016

### Outcome 02: Communication

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where residents had been reviewed in relation to their communication needs and recommendations made, the inspector found that those recommendations were not always implemented.

2. **Action Required:**
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

**Please state the actions you have taken or are planning to take:**
The Speech and Language Therapist recommendations for this service user have been reviewed by all staff and are transferred to the care plan following this inspection. All staff will adhere to the recommendations made. The Person in Charge has actioned this.

**Proposed Timescale:** 20/02/2016

### Outcome 05: Social Care Needs

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further progress was required to ensure that the review of the personal plan was multidisciplinary, as required by the Regulations. MDT meetings were outstanding for two residents. In addition, due to the lack of dedicated psychology support in the service, psychology input into the MDT review or personal plan was not available.
3. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
The recruitment process is ongoing for psychology.

The Chief Executive Officer is examining alternative avenues i.e. private consultants for psychology support for the centre. Two days prior to the inspection of this centre a full time occupational therapist was employed, who will support the service users of this centre.

Outstanding multidisciplinary team meetings will be scheduled by the Person in Charge and as part of this meeting goals will be reviewed to ensure they are multi disciplinary. All service users will have an annual multi disciplinary review. The appropriate multi disciplinary members will be in attendance at the annual review. The person in charge and the Clinical nurse manager 3 will plan the schedule of dates for the reviews. The nominee provider has addressed the requirement for multi disciplinary involvement in the annual reviews for service users and in the review of goals at a meeting on 26/03/2016 with the assistant CEO and with the heads of multi disciplinary teams. At present due to lack of psychology support for the centre the nominee provider has arranged for the support of an instructor in the therapeutic management of aggression and violence to support the service users and staff teams around supporting people with challenging behaviour. The person in charge is currently arranging dates with the instructor to support the team in the centre. The multi disciplinary team involved in service users care will have their recommendations included as part of the service users plan of care, when plans of care are reviewed the person in charge will involve the relevant multi disciplinary team member to ensure the effectiveness of the plan that the recommendations and plan are linked and ensure the achievement of positive outcomes for the service user.

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to the setting of personal goals as the supports required to meet goals were not specified.

**4. Action Required:**
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident’s personal development in accordance with his or her wishes.
Please state the actions you have taken or are planning to take:
For each goal identified for service users there will be a named responsible person to ensure the goal is monitored and achievement status tracked and the required supports regarding staffing resources or financial will be outlined and detailed for each goal. The Person in Charge will monitor this for each service user’s person centred plan goals.

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme:</td>
<td>Effective Services</td>
</tr>
</tbody>
</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As outlined under this outcome and outcome 10, a comprehensive assessment of residents’ training, education and personal development needs had not been completed for all residents with goals developed based on such an assessment.

5. **Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
An assessment tool had been piloted which was not found to meet the needs of service users. The Quality and Risk Officer is chairing a committee to further examine and develop an appropriate assessment tool.

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>30/04/2016</th>
</tr>
</thead>
</table>

### Outcome 06: Safe and suitable premises

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Effective Services</th>
</tr>
</thead>
</table>

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were issues relating to the accessibility of the centre in relation to the kitchen and in particular, residents being able to access upstairs bedrooms at all times.

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

Please state the actions you have taken or are planning to take:
The Director of Logistics has met with the Person in Charge, Nominee Provider and service user in the centre on the 04/02/2016. At this meeting outline of proposed
development of bedroom, bathroom and extension for kitchen/dining were outlined. Plans will be complete for 23/02/2016 and the Director of Logistics will again visit the staff team and service users to outline the plans and progress to submitting same for planning approval.

The plan of works and timescale for this completion is as follows preparation of planning permission, newspaper advert etc 30/04/2016. Planning approval period of 3 months 31/07/2016. Preparation of tender package and tender period of 3 months, 31/07/2016. Commence work on site 31/08/2016. Completion of works 30/11/2015. The plans are being submitted to the authority on 09/03/2016.

**Proposed Timescale:** 30/12/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was not demonstrated that the centre had provided baths, showers and toilets of a sufficient number and standard suitable to meet the needs of residents.

