Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005159
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:	Kieran Murphy
Support inspector(s):	Julie Hennessy;
Type of inspection	Announced
Number of residents on the date of inspection:	8
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.

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:
19 October 2015 10:00	19 October 2015 17:30
20 October 2015 08:30	20 October 2015 17:00

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

Outcome
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 report sets out the findings of an announced inspection of Group L St. Anne's Residential Services. This was the second inspection of this designated centre which consisted of two houses located five minutes apart near the town centre. The centre provided care and support to nine residents.

Inspectors found that the designated centre did not meet the assessed needs of all residents due to the unsuitable age mix of residents in the centre. This had been a finding on the previous inspection also. This was identified as an issue that required immediate attention to safeguard the safely and wellbeing of the residents.

Since the previous inspection in June 2015 the service had commenced two reviews into the management of residents' finances. The first was an investigation by the director of finance into the operation and control of the finance of residents in the centre. It had originally been proposed to have this investigation completed by 21 August 2015. St Anne's had extended the date for the completion of this investigation to 27 November 2015. The second was a review was into service user financial accounts across all of St Anne's residential services. The completion date of this review was also extended by St Anne's with a due date now of 30 January 2016.

Prior to the inspection the Authority had received a notification from the centre of alleged abuse. A preliminary screening of this allegation had been completed by the social worker in July 2015 and St Anne's service was undertaking an investigation of the allegation, with a report due on 30 October 2015. St Anne's had extended the date for the completion of this investigation to 11 November 2015.

Inspectors found a high level of non-compliance and significant deficits in the quality of care provided to residents. Of a total of 18 outcomes inspected, there were seven at the level of major non-compliance:
Outcome 1: Rights dignity and consultation
The provider had failed to put in place a system to ensure that the directions in a court order were understood and followed by all relevant personnel. In addition, while an advocacy committee was in place, it was not clearly demonstrated how residents in this centre would be represented.

Outcome 4: Admissions
The admission practices and policies were not transparent. In one case a resident had been recently admitted to the centre and was living with a number of other residents all of whom were actively retired. There wasn't evidence available as to what consultation there had been with other service users and what consideration had been given to the impact on their lives of a new resident being admitted to the centre.

Outcome 5: Social care needs
Improvement was required to ensure that required supports were identified for all goals and that the outcome of each goal was clearly stated (how it contributes to a resident's quality of life). The review of the personal plan was not multi-disciplinary, as required by the Regulations. In addition, where multidisciplinary input had been sought, there was no link between multidisciplinary meetings and the residents' personal plans and the care and support that is delivered to them. Not all residents had an up-to-date personal plan that had been reviewed within the previous 12 months or more frequently if necessary, as required by the Regulations. As was the case on the previous inspection, future planning was not evidenced in the personal plans.

Outcome 7: Fire safety
There was evidence that adequate means of escape was not provided for staff and residents. In one of the houses the attic had been converted and contained two bedrooms, a staff office and a bathroom. The exit from these attic rooms upstairs

was directly to the kitchen. This arrangement could not guarantee exit from the building in the event of a fire as the only exit from the rooms upstairs was through the kitchen. The staircase was narrow and steep and there was no other exit from the attic area. In addition there was no fire door at the top of the staircase to contain the spread of fire.

Outcome 8: Safeguarding
As on the previous inspection multi-disciplinary input was not sought when planning interventions for individual residents. It was also not demonstrated that all staff had received in relation to behaviour that challenges as training records for agency and relief staff who worked in the centre were not available for review during the inspection.

Outcome 14: Governance
The nominee on behalf of the Daughters of Charity Services was the 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. Inspectors were not satisfied with the uncertainty around the post of the services manager and the potential impact on the governance and leadership being currently provided.

The nominated person in charge was a registered nurse in intellectual disability. She was appointed as person in charge for four centres in total across a broad geographical area. Inspectors were not satisfied with the workload of the person in charge in circumstances where there were complex needs of residents across all four centres.

A certificate of planning compliance for the two buildings that comprise the designated centre had not been submitted to the Authority as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The Action Plan at the end of the report identifies areas where other improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities. These areas include moderate non compliance in relation to:
• care planning for identified healthcare needs
• medication management
• statement of purpose
• staffing

Improvment was also identified in relation to accessibility issues with the premises.

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

Findings:
Since the previous inspection in June 2015 the service had commenced two reviews into the management of residents' finances. The first was an investigation by the director of finance into the operation and control of the finance of residents in the centre. It had originally been proposed to have this investigation completed by 21 August 2015. St Anne's had extended the date for the completion of this investigation to 27 November 2015. The second was a review was into service user financial accounts across all of St Anne's residential services. The completion date of this review was also extended by St Anne's with a due date now of 30 January 2016.

