

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0005162
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd
<b>Provider Nominee:</b>	Breda Noonan
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
03 November 2015 10:00	03 November 2015 18:00
04 November 2015 09:00	04 November 2015 16:00

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

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

**Summary of findings from this inspection**

This inspection was carried out in response to an application by the provider to register the designated centre. It was the second inspection of this designated centre. This designated centre comprises of one community house in a rural village and can accommodate five residents.

At the previous inspection, a high-level of non-compliance was identified by inspectors with seven outcomes at the level of major non-compliance. At this inspection, inspectors found that improvement had been made in a number of areas. Major non-compliances relating to the premises, health and safety and the

notification of incidents had been reduced since the previous inspection. The centre was now visibly clean and maintenance and decorative work had taken place since the previous inspection. Staff had received support in relation to healthcare planning, personal planning and risk assessment. An additional care staff member had also been employed in the centre.

Staff demonstrated that they knew residents well. Staff were observed to support residents to use verbal and non-verbal communication to express their choices, feelings and wishes.

However, four outcomes were found to be at the level of major non-compliance at this inspection.

Outcome 5 remains at the level of major non-compliance as the designated centre did not meet the assessed needs of all residents. The centre failed to meet residents' need for either a quiet or calm environment or a safe place in which to live. Inspectors observed that the mix of residents in the centre appeared to cause tension and to upset individual residents.

Outcome 8 remains at the level of major non-compliance as an unsuitable mix of residents in the centre was leading to peer-to-peer abuse. Behaviour that challenges took the form of verbal abuse, threatening behaviour and an incident of a physical assault against another resident in the centre was documented in 2014. While steps had been taken that had helped manage the situation, the situation was on-going and was continuing to have a negative impact on residents in the centre.

Outcome 14 remains at the level of major non-compliance as failings relating to the governance of the centre had not been satisfactorily addressed since the previous inspection. The person in charge was in charge of four designated centres over a broad geographical area and it was not demonstrated that this arrangement could ensure the effective governance, operational management and administration of this designated centre.

Outcome 17 remains at the level of major non-compliance. Despite increased staffing levels since the previous inspection, it was not fully demonstrated that staffing levels and skills mix met the assessed needs of residents. Impacts included limited activities and opportunities for residents at weekends. In addition, not all mandatory training was up-to-date for relief or agency staff who worked in the centre.

HIQA did not agree the action plan with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to Regulations 5(3) and 8(2) under Outcomes 5 and 8 respectively were not accepted as they did not satisfactorily address the failings identified.

Further improvements were required in relation to healthcare planning, risk assessment and the maintenance of documentation to ensure the delivery of safe consistent care. Findings are discussed in the body of the report and outlined in the action plan at the end of this report.

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

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Improvements were required in relation to ensuring all complaints were appropriately followed-up with, in relation to personal information and consent.

There was a user-friendly complaints procedure in place and information relating to residents' rights. Inspectors found that a new complaints log was in use. Inspectors found that staff had supported four residents in the centre to make a complaint in November 2014. The complaint had been acknowledged in writing by a senior manager and the respondent had committed to meeting with the residents to discuss their concerns, however, this meeting never took place. The complaint related to peer-to-peer abuse and will be further discussed under Outcomes 5 and 8 and has yet to be resolved.

Arrangements were in place for consultation with residents. Monthly meetings were held with residents. Menus were discussed and planned weekly. Participation at such meetings was recorded. Activities since the previous meeting were also recorded. Inspectors observed a number of references in the meetings to conflict in the centre and this will also be further discussed under Outcomes 5 and 8.

Arrangements were in place to protect the privacy and dignity of residents. Bathroom doors could be locked and residents who chose to lock their bedrooms were able to do so. Staff members spoke to residents in an appropriate manner. However, personal information was not fully respected as inspectors observed healthcare information recorded in the communication diary. For example, a discussion around consent for dental extraction was recorded in the communication diary. In addition, it was not demonstrated that the decision-making process around consent for medical or healthcare treatment was understood by those with responsibility for managing the

centre.

**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):**

No actions were required from the previous inspection.

**Findings:**

Communication assessments had been completed for all residents which outlined the methods residents use to communicate their needs and wishes. Personal plans viewed by inspectors contained detailed information in relation to the individual communication requirements of each resident.

Inspectors observed that staff were aware of residents' communication plans and reflected the plans of care in practice. Inspectors observed that staff supported residents to communicate effectively. Residents, including those who did use verbal communication, were supported to communicate at all times. Picture boards were observed to be used by staff and residents to communicate.

Residents had access to specialist speech and language services. Inspectors saw that the recommendations from external professionals were implemented for residents such as the use of picture aids and computer tablets.

In the sample of healthcare files seen by the inspectors there were recommendations from the speech and language therapist that residents would benefit from a communication "passport" in an easy-to-read format. The passport identified issues including family support, home life, work life, likes/dislikes and any particular area where support was required. This work was being developed with the speech and language therapist.