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

**Please state the actions you have taken or are planning to take:**
The Person in Charge has met with staff team and outlined that the shower room is to have its floor dried after each service user exits the room, so that it is dry and clean for the next residents use.

The second bathroom will be reviewed by the Director of Logistics. Based on service users wishes the bath can be replaced with a shower/wet room to provide an additional shower area. This work will be included in the overall building works to the centre. The plan of works and timescale for this completion is as follows preparation of planning permission, newspaper advert etc 30/04/2016. Planning approval period of 3 months 31/07/2016. Preparation of tender package and tender period of 3 months, 31/07/2016. Commence work on site 31/08/2016. Completion of works 30/11/2015. The plans are being submitted to the authority on 09/03/2016.

**Proposed Timescale:** 30/12/2016
## Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further improvement was required to the risk management system. Failings were again identified in a sample of risk assessments reviewed. The measures in place to control risks were not always up-to-date. For example, risk assessments referenced a stair-lift to manage the risk of falls on the stairs for those accessing upstairs bedrooms. However, the installation of a stair-lift was no longer a consideration in this centre. Falls risk assessments under-estimated the risk of falls. The initial risk rating in some risk assessments did not reflect other information. Occupational therapy reviews in relation to the safety of residents on the stairs and in their bedrooms, categorised as a priority, were outstanding. One review was outstanding since 15 May 2015 (8 months previously).

### 8. 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:
Training for all staff in risk assessment will be scheduled by the Person in Charge.

All risk assessments in the centre will be reviewed by the Person in charge, Clinical Nurse Manager 3 and home manager to ensure all are appropriate to service user needs and that all risks are identified and appropriate control measures put in place.

The current falls risk assessment is being reviewed at service level. This assessment will be piloted and circulated for use in the centre.

### Proposed Timescale: 30/04/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents' names had been removed from the evacuation plan. As a result, it could not be demonstrated that staff would know what support each individual resident would require in the event of an emergency.

### 9. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.
Please state the actions you have taken or are planning to take:
At inspection the staff entered all service users names on the Personal Emergency Evacuation Plans. Same now available at exit doors in centre.

**Proposed Timescale:** 20/01/2016

---

**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:

As detailed within the findings, further improvement was required with respect to the management of behaviours that may challenge to address previously identified failings:

- Multi-disciplinary input into behaviour support plans viewed in the centre was limited.
- Behaviour support plans for residents with behaviour that challenges did not provide adequate guidance for staff.
- There was no link between the residents' risk assessments relating to behaviour that challenges and the behaviour support plan and risk assessments were inadequate.

10. **Action Required:**

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The Service Chief Executive Officer is continuing in the efforts to recruit and/or purchase contracted designated psychology posts for the centre. A Therapeutic Management of Aggression and Violence (TMAV) instructor from another part of the service will deliver support to staff in the centre. On developing behaviour support plan that provide guidance to staff to support service users that present with challenging behaviour.

Person in Charge, Clinical Nurse Manager 3 and home manager will review all behaviour support plans. Where behaviours present and there are associated risks, a risk assessment will also be completed to support the individual and to help control the risk indicated. The behaviour support plan and the risk assessment will complement each other.

**Proposed Timescale:** 30/04/2016
### 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:

While progress had been made in relation to completing an assessment of residents' education, training and skills development wishes and abilities and developing goals based on such an assessment, some actions were outstanding.

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

**Please state the actions you have taken or are planning to take:**
The development of the training, development and education tool is being drafted by a committee chaired by the Quality and Risk Officer.

All service users care plan will include a plan of their training needs and wishes. These will be broken into short, medium and long term goals as appropriate to each individual.

**Proposed Timescale:** 30/04/2016

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

Where residents had healthcare needs, these needs were not always written in a plan to direct care. This raised the risk of inconsistent delivery of care to residents.

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

**Please state the actions you have taken or are planning to take:**
The plan of care will include the recommendation from multidisciplinary staff to ensure that care is appropriately directed to meet service users assessed need.

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

**Theme:** Health and Development

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

It was not demonstrated that multi-disciplinary team input was always facilitated, based on residents' needs.
A delay was noted in following up on a recommendation from an allied health professional. A speech and language therapist (SLT) had recommended an onward referral to an occupational therapist (OT) on 15/5/2015 but this referral was not made until 6/9/2015.