At the last inspection it was found that one resident had purchased a number of items including a television, a leather couch and garden furniture that were used by all residents in the house. The person in charge outlined that this resident had been re-paid the cost of these items. However, the person in charge outlined that other residents who had charged for the purchase of items that the service was to provide had not yet been re-paid. Following the inspection in June 2015 St Anne's service had found that one resident had been overcharged for residential care. There were records to show that this resident had been re-paid this amount in full. Of note is that for future service user expenditure the service user, house manager and person in charge will have a robust discussion, and the services of an advocate will be made available to all services where necessary. The nominee provider will be informed of all purchases and expenditure for this centre. There were records to show that the nominee provider and the director of nursing had delivered training to all staff in the centre on the residents private property.

At the previous inspection, it was found that the provider had failed to put in place a system to ensure that the directions in a court order were understood and followed by all relevant personnel. At this inspection, inspectors found that while information was now on file in relation to the court order and a very clear protocol had been developed for one key area, it was not demonstrated that the failing had been satisfactorily addressed. Some information on file was potentially misleading. Relevant care plans did not reflect the court order and relevant information was contained in two separate files (the medical file and personal file). Staff spoken with did not demonstrate a clear understanding of the extent of the court order.

Since the last inspection, while an advocacy committee was in place, it was not clearly demonstrated how residents in this centre would be represented. The person in charge said that they received minutes from the committee. However, no resident from this centre participated in the advocacy committee.

At the previous inspection, it was found that residents' personal living space was not protected as one resident used the en-suite shower in another resident's bedroom. There was a plan for more appropriate showering facilities, to ensure that the individual with the ensuite has sole use of the ensuite, and that other service users have access to a suitable and appropriate bathroom/shower area. However, these new bathroom facilities were not yet available.

At the previous inspection, it was found that personal emergency evacuation plans were available for each resident and were on display at each fire exit door. These records contained personal information relating to the residents. While the information needed to readily available, the information could be made available in a more discrete manner. At this inspection, it was found that a personal evacuation plan on display did not identify the supports required by residents to evacuate in the event of a fire, as the names had been blanked out. This was rectified immediately by the person in charge and the required information was displayed in an appropriate manner.

Judgment:
Non Compliant - Major

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:

There was a policy on communication and in the sample of care plans reviewed there was evidence that residents were assisted and supported to communicate.

Each resident had a communication assessment which identified issues including:
- How the resident communicated
- how people could help the resident to communicate
- things the resident liked to communicate about .

Inspector observed a communication board in the kitchen areas which contained a picture rota of which staff were on duty. There were also pictures available which residents put on the communication board to help plan their day. A number of residents had communication books with pictures of important things to the resident and also things they liked to do. One resident showed inspectors a photo album of a pilgrimage the residents had made to Knock.

Residents who required it were seen by the speech and language therapist. These reviews helped staff to identify how the resident communicated and also gave guidelines to staff in how to help the resident communicate.

At the previous inspection, it was found that personal communications did not always respect residents' dignity. At this inspection, communications were now written in a more appropriate manner.

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:
Residents were supported to develop and maintain personal relationships and links with the wider community.

Positive relationships between residents and family members were supported Residents were facilitated to keep in regular contact with family through telephone calls and the inspector observed that family members were made welcome when visiting. There were adequate facilities for each resident to receive visitors and a number of areas were available if residents wished to meet visitors in private.

Staff stated and the inspector saw that families were kept informed of residents' well

being on an ongoing basis. Records confirmed that families and residents attended personal planning meetings and reviews in accordance with the wishes of the resident.

A flexible and tailored day service was provided for residents within the centre. The inspector reviewed residents' activity schedules and saw that residents were facilitated to participate in a range of activities in the local and wider community including meals out and shopping in the locality.

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 were not transparent. The statement of purpose, which is a document that describes the service provided in the centre, did not provide any clear guidance as to how residents were admitted to the centre. In one case a resident had been recently admitted to the centre and was living with a number of other residents all of whom were actively retired. There wasn't evidence available as to what consultation there had been with other service users and what consideration had been given to the impact on their lives of a new resident being admitted to the centre.

Inspectors reviewed a sample of resident 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
• 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:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
While improvements were found in relation to recently updated personal plans, not all personal plans had been updated within the previous 12 months or more frequently if necessary, as required by the Regulations. Failings in relation to the suitability of the designated centre had not been adequately progressed since the previous inspection. Inspectors found this to be at the level of major non-compliance due to the impact on residents in the centre.

Inspectors found that the designated centre did not meet the assessed needs of all residents as there was an unsuitable age mix of residents in the centre. The centre failed to meet an individual resident's emotional, social or developmental needs in an acceptable and age-appropriate way. Staff outlined that this was having a negative impact on both the resident who required alternative accommodation more suited to the needs of a younger more active person and older residents in the centre who required a quieter environment. The provider failed to demonstrate that this unsuitable arrangement had been progressed in a satisfactory manner since the previous inspection.