Each resident had an acute hospital communication booklet which was available in case a resident had to be admitted to hospital which outlined things that hospital staff needed to know about the resident.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that positive family and personal relationships were supported. Residents were part of the community in a meaningful way.

There was a policy on visiting and it was demonstrated that families were welcome and free to visit. Family relationships were supported by staff in various ways as applicable to each individual resident. Residents were supported to visit their family members and to stay in their family home. Family were invited to attend personal planning review meetings. Relationships with friends were also supported and encouraged.

Residents participated in the community as part of their day-to-day lives. Residents told inspectors that they enjoyed going for walks in the nearby 'eco-village', for a drink in the local pub or to the local church. This was facilitated by staff where required. One resident was a member of a local community group and attended along with neighbours. Other community-based facilities were accessed according to the wishes and interest of residents, including weight-loss programmes and sports and leisure facilities.

Community participation also formed part of residents' personal plans and life skills development programmes. Residents were supported to go to the bank, grocery shopping, Mass, massage therapy and the hairdresser. Residents identified new opportunities they may wish to participate in as part of their personal plan, such as joining 'tidy towns' and visiting the local radio station.

**Judgment:**

Compliant

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

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The admission practices and policies had been updated to take account of the need to protect residents from abuse by other service users.

Inspectors reviewed a sample of resident's contracts of care and found that they had been signed either by the resident or their representative. The sample contracts seen by the inspectors included: personal effects; staffing arrangements; provision for family contact; policies; assessment/care planning; medication management; suggestions; comments/complaints and; insurance.

The contract also outlined the residential charges for accommodation of the resident. Two appendices at the back of the contract outlined a number of different charges that could be applied.

**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:**

Actions arising from the previous inspection were followed up on this inspection.

At the previous inspection, it was found that the centre was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the centre. There were queries relating to the future accommodation needs of two residents. While the future accommodation needs of one resident had been clarified since the previous inspection, the centre did not meet the needs of another resident. The environment did not meet this resident's need for either a quieter or calmer environment. There was documentary evidence that this was having a negative impact

on behaviours that may challenge of both the individual resident and other residents in the house. Inspectors found that these issues had been identified and documented since July 2014. Since the previous inspection, a referral had been made to the organisation's relevant committees that oversee such placement issues (the Admissions, Discharges and Transfers Committee and the 'service user review committee'). Individual resident's wishes regarding their future living arrangements had been explored and discussed. Inspectors reviewed minutes dated 3 November 2015 that outlined the next steps involved in addressing this issue. At the time of inspection there was no concrete plan to resolve this issue, however, the timeframe for resolving this issue of 31 December 2015 had not yet passed. This failing however will remain at the level of major non-compliance due to the negative impacts on residents in the centre of the unsuitable arrangement until it is resolved.

At the previous inspection, it was found that the assessment of needs was not comprehensive, where needs supports or risks were identified other specific plans had not always been completed (including health plans, risk assessments and behaviour intervention plans) and some needs had not been appropriately assessed. At this inspection, it was found that health plans, risk assessments and behaviour intervention plans were in place for any assessed needs. Where areas required improvement, these are discussed further under the relevant outcomes relating to risk management, behaviour support and documentation (Outcomes 7, 8 and 18).

At the previous inspection, it was found that the review of personal plans was not multidisciplinary, as required by the Regulations. At this inspection, this finding was unchanged as multidisciplinary reviews were not informing personal planning. The timeframe for meeting this action following the previous inspection was 30 September 2015 and had passed.

At the previous inspection, it was found that the system in place for the review of personal plans did not meet the requirements of the Regulations. For example, the setting and monitoring of personal goals required improvement. Also, it was not always clear who was responsible for each goals and within what timeframe. The supports required for residents to achieve their goals were not specified. At this inspection, inspectors reviewed personal plans and found that they were all up-to-date. Goals reflected residents' individual interests, wishes and abilities. Examples of goals included continuing Special Olympics membership, joining community groups, personal development and pursuing interests such as gardening. Goals were reviewed on a monthly basis. Improvements required related to inconsistencies about what constituted a goal, for example, some goals viewed were healthcare requirements. In addition, the supports required for residents to realise their goals were outlined in some personal plans but not others. There were inconsistencies between personal plans. The expected outcome of the goal was not always clear.

**Judgment:**  
Non Compliant - Major

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The centre was a seven day residence and provided accommodation for five residents in a three-storey house located in a community setting in the town.

Since the previous inspection works had been completed in relation to ensuring the premises was clean; this included living areas, bathroom and shower areas. There had been upgrading of the centre by painting, repairing damaged walls and undertaking some tiling work in the hallway. However, the carpet on the landing on the first floor had not been replaced and the door handles on the front door still appeared to be damaged.