Occupational therapy assessments were outstanding in relation to suitability of upstairs bedrooms and in relation to falls management.

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

**Please state the actions you have taken or are planning to take:**
The Person in Charge will follow up on all multidisciplinary referrals and ensure dates agreed and confirmed for assessments to be completed.

The Clinical Nurse manager 3, Person in charge and key workers will review all care plans and ensure that all clinicians recommendation are included with each plan of care for each assessed need.

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

---

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Statement of Purpose still did not meet the requirements set out by Schedule 1 of the Regulations.

For example, the specific care needs and services to be provided by the centre to meet those care needs were not clearly set out, including nursing support. The arrangements for residents to access employment were not outlined. In addition, the number, age range and gender of the residents for whom it is intended that accommodation should be provided was not acceptable. The admissions criteria was not sufficiently detailed. Separate facilities for day care were not adequately outlined. This was discussed again with the person in charge during the inspection.

14. **Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
Please state the actions you have taken or are planning to take:
Statement of Purpose will be reviewed and submitted to the Authority.

Proposed Timescale: 02/03/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Notwithstanding the overall improvements in this centre since the previous inspection, the number of failings at the level of moderate non-compliance indicate that the arrangements in place in relation to the governance and management of the centre are still not satisfactory. This is evidenced in particular by on-going gaps in risk management and healthcare planning, which is further compounded by outstanding allied health support in the form of occupational therapy assessments and psychology input into behaviour support plans.

15. Action Required:
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.

Please state the actions you have taken or are planning to take:
The service is continuing its recruitment for a Person in Charge post, this post when appointed will reduce the current number of areas of responsibility to the current Person in Charge.

The vacant Clinical Nurse Manager 3 post has been filled and the post holder is due to commence in March 2016. This will provide additional clinical supervision and support to the centre.

The Chief Executive Officer and Director of H.R. in addition to recruitment are also sourcing psychologists on a consultancy basis to support the designated centre.

Proposed Timescale: 30/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings, while improvement was demonstrated across relevant outcomes, staff required further support to ensure that residents' needs were met.
16. **Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
Staff without a formal healthcare qualification are undertaking FETAC Level 5 - due to complete same in November 2016.

Staff nurse hours assigned to the centre are in place since inspection.

The request has been made prior to the inspection to the volunteer co-ordinator for further volunteer support to the centre. The Person in Charge will link with the volunteer co-ordinator to establish any progress on this.

TMAV (Therapeutic Management of Aggression and Violence) instructor will be sourced to deliver training on behaviour support plan to the centre.

A Clinical Nurse Manager 3 from another part of the organisation will deliver training to the staff in the centre on risk assessments and identification of risks and identifying control measures.

The Person in Charge will arrange first aid training for all staff in the centre, from the “first responder” local community team.

**Proposed Timescale:** 15/05/2016

---

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The residents’ guide did not include the terms and conditions relating to residency.

17. **Action Required:**
Under Regulation 20 (2) (b) you are required to: Ensure that the guide prepared in respect of the designated centre includes the terms and conditions relating to residency.

**Please state the actions you have taken or are planning to take:**
The residents guide will be revised and submitted to the Authority to meet the regulations.

The Person in Charge, Clinical Nurse Manager 3 and home manager will meet with the Nominee Provider who will support and outline information to be stored in up to date files. Completed by 15/03/2016.
Out of date information, not relevant to directing care to date will be archived in a retrievable fashion.

**Proposed Timescale:** 15/03/2016

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At detailed within the findings, residents' information overall was disjointed, repetitive and difficult to retrieve.

18. **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:
The Service has a committee reviewing the care plan document. The new reviewed care plan will identify all care and support needs, however will have a focus on the social and development aspects.

The Nominee Provider and Person in Charge are meeting re archiving of documentation on 01/03/2016, to ensure relevant and necessary information is available in the care plan and all other information will be removed and archived to ensure that it is in a retrievable format if/when needed.

**Proposed Timescale:** 30/06/2016