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. In addition, goals were not based on an assessment of residents' needs and there were no planned goals to address some identifiable needs. In addition, the supports required to meet goals were not specified. At this inspection, inspectors reviewed a sample of recently reviewed personal plans and found notable improvement. Overall, the personal plan was comprehensive, goals were wide-ranging and reflected residents' abilities, interests and key areas such as skills development and community participation. Required supports to achieve goals were outlined for most goals. Some further

improvement was required to ensure that required supports were identified for all goals and that the outcome of each goal was clearly stated.

At the previous inspection, it was found that the review of the personal plan was not multi-disciplinary, as required by the Regulations. In addition, where multi-disciplinary team input had been sought, there was no link between the multi-disciplinary team meetings and the residents' personal plans and the care and support that is delivered to them. This action was still outstanding on this inspection.In addition, not all residents had an up-to-date personal plan that had been reviewed by the multidisciplinary team within the previous 12 months or more frequently if necessary, as required by the Regulations. As was the case on the previous inspection, future planning was not evidenced in the personal plans, which is indicative of the absence of multidisciplinary input in the personal planning process.

At this inspection, progress had been made at service-level in relation to ensuring that a robust assessment was in place that would allow for the development of residents' training, education, employment and skills development goals but the actions has yet to be completed in full.

Staff endeavoured to ensure that activities and interests pursued were individual, age-appropriate and based on residents' wishes and preferences and appropriate. Individual residents said that they enjoyed horse riding, reflexology, baking, going for walks, meals out and meeting friends and family. Where residents benefited from 1:1 time, this was included in the staffing rota.

At the previous inspection, it was not clear how a resident could be discharged from the service. The provider nominee told inspectors that this was being addressed via the organisation's policy relating to admissions, transfers and discharges from the service. However, this also needed to be clarified in the statement of purpose for the centre.

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 consisted of two houses located five minutes apart in the centre of town.

Since the previous inspection works had been completed in relation to:
• Ensuring the premises was clean
• replacing a tap in an en-suite bathroom
• removing a fridge freezer from a dining room
• upgrading the centre by painting and undertaking some remedial building work to a porch.

As identified on the previous inspection there were four people who were generally elderly and some with restricted mobility living in the first house. The house was a two-storey house and all of the residents' bedrooms were on the ground floor. There was a large kitchen/dining area leading to a well maintained garden. There were stairs in the kitchen leading to the first floor. However, where residents had mobility needs, adequate measures had not been put in place. There were no handrails or grab rails in one bathroom. A referral for an occupational therapy (OT) assessment had been received in April 2015 and identified as a priority. It was not clear from a resident's mobility care plan if this referral for an assessment of a resident getting in and out of the bath had been completed.

There were four people living in the second house, a bungalow, which could accommodate five residents. There were two residents with mobility issues in this house and there was a wheelchair accessible entrance. This house had a large kitchen/dining area and a separate sitting room in addition to single bedrooms for residents. All of the residents' bedrooms in both houses were personalised and homely.

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

Findings:
Inspectors had concerns regarding fire safety arrangements and in particular adequate means of escape from one building in the centre.

There was evidence that adequate means of escape was not provided for staff and residents. In one of the houses the attic had been converted and contained two bedrooms, a staff office and a bathroom. One of the bedrooms was a staff sleepover room and the other bedroom had been used as a resident bedroom but was now vacant. The vacant bedroom had an en-suite bathroom and inspectors were informed that one resident used the shower in this ensuite facility. The exit from these attic rooms

upstairs was directly to the kitchen. This arrangement could not guarantee exit from the building in the event of a fire as the only exit from the rooms upstairs was through another room. The staircase was narrow and steep and there was no other exit from the attic area. In addition there was no fire door at the top of the staircase to contain the spread of fire.

While there were monthly fire evacuation drills being undertaken monthly involving the residents, the records of these drills indicated that it had taken between 3 and 8 minutes to evacuate the premises in drills. The design and layout of the premises was such that these evacuation times would not be sufficient in the event of a fire.

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 October 2015
- fire extinguisher servicing and inspection October 2015
- servicing of emergency lighting October 2015.

Since the last inspection fire procedures had been updated so that the location of the fire panel was now available to all staff.

Since the last inspection there was now a centre 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. It also included how hazards were identified and the method by which incidents were reviewed.

It was not demonstrated that risk assessments were being developed by suitably competent persons or that input from other suitably competent persons was obtained where needed. For example, inspectors reviewed a risk assessment for a significant safeguarding risk. The risk assessment had not been developed with the necessary input from the multi-disciplinary team. In addition, the initial and residual risk ratings significantly underestimated the level of risk involved or the severity of the consequences. In addition, there was no moving and handling risk assessment on file for the same resident in relation to this hazard. Finally, the falls risk assessment had been incorrectly calculated as a low risk, as it had not been fully or accurately completed.

Since the last inspection the centre was visibly clean and had been the subject of an infection control audit in October 2015. This audit had identified a number of issues for improvement and these had been completed.