In terms of layout of the house, the front door led to a hallway. There was a large kitchen/dining room with dining table and chairs. The kitchen led to a living room which had a large couch and two armchairs. There was a large garden with a 'men's shed' for one of the residents who liked to go there for quiet time.

Each resident had their own bedroom which was personalised with soft furnishings of their choice, photographs and personal memorabilia. Ample space was provided for each resident to store and maintain clothes and other personal possessions. One resident's bedroom was downstairs. There were four other residents' bedrooms; two on the first floor and two on the second floor.

There were four bathrooms, one on the ground floor, two on the first floor and one on the second floor. The person in charge outlined proposals to convert the bathroom on the ground floor into a "wet room".

**Judgment:**

Substantially Compliant

## Outcome 07: Health and Safety and Risk Management

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

### Theme:

Effective Services

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

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

### Findings:

Actions arising from the previous inspection were followed-up on this inspection.

Since the last inspection there had been a review of infection control practices. A deep clean of the centre had been carried out and up-to-date cleaning schedules were in place. Towels and facecloths were no longer being shared and paper towels for drying hands were now available in all bathrooms. There had been an infection control audit by a nurse from the St Anne's service in October 2015 with a score of 92%. A number of issues had been identified on that audit which had all been remedied. There was an infection control folder in place and inspectors noted that the infection control guidance and information available was not up-to-date. This will be addressed under Outcome 18: Records Management.

There had been some actions undertaken in relation to fire safety since the last inspection. The chair blocking the fire exit in the front hallway had been removed. The other fire exits were unobstructed and each final exit door had a key in a break glass unit. In addition, fire evacuation arrangements were on display at each fire exit. However, in relation to emergency planning, the personal evacuation plan that was to outline the assistance that residents would need in the event of an evacuation only indicated residents' mobility status and not the assistance that each resident required to leave the building in an emergency.

Records showed that all staff had received fire safety training. There were monthly fire evacuation drills being undertaken involving the residents. The records available of drills conducted since July showed that the response time to evacuate the premises ranged from two to five minutes. The evacuation route from the second floor included accessing an external stairwell via an exit on the first floor. Inspectors were not given a copy of a risk assessment on the access to this external stairwell from outside.

The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of servicing of fire alarm system and alarm panel, fire extinguishers and emergency lighting in October 2015.

There was a St Anne's service risk management policy which was supplemented by a local procedure on risk management. This local procedure included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm, as required by the Regulations.

At the previous inspection, it was found that the process for hazard identification and assessment of risk throughout the designated centre was not understood by staff. At this inspection, risk assessments had been updated and were in place where required. Some further improvement was required in relation to ensuring that controls were specific to managing the risk posed to an individual and that risk ratings adequately reflected the actual risk to residents. For example, where a resident had unsupervised time in the house, it was not demonstrated how this relatively new arrangement constituted a low risk.

Inspectors reviewed the incident reporting records from May 2015 to October 2015 and saw records for six incidents relating to behaviour issues, medication error and accidents. There was evidence that these incidents had been followed-up appropriately.

**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:**

Actions arising from the previous inspection were followed-up on this inspection. The actions from the previous inspection had not been satisfactorily implemented.

As previously mentioned under Outcome 5, there was an unsuitable mix of residents in the centre. This was leading to behaviour that challenges against other residents in the centre. Behaviour that challenges took the form of verbal abuse, threatening behaviour and an incident of a physical assault against another resident in the centre was documented in 2014. These incidents were being recorded and multidisciplinary involvement had been sought. On the evening of the first day of inspection, a resident was observed to shout at another resident to "shut-up" and proceeded to slam the TV room door shut, in which the second resident was sitting. The resident in the TV room could be heard becoming agitated and calling out loudly as a result before being re-assured by a staff member. Through observation, inspectors formed the opinion that

another resident appeared to be anxiously waiting to see what form the same resident who had shouted and slammed the door was in on their arrival home. The person in charge told inspectors about changes since the previous inspection that had helped manage the situation, such as the provision of an individualised day service. However, inspectors found that this failing was at the level of major non-compliance as the situation was on-going and was continuing to have a negative impact on residents in the centre.

At the previous inspection, a staff member had not received up-to-date training in relation to the protection of vulnerable adults and all staff required up-to-date training in relation to the management of behaviour that challenges. Training records for agency staff were not available for review at the time of inspection. At this inspection, 'core staff' had received mandatory training in relation to the protection of vulnerable adults and the management of behaviour that challenges. However, not all relief or agency staff who worked in the centre had received training in the management of behaviour that challenges.

At the previous inspection, the person in charge had failed to ensure that every effort was made to identify and alleviate the cause of residents' behaviour; 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. In addition, the required documentation was not in place, in accordance with national policy. Since the previous inspection, restrictions had been reviewed and the issues identified at the previous inspection had been addressed. However, further improvement was required in relation to the use of p.r.n. medicine (a medicine only taken as the need arises). Inspectors spoke with a staff member who was able to clearly articulate when to administer p.r.n. medicine. However, the written guidance in place in relation to the use of that p.r.n. medicine was not sufficiently clear to ensure that all staff were clear in relation to when to administer the medication and had not been signed off or approved by the prescriber of the medication. In addition, the effects of such medication were not being properly recorded (for example, whether a resident was drowsy following administration of the medicine). This gap had also been identified in a recent audit by the pharmacist.

It was not demonstrated that staff had up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that challenged and to support residents to manage their behaviour. Behaviour support plans were not always sufficient to direct staff, as identified at the previous inspection, and had not been developed with specialist behaviour support input. This action was to have been completed by 31 July 2015 but was outstanding at the time of inspection.

**Judgment:**  
Non Compliant - Major

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

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

**Findings:**

At the previous inspection it was found that while incidents of peer-on-peer abuse were being recorded, they had not been notified to HIQA in line with the Regulations.

Since the previous inspection, all incidents had been notified as required. In addition, a written report at the end of each quarter in relation to incidents occurring in the centre was submitted 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):**

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

**Findings:**

At the previous inspection, it was identified that not all residents availed of a suitable day service. Since the previous inspection, an individualised day service was being provided 25 hours per week and a resident had access to a 'drop-in' day service, should they wish to avail of such a service. A weekly schedule was now in place for the same resident. Where a resident was nearing retirement and wished to reduce the number of hours that they attended their day service, a plan was in place to facilitate this. Other residents attended day services and residents told inspectors that they enjoyed their day service. Residents also had programmes relating to skills development, including using the phone and hand hygiene.

However, a robust assessment was not in place to establish each resident's educational, employment or training goals, as required by the Regulations.

**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):**

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

**Findings:**

At the previous inspection, assessments that considered residents' healthcare needs were not comprehensive and required significant improvement. In addition, where a resident displayed weight loss, an assessment for malnutrition screening had not been organised by the person in charge. At this inspection, inspectors found that residents' healthcare needs were being met. Where a resident displayed weight loss, a review by a dietician and clinical nurse specialist in food and nutrition had been completed. A special diet had been developed and was being followed by staff. A care plan had been developed and weekly weights were recorded.

Residents had access to a general practitioner (GP) and other healthcare professionals as required. However, inspectors found that a resident had been attending and paying for an alternative therapy and it was not clear how this recommendation for therapy had been made. There was no recommendation for the therapy in the most recent multidisciplinary team actions contained in that resident's file dated 6 July 2015.

**Judgment:**  
Substantially Compliant

**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:**

Since the previous inspection it was found that all medication prescription records now contained the signature of a second nurse to check the transcribed record as required by the centre's medication policy. The practice of transcription was now in accordance with professional guidance issued by An Bord Altranais.

Medication was dispensed from the pharmacy in a monitored dosage system which packaged the medication for each resident for the correct time each day. The monitored dosage system also contained the name, address and date of birth of the resident. The medication was checked by staff on delivery from the pharmacist and was kept securely in a locked cabinet. Staff spoken with knew what medication was needed for each resident. Staff also demonstrated a knowledge of how medications might be withheld, if required.

Staff with whom inspectors spoke demonstrated knowledge and understanding of principles in relation to safe medication management practices. An inspector observed the administration of medicines and saw that this was evidenced in practice.

An inspector reviewed a sample of prescription and medication administration records. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications.

There were no medicines requiring refrigeration at the time of inspection. The person in charge confirmed that they had access to a refrigerator for the storage of medicines that required refrigeration if needed. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

Staff outlined the manner in which medicines which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

A medicines management audit had been completed in October 2015 by the supplying pharmacist with a number of findings and actions identified. These recommendations were being reviewed by the service.

**Judgment:**

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):**

No actions were required from the previous inspection.

**Findings:**

There was a written Statement of Purpose which outlined the aims, objectives and ethos of the centre and the services provided in the centre. However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, the criteria used for admission to this centre were not specified, the age range was too broad and it was not specified that the centre could provide an individualised day service.

**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):**

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

**Findings:**

The nominee on behalf of the Daughters of Charity Services was a registered general nurse and a registered nurse in intellectual disability. She had been appointed in February 2015 as services manager in this service in North Tipperary/Offaly on a secondment from another service managed by the Daughters of Charity. However, this appointment was only a temporary post until the end of the year and St Anne's had advertised for a permanent services manager for North Tipperary/Offaly. At the time of inspection, there was uncertainty around the post of the services manager and the potential impact on the governance and leadership currently being provided.