Judgment:
Non Compliant - Major

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:
As on the previous inspection improvement was still required in relation to multi-disciplinary input when planning interventions for individual residents and the provision of training on behaviour that challenges for all staff.

Prior to the inspection the Authority had received a notification from the centre of alleged abuse. A preliminary screening of this allegation had been completed by the social worker in July 2015 and St Anne's service was undertaking an investigation of the allegation, with a report due on 30 October 2015. St Anne's had extended the date for the completion of this investigation to 11 November 2015.

As previously mentioned under Outcome 7, multi-disciplinary input had not been sought in relation to the development of a risk assessment necessary to ensure that the measures in place adequately safeguarded a resident (or others) from abuse. There was a protocol was in place in relation to one key area and there was relevant information in the file. However, it was not satisfactorily demonstrated that the system or arrangements in place were sufficiently robust to ensure that all personnel were fully aware of a significant safeguarding risk and the necessary measures in place to protect resident(s) and others from abuse. Inspectors found that this was at the level of major non-compliance due to the potential impact in the event of an incident occurring.

At the previous inspection, it was found that multi-disciplinary input into behaviour support plans viewed in the centre was limited and was not sought when planning interventions for individual residents. Inspectors reviewed a sample of behaviour support plans and found that they varied in quality. A number of behaviour support plans were comprehensive, demonstrated a positive approach to behaviour that challenges and includes information such as residents' likes and dislikes, suggested staff responses to phrases or utterances, known triggers, proactive strategies, skills teaching and reactive strategies. However, other behaviour support plans did not provide sufficient guidance for staff. For example, for one resident it was not clear at what point and on what basis different supports following behaviours should be implemented (including the arrangement of an emergency psychiatric visit).

At the previous inspection, it was found that the reasons for using restrictive practices were not documented. In addition, the use of restrictive practice in the centre was not subject to the organisation's monitoring or review procedures. At this inspection, some restrictive practices outlined in restrictive practice documentation for individual resident's were still not reflective of restrictive practices in use, such as those relating to restrictions on person liberty.

At the previous inspection, staff training records indicated that mandatory training in relation to behaviour that challenges was not up-to-date for all staff. At this inspection, training records indicated that core staff had received in relation to behaviour that challenges. However, it was not demonstrated that all staff had received in relation to behaviour that challenges as training records for agency and relief staff who worked in the centre were not available for review during the inspection.

At the previous inspection, it was found that the personal plan for continence care did not respect resident's dignity and bodily integrity. At this inspection, it was found that the personal plan had been updated and revised and now reflected a person-centred approach.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
The nominated provider and person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents.To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

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):
No actions were required from the previous inspection.

Findings:
Improvements were required to ensure that the day service provided was suitable to meet each resident's capabilities, interests, stated wishes and preferences. Inspectors found that not all residents were happy with the day service that was available to them and this had also been identified in the previous inspection (under Outcome 5). This was known to the provider nominee and recent minutes also reflected the same resident's dissatisfaction with their day service. Inspectors found that this was at the level of major non-compliance.

The policy on access to education, training and development was made available to inspectors. Improvements were required to the policy to ensure that it addressed relevant regulatory requirements. Residents had access to education, training and development.

Support was provided for residents to attend a day service where applicable. Some residents were retired and were supported to enjoy their retirement from the centre. Where residents chose to have a shorter week in day service, this was facilitated. Inspectors observed residents being supported to communicate what they wanted to do that day and those choices were facilitated, such as going shopping, to the local church, for a coffee, to visit sites of interest, for a social drink or for a walk. Other residents had identified activities and interests that were appropriate to those of a younger age-group and these were included in their personal goals. Examples included to participate in a drama production, a walking challenge or a fashion show.

Residents each had an activity or daily calendar and logs were kept of outings and events. Residents were supported to develop life skills and new skills and this was incorporated into residents' personal plans. However, inspectors found that there were challenges to meeting all residents needs due to the unsuitable age-mix in the centre. Staff explained that recent staff increases meant that it was now easier to facilitate greater options for pursuing outings and interests for all residents in the centre, in an age-appropriate way and based on individual wishes and preferences.

In addition, an assessment of each resident's training and development needs and goals was not available in the centre for each resident.

Judgment:
Non Compliant - Major

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:
The care planning process required improvement. As on the previous inspection it was not always clear if recommendations from members of the multidisciplinary team were being implemented.

Healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan to direct care. There was evidence that residents were referred for treatment by allied health professionals including physiotherapy and occupational therapy. However, the care plans were not always updated to include these reviews. For example, two residents' mobility care plans indicated that they had been referred for review by an occupational therapist. However, neither care plan had been updated to include that the review had taken place and what the recommendations were.

As was found on the previous inspection each resident had access to a general practitioner (GP) who saw residents at regular intervals.