The person in charge had a management qualification and a General National Vocational Qualification (GNVQ) level 2 in health and social care from Britain. He had over 10 years experience of working with people with a disability in Britain and had been the area manager with the Daughters of Charity service since 2006. Since the previous inspection, the person in charge had commenced a diploma course in social care in National University of Ireland, Galway with an option to progress to a degree. However,

the person in charge was in charge of four designated centres, comprising five houses across a broad geographical area. As found on the previous inspection, it was not demonstrated that this arrangement ensured the effective governance, management and administration of the designated centre.

At the previous inspection, inspectors found that while there was a defined management structure in place, this required review as both the person in charge and the provider nominee were actively managing a number of other centres across a broad geographical area. The house manager was part-time in this centre (17.5 hours per week) and worked the remainder of the week in another centre 10kms away. At this inspection, it was found that additional support to the provider nominee was in place, in the form of a level 3 clinical nurse manager (CNM3). Additional training and support had also been provided to the staff team to assist with personal planning and healthcare plans. However, inspectors found that while there was a management system in place in the designated centre, it did not ensure that the service provided was safe, appropriate to residents' needs and effectively monitored as evidenced in outcomes 1, 5 and 8. For example, the supports in place were still not sufficient to meet the needs of residents, particularly in relation to supports for behaviour that challenges. In addition, the remit of the person in charge had yet to be reduced and the person in charge was still in charge of four designated centres comprising five houses. The effectiveness of this arrangement had not been demonstrated.

Provider visits to review quality and safety are required under the Regulations every six months. A review had not been completed within this timeframe since the Regulations commenced. The most recent review available in the centre was 19 October 2015. While some aspects of the review were comprehensive, other aspects did not meet the requirements of the Regulations. For example, the suitability of the designated centre to meet the needs of residents was not reviewed.

An annual review had been completed in January 2015, as required by the Regulations. Gaps in relation to the annual review had been highlighted at service level and steps were being taken to address this before the next review would be completed. For example, a satisfaction survey was being completed with families.

**Judgment:**  
Non Compliant - Major

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

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

**Theme:**  
Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. There had not been any period where the person in charge was absent for 28 days or more since the last inspection. The person in charge and the nominated registered provider were aware of the obligation to inform the Chief Inspector if there was any proposed absence of the person in charge. There were clear arrangements to cover for the absence of the person in charge with the level 3 clinical nurse manager (CNM3) having responsibility for management of the centre during any such periods of absence.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

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

**Theme:**

Use of Resources

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

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

**Findings:**

The facilities and services in the centre reflected the Statement of Purpose. Maintenance issues identified at the previous inspection had been addressed or were in the process of being addressed. Outstanding repairs were scheduled to be completed. Resources had been allocated to cleaning of the centre since the previous inspection. Equipment and furniture was provided in accordance with residents' wishes.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

At the previous inspection, a major non-compliance was identified in relation to staff numbers, staff training and skills mix in this centre. At this inspection, inspectors found that while steps had been taken, the failings had not been adequately addressed.

At the previous inspection, it was not demonstrated that staffing levels and skills mix met the assessed needs of residents. Since the previous inspection, an extra full-time care staff had commenced in the centre (35 hours per week). The person in charge told inspectors that this allowed for an extra staff member to be rostered in the mornings. The house manager explained that arrangements in relation to transporting residents to and from their day service were now being shared with another centre and this freed staff up to be in the centre more. The person in charge told inspectors that additional staff were still required and that a recruitment process was underway with an additional care assistant due to be assigned to the centre.

Also at the previous inspection, it was not demonstrated that staffing levels were sufficient to facilitate residents' activities and interests at weekends. The house manager told inspectors that they were trialling a new rota at weekends to increase staffing levels. Inspectors reviewed the rota and observed that this change was very recent. As a result, any positive impact of such changes since the previous inspection was not yet demonstrated. Inspectors reviewed activities at weekends in September and October and found that activities were limited. For example, one resident did not avail of any opportunities outside of the centre for two consecutive weekends in October. According to the provider's response following the previous inspection, this was meant to have been addressed by 31 July 2015.

At the previous inspection, it was not demonstrated that the skills mix of staff met the assessed needs of residents. Since the previous inspection, support had been provided to the centre from clinical nurse managers (CNMs) in other parts of the service in relation to risk assessments, personal plans and healthcare planning. However, as previously mentioned, further support was required in relation to risk assessment and behaviour that challenges. As is mentioned under Outcome 18, a review of healthcare planning in the centre is required.

At the previous inspection, it was not demonstrated that staff were adequately supervised. Formal 1:1 communication meetings between the person in charge and the house manager had not taken place since the house manager commenced in her role in the centre. Since the previous inspection, the person in charge had held two formal meetings with the house manager and a supervision meeting had also taken place between the CNM3 and the person in charge. House meetings were held regularly and

minutes clearly outlined agenda items, discussions that took place and any required actions.

At the previous inspection, it was found that not all mandatory training was up-to-date. At this inspection, it was found that mandatory training for all permanent staff was up-to-date. However, there were gaps in mandatory training for relief or agency staff who worked in the centre. Two staff required training in relation to the management of behaviour that challenges and fire safety. Training records were not available for three staff in relation to hand hygiene. According to the provider's response following the previous inspection, this was meant to have been addressed by 17 June 2015.

**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):**

No actions were required from the previous inspection.

**Findings:**

Improvements were required in relation to the management of records and policies.

Residents' records were stored securely. Residents' records as required under Schedule 3 of the Regulations were maintained. As mentioned in Outcome 8, improvements were required to the documentation pertaining to behaviour that challenges. Behaviour support plans required review and updating by persons with specialist training and experience in relation to behaviour that challenges.

Healthcare records also required improvement. Medical files required streamlining, for example, reviews that had been completed by the psychiatrist were held in two different files and in different parts of the same file. Some medical information had been paraphrased by care staff inaccurately. For example, where a medication had been reduced, care staff had recorded that it had been discontinued. This practice required review. In addition, while healthcare plans were up-to-date since the previous inspection, it was not demonstrated that they directed the care to be given to the

resident. This was discussed in detail with the provider nominee at the close of inspection.

There was also evidence of inconsistent information being maintained on residents' healthcare files. For example, in one resident's profile it had said that "staff keep a sleep pattern monitoring sheet" for the resident. However, in the resident's intimate care plan it had indicated that the sleep charts had been stopped from November 2014 as "correct recording could not be made when staff are asleep on sleepovers".

Records listed in Schedule 4 to be kept in a designated centre were all made available to the inspector. Staff records were held centrally in the Dublin office of the Daughters of Charity and were not inspected as part of this inspection.

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

All of the key policies as listed in Schedule 5 of the Regulations were in place and were made available to staff who had signed each policy as read and understood. However, improvements were required to a number of policies. The guidance on infection control available in the centre did not reflect current national policy in relation to hand hygiene training or audits. The safeguarding policy required improvement to ensure that it addressed how to manage anonymous concerns in a satisfactory manner.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0005162
<b>Date of Inspection:</b>	03 November 2015
<b>Date of response:</b>	10 December 2015

### Requirements

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

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

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

**Theme:** Individualised Supports and Care

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

It was not demonstrated that the decision-making process around consent for medical or healthcare treatment was understood by those with responsibility for managing the centre.

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

**1. Action Required:**

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

The Clinical Nurse Manager 3 and the Social Worker will provide input to the team of the centre on ensuring that staff understand a service user's rights around decision making and consent.

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

**Theme:** Individualised Supports and Care

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

Residents' privacy and dignity was not respected in relation to personal information.

**2. Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The Nominee Provider and the Person In Charge will meet with service users of the centre to discuss their concerns at their next house meeting.

All personal information relating to the individual service users will be recorded and dated in their care plan.

**Proposed Timescale:** 15/01/2016

**Theme:** Individualised Supports and Care

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

A complaint made by residents in November 2014 had not been properly investigated.

**3. Action Required:**

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

The Nominee Provider and the Person In Charge will meet with service users of the centre to discuss and progress action on their complaint of 2014.

**Proposed Timescale:** 23/12/2015

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

The centre was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the centre. This had a negative impact on both the individual and other residents in this centre

**4. Action Required:**

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

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

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response

**Proposed Timescale:**

**Theme:** Effective Services

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

The review of the personal plan was not multi-disciplinary, as required by the Regulations.

**5. Action Required:**

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

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

Since inspection two job sharing social workers have been appointed. A full time senior occupational therapist will commence on the 18/01/2016. The Service continues the recruitment process for Psychologists x 2 posts. Since inspection an instructor in the Therapeutic Management of Aggression and Violence has given further input to the staff team of the centre around the management of challenging behaviour and further input to the resident's behaviour support plans.

All personal plans will be reviewed by the current multidisciplinary team and their input reflected in same. These will be reviewed by the 25/01/2016.

The Person in Charge and the keyworker will ensure that the multidisciplinary team members involved in each service user's care are involved in the assessment and personal plans of care for each service user.

The keyworker after each multidisciplinary team meeting will ensure that personal plans of care are updated to include recommendations from the multidisciplinary meetings.

Where a multidisciplinary team member has a consultation with a service user, the keyworker will update the plan of care to reflect recommendations and advice given.

The Person in Charge and Clinical Nurse Manager 3 will monitor and review the care plans and audit the quality of same quarterly.

**Proposed Timescale: 25/01/2016**

**Theme: Effective Services**

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

There were inconsistencies between personal plans. Improvements were required in relation to what constituted a goal, for example, some goals viewed were healthcare requirements. The supports required for residents to realise their goals were outlined in some personal plans but not others. The expected outcome of the goal was not always clear.