Each resident had a nutritional care plan and there was evidence that a dietitian was available to residents if required. Some care plans outlined if residents required assistance including adapted plates and cutlery. Residents were involved in the day to day activities around mealtimes including going shopping for groceries. The inspectors found adequate quantities of food available for snacks and refreshments.

Judgment:
Non Compliant - Moderate

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, medication prescription records did not contain the signature of the nurse who transcribed the record. At this inspection, the practice of transcription was now in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet his/her obligations to residents. Inspectors observed that blister pack systems were used by staff to administer medications to residents. The person in charge outlined that they were unable to withhold a medication from the blister pack system if necessary. Inspectors were not satisfied that this system as it could potentially lead to other medications in the blister pack not being administered as prescribed.

Inspectors reviewed medication errors in the centre, which were being recorded and reported as is good practice. Incidents included:
• 4 errors of medication not being given at the correct time
• 1 incident of an incorrect dose of medication being given
• 1 incident where medication was not brought back to the centre.
One error had been made by an agency staff member and training records were not available in the centre for review. In addition, the action arising from the incident did not demonstrate learning or that sufficient steps had been taken to avoid a re-occurrence of the error.

At the previous inspection, there was no designated fridge available in the centre in the event of a resident commencing on medication requiring refrigeration. At this inspection, while there was a designated fridge in one house, there was no dedicated fridge in the second house. As a result, medicines requiring refrigeration were not stored appropriately as medication was stored in a domestic fridge instead of a dedicated fridge. This practice was not in line with professional guidance issued by An Bord Altranais agus Cnáimhseachais. Where there was a dedicated fridge, an inspector found that while daily recordings of the fridge temperature were documented, a number of recordings exceeded the recommended upper temperature range and corrective action had not been taken, as necessary to ensure that medicines are stored in accordance with the manufacturer's instructions.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose, which is a document that describes the service provided in

the centre, did not have sufficient information in relation to:
• The specific care and support needs the centre was intended to meet;
• criteria used for admission to the designated centre, including the policy and procedures (if any) for emergency admissions
• the correct number of the residents for whom it was intended that accommodation should be provided
• an accurate description of the rooms in the centre.

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:
As on the previous inspection the governance arrangements were not satisfactory.

The house manager had been appointed to cover both houses in this centre. Inspectors reviewed minutes of communication meetings where it had been outlined by staff that "the delivery of care (to residents) was compromised by the limited scope of the house manager's roster covering both houses in the centre. This was due to the complex needs of service users and reduced staff complement." There was also evidence of inconsistency in relation to documentation and information in relation to resdients in both houses. Staff said this was due to the house manager not being present in each house for the entire week.

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. Inspectors were not satisfied with the uncertainty around the post of the services manager and the potential impact on the governance and leadership being currently provided.

The nominated person in charge was a registered nurse in intellectual disability. She was appointed as person in charge for four centres in total across a broad geographical area. Inspectors were not satisfied with the workload of the person in charge in circumstances where there were complex needs of residents across all four centres.

A certificate of planning compliance for the two buildings that comprise the designated centre had not been submitted to the Authority as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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:
The inspector found that adequate arrangements were in place through the appointment of a named person to deputise in the absence of the person in charge. The person in charge had not been absent for a prolonged period since commencement and there was no requirement to notify the Authority of any such absence. The provider was aware of the need to notify the Authority in the event of the person in charge being absent.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
The inspectors formed the opinion that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Since the previous inspection, staff training needs had been identified and funding was secured to support healthcare assistant training for all staff. In addition works had been completed in relation to:
• Ensuring the premises was clean
• replacing a tap in an en-suite bathroom
• removing a fridge freezer from a dining room
• upgrading the centre by painting and undertaking some remedial building work to a porch.

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:
As on the previous inspection it was not demonstrated that the skill mix of staff was appropriate to the needs of the residents in the centre. On this inspection there were repeated findings in relation to ensuring:
• that residents' health needs were met
• that personal plans were effective and took into account changes in circumstances and new developments and
• to support residents with behaviours that may challenge.

At the previous inspection, it was not demonstrated that staff had the required skills and qualifications to meet the needs of residents. Since the previous inspection, staff training needs had been identified and funding was secured to support further education and training awards council (FETAC) certificate in healthcare support for all staff.

In addition, 'core staff' had received mandatory training and training relevant to their roles, including food safety, infection control, fire safety, advocacy and behaviour that challenges. However, training received by agency and relief staff who worked in the

centre could not be confirmed as those training records were not available for review in the centre during the inspection. As mentioned under Outcomes 8 and 12, inspectors could not verify whether agency staff members had the required training in relation to behaviour that challenges, the protection of vulnerable adults or medication management.

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

Findings:
Since the last inspection healthcare information was being maintained and stored in accordance with the centre's records management policy.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Kieran Murphy
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[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005159
Date of Inspection:	19 October 2015
Date of response:	27 November 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a significant failing by the provider who had failed to put in place a system to ensure that the directions in a court order were understood and followed by all relevant personnel.