**6. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

The Person in Charge, house manager and keyworker will review all goals and ensure that there is a named responsible person to support the resident in the goal achievement. The Person in Charge and house manager will ensure that supports necessary for each goal are identified and available and liaise with the Nominee provider where necessary.

The outcome for each goal and how it contributes to each resident's quality of life will be documented and reviews completed to ensure that the goals have positive outcomes for residents.

The Person in charge in this centre is a person centred planning facilitator and trainer and is attending refresher training on 09/12/2015 and will then be rolling out further training to staff team in the centre in 25th January 2016. This training will include input to all staff to what constitutes a goal and how to break it down into measurable steps to ensure it meet the individual needs of the resident. Multidisciplinary team members will be a key part in the development and review of goals and long term goals for residents.

**Proposed Timescale: 25/01/2016**

## 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 door handles on the front door appeared broken.

**7. Action Required:**

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

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

The Person in Charge will ensure that the door handle on the front door will be replaced.

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

Theme: Effective Services

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

The carpet on the landing on the first floor had not been replaced.

**8. Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

The Nominee Provider will ensure that the carpet is replaced. The resident's have already chosen a colour.

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

## 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 assessment of risk throughout the designated centre and the development of controls in place to manage such risks.

**9. 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:**

The HSE have approved the input and support to the centre of its Quality Improvement Enablement Team. This team is commencing onsite work on the 08/12/2015 and have prioritised risk management. The Quality Improvement Enablement Team will be working directly with the Person in Charge.

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

**Theme:** Effective Services

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

The personal evacuation plan that was to outline the assessment that residents would need in the event of an evacuation only indicated the mobility status of residents and not the assistance that each resident required to leave the building in an emergency.

**10. Action Required:**

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

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

The Person in Charge and Health and Safety Officer with the staff team will review each resident's personal emergency evacuation plan and ensure that each contains the detail of assistance and support needed by each person to evacuate the premises in an emergency.

**Proposed Timescale:** 22/12/2015

**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:**

It was not demonstrated that staff had up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. Behaviour support plans were not always sufficient to direct staff, as identified at the previous inspection and had not been developed with specialist behaviour support input.

**11. Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Since inspection an instructor in the Therapeutic Management of Aggression and Violence has given further input to the staff team of the centre around the management of challenging behaviour and further input to the development of resident's behaviour support plans.

The Person in Charge in the centre is working closely with this instructor and updating her on staff progress in completing the actions outlined by her around the development of the behaviour support plans for each resident.

**Proposed Timescale:** 15/01/2016

**Theme:** Safe Services

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

Not all staff who worked in the centre had received training in the management of behaviour that challenges.

**12. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

All staff including agency working in the centre will have training completed in the management of behaviour that challenges.

**Proposed Timescale:** 21/12/2015

**Theme:** Safe Services

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

The written guidance in place in relation to the use of PRN ("as required") medication was not sufficiently clear to ensure that all staff were clear in relation to when to administer the medication. In addition, the guidance had been developed by the person in charge without input from or approval by the prescriber of the medication. In addition, the effects of such medication were not being properly recorded (e.g. whether a resident was drowsy following administration of medication).

**13. 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 written guidelines in relation to the use of PRN will be approved by the prescriber of the medication.

The Clinical Nurse Manager 3 will deliver input to all staff in the centre around the importance of recording the effects of all PRN medication following its administration.

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

**Theme:** Safe Services

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

There was an unsuitable mix of residents in the centre, which was leading to challenging behaviour against other residents in the centre. This was continuing to have a negative impact on residents in the centre.

**14. Action Required:**

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

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

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response".

**Proposed Timescale:** 31/05/2016

**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:**

A robust assessment was not in place to establish each resident's educational, employment or training goals, as required by the Regulations.

**15. 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:**

Development of an educational assessment tool has been drafted and is currently being piloted along with a standardised assessment tool (CANDID) on a small number of residents to establish reliability and effectiveness in meeting this requirement. It is planned to have this validated by the end of the year by the Person Centred Plan Steering Committee. The implementation and audit of this process will be incorporated as part of the service policy on Education Training and Development.

The Policy on Education Training and Development has been reviewed by the Quality and Risk Officer in relation to the regulations. The implementation and audit of the assessment process will be incorporated into this policy once the assessment tool has been approved. It is planned to be completed by the 31/12/2015.

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

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

The appropriateness of a resident accessing a therapy was not demonstrated.

**16. 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:**

All personal plans will be reviewed by the current multidisciplinary team and their input reflected in same. All recommendations made by the multidisciplinary team will be dated and reflected in their care plans.

**Proposed Timescale:** 25/01/2016

### **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 did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, the criteria used for admission to this centre were not specified, the age range was too broad and it was not specified that the centre could provide an individualised day service.

**17. Action Required:**

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

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

The Person in Charge and the Clinical Nurse Manager 3 will review the statement of purpose and will make the relevant changes in line with the regulations.

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

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

While there was a defined management structure, this required review as the person in charge was actively managing a number of other centres across a broad geographical area.

**18. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The Organisation is in the process of appointing an additional person in Charge to the organisation. This will reduce the number of areas of responsibility for the person in charge in this centre.

**Proposed Timescale:** 15/01/2016

**Theme:** Leadership, Governance and Management

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

While there was a management system in place in the designated centre, it did not ensure that the service provided was safe and appropriate to residents' needs and effectively monitored

**19. 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 Organisation is in the process of appointing an additional person in Charge to the organisation. This will reduce the number of areas of responsibility for the person in charge in this centre. The post will be filled by 15/01/2015.

The nominee provider's contract of employment for the service has been extended to the end of March 2016. The organisation has commenced the recruitment process for a service manager both in Ireland and the UK.

Since inspection an instructor in the Therapeutic Management of Aggression and Violence has given further input to the staff team of the centre around the management of challenging behaviour and further input to the development of resident's behaviour support plans.

The Person in Charge in the centre is working closely with this instructor and updating her on staff progress in completing the actions outlined by her around the development of the behaviour support plans for each resident.

The organisation is continuing the recruitment process for two psychology posts, and has extended the advert to the UK.

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

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

It was not demonstrated that staffing levels and skills mix met the assessed needs of residents, as detailed in the body of this report.

#### **20. 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:**

All staff that require healthcare training are currently undertaking the FETAC Level 5 training programme and are being supported by the organisation to do so. The Clinical Nurse Manager 3 and the Person in Charge will review rosters with particular attention to the weekends to ensure there is adequate staffing available to residents to engage in appropriate social activities. These activities will be documented and recorded in their personal plans.

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

**Theme:** Responsive Workforce

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

Not all mandatory training was up to date for relief or agency staff who worked in the centre. Two staff required training in relation to the management of behaviour that challenges and fire safety. Training records were not available for three staff in relation to hand hygiene.

**21. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Only agency staff who have the required mandatory training will be contracted to work in this centre, all staff in the centre will have completed mandatory training required by the 21/12/2015.

The recruitment process for new staff who will displace all agency is near completion in the centre. Staff will have commenced employment by 15/01/2016.

**Proposed Timescale:** 15/01/2016

**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 guidance on infection control available in the centre did not reflect current national policy in relation to hand hygiene training or audits. The safeguarding policy required improvement to ensure that it addressed how to manage anonymous concerns in a satisfactory manner.

**22. Action Required:**

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

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

The guidance on infection control in the centre will be reviewed to reflect national policy in relation to hand hygiene and training and audits.

The service has circulated a policy to all staff on making and receiving protected disclosures/anonymous complaints. This policy is in place since the 25/09/2015.

The safeguarding policy is currently under review and the Nominee Provider who is part of the review committee will ensure that the protected disclosure policy is referenced in the safeguarding policy.

**Proposed Timescale:** 15/01/2016

**Theme:** Use of Information

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

Residents' records were stored securely. Residents' records as required under Schedule 3 of the Regulations were maintained. Improvements were required to the documentation pertaining to behaviour that challenges. Behaviour support plans required review and updating by persons with specialist training and experience in relation to behaviour that challenges.

Healthcare records also required improvement. Medical files required streamlining, for example, reviews that had been completed by the psychiatrist were held in two different files and in different parts of the same file. Some medical information had been paraphrased by care staff inaccurately. For example, where a medication had been reduced, care staff had recorded that it had been discontinued. This practice required review.

It was not demonstrated that healthcare plans directed the care to be given to the resident.

**23. 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:**

Since inspection an instructor in the Therapeutic Management of Aggression and Violence has given further input to the staff team of the centre around the management of challenging behaviour and further input to the resident's behaviour support plans.

The service is continuing the recruitment process for two psychology posts closing date for the most recent advertisement is 11/12/2015.

All staff in the centre will receive further training on the management of behaviour that challenges from the Person in Charge and the Clinical Nurse Manager 3 on the 18/12/2015.

The Clinical Nurse Manager 3 will deliver training to all staff in the centre on care planning, this will include informing staff that "paraphrasing" is an unsafe practice.

All medical files in the centre will be reviewed by the Nominee Provider, the Clinical Nurse Manager 3 in the centre to ensure that all appropriate, up to date relevant information from psychiatrists and all other disciplines is available in one place to the staff team providing care to the resident. This will be completed by the 08/02/2016.

The Person in Charge and Clinical Nurse Manager 3 are part of a working group reviewing the current plans of care document. The new plan of care will ensure that the information is streamlined and available to all staff in one file. Support will be given from the HSE Quality Improvement Enablement Team in this process. This process will

be completed to draft form and piloted in April 2016.

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