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

1. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
All relevant information relating to Ward of Court will be available in the service users files and reflected also in the relevant section of the care plan. The Person in Charge will at a staff meeting share the directions in the court order with all staff.

Proposed Timescale: 26/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Since the last inspection, while an advocacy committee was in place, it was not clearly demonstrated how residents in this centre would be represented. The person in charge said that they received minutes from the committee. However, no resident from this centre participated in the advocacy committee.

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

Please state the actions you have taken or are planning to take:
This centre comprises of two houses. Two service users from this centre attend local advocacy meetings representing this part of the organisation. The outcomes and information shared at these meetings are fed back to the Service advocacy committee to ensure service users views are represented. Minutes of the advocacy committee meeting are available in the centre and are shared at service user meetings. Two service users in the centre have independent advocates.

The Person in Charge will ensure that resident's views and wishes as raised in the residents meetings will be brought forward to the advocacy committee meeting by the two representative service users and their staff representatives.

Proposed Timescale: 23/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' personal living space was not protected as one resident used the en-suite shower in another resident's bedroom.

3. 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:
Work commenced on the 26/10/2015 to provide more appropriate showering facilities in the centre to ensure that one individual had sole use of their own ensuite and that all service users have access to appropriate bathroom facilities. This work is scheduled to be completed on 17/12/2015.

Proposed Timescale: 17/12/2015

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The two investigation reviews by St Anne's service of resident finances which had been identified as a non-compliance in the previous inspection had not yet been completed.

4. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
The first investigation into the finances within the centre is due for completion with a final report on 27/11/15.

The review into service user finances across the service is scheduled for completion on the 30/01/16.

Proposed Timescale: 30/01/2016

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents who had charged for the purchase of items that the service was to provide had not yet been re-paid.

5. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
Repayment will be made to all service users who purchased items which should have

been purchased by the service. The Person in Charge, Nominee Provider and Financial Accountant will ensure that this will occur.

Proposed Timescale: 27/11/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission practices and policies were not transparent. The statement of purpose, which is a document that describes the service provided in the centre, did not provide any clear guidance as to how residents were admitted to the centre. In one case a resident had been recently admitted to the centre and was living with a number of other residents all of whom were actively retired. There wasn't evidence available as to what consultation there had been with other service users and what consideration had been given to the impact on their lives of a new resident being admitted to the centre.

6. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The statement of purpose has been revised to include admission criteria and submitted to the Authority post inspection. The Service Admission Discharge and Transfer Policy has since inspection been updated to include clear guidance as to how residents are admitted to any centre in the service. This policy is now available in the centre.

Proposed Timescale: 29/10/2015

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 designated centre did not meet the assessed needs of all residents due to the unsuitable age mix of residents in the centre. The centre failed to meet an individual resident's emotional, social or developmental needs in an acceptable and age-appropriate way. The unsuitable arrangement did not meet other residents' need for a quieter environment. The provider failed to demonstrate that this unsuitable arrangement had been progressed in a satisfactory manner since the previous inspection

7. Action Required:

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

Please state the actions you have taken or are planning to take:
Following a meeting in September 2015 of the service user, advocate and family, HSE and the team involved in the service user's care around the unsuitable placement of this particular resident in the centre is being progressed.

The service user and independent advocate have since inspection met with an alternative service provider to outline what the service user's wishes/needs and choices around a more appropriate placement both Day and Residential.

The potential provider along with the HSE, the Nominee Provider, the Person in Charge, service user and their representative will formulate a plan to progress this further.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that required supports were identified for all goals and that the outcome of each goal was clearly stated (how it contributes to a resident's quality of life).

8. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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 service user 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 service user's quality of life will be documented and reviews completed to ensure that the goals have positive outcomes for service users.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of the personal plan was not multi-disciplinary, as required by the Regulations. In addition, where multidisciplinary input had been sought, there was no link between multidisciplinary meetings and the residents' personal plans and the care and support that is delivered to them.

9. 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 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.

Proposed Timescale: 11/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had an up-to-date personal plan that had been reviewed within the previous 12 months or more frequently if necessary, as required by the Regulations. As was the case on the previous inspection, future planning was not evidenced in the personal plans.

10. 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:
All residents in the centre will have up to date person centred plans in place with review dates. All goals will have set timeframes, be broken down into achievable steps and will have named responsible persons to help the service user in the achievement of these goals.

Proposed Timescale: 25/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not clear how a resident could be discharged from the service.

11. Action Required:
Under Regulation 25 (4) (d) you are required to: Ensure the discharge of residents from the designated centre is discussed, planned for and agreed with residents and, where appropriate, with residents' representatives.

Please state the actions you have taken or are planning to take:
The Admission Transfer and Discharge Policy has been updated in October 2015 and circulated to the centre.

Proposed Timescale: 23/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no handrails or grab rails in the bathroom. A referral for an occupational therapy (OT) assessment had been received in April 2015 and identified as a priority. It was not clear from a resident's mobility care plan if this referral for an assessment of a resident getting in and out of the bath had been completed.

12. 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:
Work commenced on the 26/10/2015 to provide more appropriate showering facilities in the centre to ensure that one individual had sole use of their own ensuite and that all service users have access to appropriate bathroom facilities. This work is scheduled to be completed on 17/12/2015. The occupational therapist has been involved in this new bathroom and has advised that once work is completed she will recommend the aids required by individual service users to support their mobility needs.

The Person in Charge will ensure that the recommendations from the occupational therapy assessment will be documented and actioned.

Proposed Timescale: 17/12/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management system was not robust. It was not demonstrated that risk assessments were being developed by suitably competent persons or that input from other suitably competent persons was obtained where necessary. Also, where residents had mobility needs, adequate measures had not been put in place.

13. 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:
Since inspection the Person in Charge, house manager and Clinical Nurse Manager 3 have reviewed risk assessments of the centre. Staff will receive further training from the Person in Charge and Clinical Nurse Manager 3. A manual handling instructor is scheduled to review all manual handling risk assessments in the centre on the 10/12/2015 with the Person in Charge and staff of the centre.

The fire safety arrangements with particular focus on means of escape from one house in the centre will be reviewed by the Director of Logistics who is also a qualified fire engineer by the 11/12/2015 and measures will be taken to address the issues identified.

Proposed Timescale: 17/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that adequate means of escape was not provided for staff and residents. In one of the houses the attic had been converted and contained two bedrooms, a staff office and a bathroom. One of the bedrooms was a staff sleepover room and the other bedroom had been used as a resident bedroom but was now vacant. The vacant bedroom had an en-suite bathroom and inspectors were informed that one resident used the shower in this ensuite facility. The exit from these attic rooms upstairs was directly to the kitchen. This arrangement could not guarantee exit from the building in the event of a fire as the only exit from the rooms upstairs was through another room. The staircase was narrow and steep and there was no other exit from the attic area. In addition there was no fire door at the top of the staircase to contain the spread of fire.

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

Please state the actions you have taken or are planning to take:
The fire safety arrangements with particular focus on means of escape from one house in the centre will be reviewed by the Director of Logistics who is also a qualified fire engineer by the 11/12/2015 and measures will be taken to address the issues identified.

All service users since July 2015 that reside in the centre sleep in downstairs bedrooms and use downstairs showering facilities.

There is currently a new bathroom being developed in one house in the centre to ensure that all service users have access to an appropriate bathroom area that meets their needs.

Proposed Timescale: 15/01/2016

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:
Some behaviour support plans did not provide sufficient guidance for staff.

15. 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 the behaviour support plans for individuals in the centre have been reviewed by staff. The Person in Charge and Clinical Nurse Manager 3 have supported the staff in this review to ensure that the behaviour support plans provide greater guidance to staff in supporting service users with behaviour needs in achieving a better quality of life and in managing their behaviour. These plans are now with psychologist for their input and recommendations.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that all staff had received in relation to behaviour that challenges as training records for agency and relief staff who worked in the centre were not available for review during the inspection.

16. 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:
Since inspection the training records for all staff including agency staff are now available in the centre. The Person in Charge will ensure that these continue to be in place and up to date.

All staff working in the centre are trained in challenging behaviour.

Proposed Timescale: 24/11/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices outlined in restrictive practice documentation for individual resident's were still not reflective of restrictive practices in use.

17. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
All restrictive practices in the centre were reviewed by the restrictive practice committee on the 19/11/2015, in attendance was the Person in Charge as part of this committee. All restrictive procedures are reflected in service user care plans.

Proposed Timescale: 27/11/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not satisfactorily demonstrated that the system in place was sufficiently robust to ensure that all personnel were fully aware of a significant safeguarding risk and the necessary measures in place to protect resident(s) and others from abuse.

18. 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:
Since inspection the behaviour support plans for individuals in the centre have been reviewed by staff. The Person in Charge and Clinical Nurse Manager 3 have supported

the staff in this review to ensure that the behaviour support plans provide greater guidance to staff in supporting service users with behaviour needs in achieving a better quality of life and in managing their behaviour. These plans are now with psychologist for their input and recommendations.

Where service users have mental health diagnosis the Person in Charge and house manager will work with the Community Mental Health Team to support the service user's needs. There will be a plan developed that all personnel of the centre are fully aware of in the event of the service user having an acute mental health episode indicating the interventions and plan of care to be put in place.

The Person in Charge at staff meetings will reiterate the importance of safeguarding service users from abuse by their peers or others.

At service user house meetings the Person in Charge and house manager will reiterate to service users how to express a concern and who to go to should they have any concerns.

Proposed Timescale: 31/12/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident was attending a day service against their expressed wishes.

An assessment of each resident's training and development needs and goals was not available.

The policy on access to education, training and development required improvement to ensure that it addressed relevant regulatory requirements.

19. 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:
Following a meeting in September 2015 of the service user, advocate and family, HSE and the team involved in the service user's care around the unsuitable placement of this particular resident in the centre is being progressed.

The service user and independent advocate have since inspection met with an alternative service provider to outline what the service user's wishes/needs and choices around a more appropriate placement both Day and Residential.

The potential provider along with the HSE, the Nominee Provider, the Person in

Charge, service user and their representative will formulate a plan to progress this further.

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: 31/03/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans had not been developed in line with residents' needs.

20. 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 service user care plans will be reviewed by the Person in Charge, the house manager, key worker and with the support and training input from the Clinical Nurse Manager 3. Where an assessment has not already been completed or a care need identified an assessment will be completed by a registered nurse and a multi disciplinary team member where required, and plans of care set out. The plan of care will have review dates as necessary depending on the service users care needs, and changes in same. The Person in Charge will monitor and the Clinical Nurse Manager 3 will audit the effectiveness and ensure the completion of these assessments and plans of care, and reviews as recommended. All identified health care needs will have a plan of care in place.

All plans of care will have a review date and the review will be completed by the named keyworker.

Proposed Timescale: 31/12/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that medicines were administered as prescribed as staff were unable to withhold a medication from the blister pack system if necessary. This practice could potentially lead to other medications in the blister pack not being administered as prescribed.

21. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
This practice has been reviewed by the Medication Management Co-ordinator and the Clinical Nurse Manager 3 and where necessary, medication can be withheld from a blister pack and the other medications in that pack will be administered to the service user. This will ensure the service users receive their prescribed medication.

Proposed Timescale: 24/11/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An inspector reviewed the recording of temperatures of a dedicated fridge for the storage of medicines in one house. While daily recordings were documented, a number of recordings exceeded the recommended upper temperature range and corrective action had not been taken, as necessary to ensure that medicines are stored in accordance with the manufacturer's instructions.

In the second house, medicines requiring refrigeration were not stored appropriately as medication was stored in a domestic fridge instead of a dedicated fridge. This practice was not in line with professional guidance issued by An Bord Altranais agus Cnáimhseachais.

22. Action Required:
Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

The Nominee Provider has advised the Person in Charge that Temperature recordings outside of the normal range will immediately be reported to the maintenance manager and the fridge will be either repaired or replaced. The Person in Charge has advised all house staff of this.

The fridge in the second house in the centre has been replaced post inspection.

Proposed Timescale: 23/10/2015

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, which is a document that describes the service provided in the centre, did not have sufficient information in relation to:
• The specific care and support needs the centre was intended to meet;
• criteria used for admission to the designated centre, including the policy and procedures (if any) for emergency admissions
• the correct number of the residents for whom it was intended that accommodation should be provided
• an accurate description of the rooms in the centre.

23. 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 revised Statement of Purpose was submitted to the Authority post inspection to include all of the above.

Proposed Timescale: 24/11/2015

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:
A certificate of planning compliance for the two buildings that comprise the designated centre had not been submitted to the Authority as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

24. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Nominee Provider has consulted with the Director of Logistics regarding certificates of compliance for the two buildings. These will be completed and forwarded to the Authority.

Proposed Timescale: 04/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied with the uncertainty around the post of the services manager and the potential impact on the governance and leadership being currently provided.

25. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The current service manager's contract is extended to ensure current governance and leadership is not impacted upon.

The second recruitment process has commenced for the post of service manager.

Proposed Timescale: 28/02/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied with the workload of the person in charge in circumstances where there were complex needs of residents across all four centres.

26. 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 number of areas of responsibility of the Person in Charge will be reduced in December 2015.

Proposed Timescale: 09/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The house manager had been appointed to cover both houses in this centre. Inspectors reviewed minutes of communication meetings where it had been outlined by staff that "the delivery of care (to residents) was compromised by the limited scope of the house manager's roster covering both houses in the centre. This was due to the complex needs of service users and reduced staff complement."

27. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
The Clinical Nurse Manager 3, the Person in Charge and the house manager will review the roster of the house manager to ensure that the house manager is present in both houses and available to lead staff in the delivery of care to service users. The Person in Charge will have weekly communication meetings with the house manager where areas of support for the manager will be identified. The Clinical Nurse Manager 3 will support this process also.

Proposed Timescale: 11/12/2015

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 staff had the required skills and qualifications to meet the needs of residents.

28. 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 schedule dates to review service user care plans with the relevant keyworkers to ensure that the service user's needs are appropriately met. The Clinical Nurse Manager 3 will deliver training to staff in both houses on personal plans and completing healthcare need assessments and plans of care.

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:
Training received by agency and relief staff who worked in the centre could not be confirmed as those training records were not available for review in the centre during the inspection.

29. 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:
Since inspection the training records for all staff including agency staff are now available in the centre. The Person in Charge will ensure that these continue to be in place and up to date.

Proposed Timescale: 24/11/2015