

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Dun Aoibhinn Services - Cashel
<b>Centre ID:</b>	OSV-0004726
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services South East
<b>Provider Nominee:</b>	Johanna Cooney
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	Maureen Burns Rees
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	10
<b>Number of vacancies on the date of inspection:</b>	2

## 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:
30 August 2016 10:00	30 August 2016 18:30
31 August 2016 08:30	31 August 2016 14:30

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

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

**Summary of findings from this inspection**

Background to inspection:

This was the second inspection of this centre which forms part of an organisation which has a number of designated centres in the region and others nationwide. The purpose of the inspection was to determine the registration status of the centre.

A monitoring inspection had been undertaken on 2 March 2016 at which time four major non-compliances were identified in Health and Safety, Governance, Workforce and Safeguarding. Following that inspection and further inspections of a number of other centres operated by the provider in the region, where a significant number of

non-compliances, were also identified the provider was requested to attend a meeting with The Health Information and Quality Authority (HIQA) on 25 April 2016.

In response the provider submitted a detailed proposal outlining changes to governance structures, reconfiguration of the centres and actions to mediate the significant fire safety risks identified. On this inspection it was found that the actions outlined in the provider plan in relation to this centre had been satisfactorily completed.

How we gathered our evidence:

The inspection was announced and took place over two days. A full review of all 18 outcomes was undertaken. As part of the inspection inspectors met with residents and staff members, senior staff and the service manager.

Three residents spoke with inspectors and a number were assisted by staff to complete questionnaires. They expressed satisfaction with the service, and said they felt safe because there were staff always present and the doors and windows were looked at night. They could do the activities they liked and also liked having their own bedrooms where they could watch TV and listen to their music. They said if they had a complaint, staff would help them to put the "I'm Not Happy Card" in the box provided. Other residents communicated according to their own preferences and allowed inspectors to spend time with them.

Two relatives /significant persons communicated with inspectors and they were very happy with the care provided, staff went above and beyond to make the residents happy, they had lots of good activities, very good medical care and they could visit them at any time.

Inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, and policies, procedures and personnel files.

Description of the service:

This centre is designed to provide care for male and female adults with moderate to severe intellectual and physical disability and age related needs. The care practices and systems were congruent with the statement as outlined. A part of the reconfiguration outlined in the provider's action plan one of the original three units was removed from the centre profile and assigned to another of the provider's designated centres.

At the time of this inspection the centre was comprised of two detached bungalows in a suitable and easily accessible location with ease of access to all amenities and services.

Overall judgment of our findings:

Inspectors found that the provider had made improvements in a significant number of areas which supported residents' safety and rights. The provider had made significant progress in all areas of non-compliance identified at the previous inspection. Overall, inspectors were satisfied that the provider had put governance

systems in place to ensure that the regulations were being met. This resulted in positive experiences for residents, the details of which are described in the report.

Good practice was identified in areas such as:

- Residents were to make choices and complaints were managed transparently and there was access to advocacy (outcome 1)
- Positive relationships with family and friends was promoted (outcome 3)
- The premises was suitable to meet the needs of all residents (Outcome 8)
- There was good access to a range of allied health services which promoted residents wellbeing (outcome 5 & 11)
- Risk management procedures were satisfactory which helped to keep residents safe (outcome 7)
- Staff were available to meet residents needs (outcome 7)

Improvements were required in the following areas:

- Arrangements for the absence of the person in charge (outcome 14)
- Devising and implementation of personal plans and healthcare plans (outcome 5 & 11)
- Systems for the review of the use of restrictive practice (outcome 8)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that residents were supported to participate in the life of the centre and to make choices and decision with supports where necessary.

The complaint policy was in accordance with the regulations and there was evidence on records of the actions taken where any concerns were raised. This indicated that the person in charge had responded appropriately to complaints and did seek the views of the complainant on the outcome of any issues. The policy was available in pictorial and easy read format. Where families raised issues on behalf of residents they were also seen to be managed transparently.

Residents' meetings were held daily in each house. The records indicated that matters such as menus and activities and achievements were discussed. They were also used as mediums to inform residents of what their schedules' and chosen activities were.

The capacity of the residents to communicate differed between the units. Where residents could not participate in such meetings there was evidence that staff individually and in consultation with relatives sought to ensure they were included and were happy with their routines and plans. Inspectors observed staff using objects of reference to elicit preferences.

Residents had been enabled to make decisions regarding their day care arrangements and these had been facilitated. A review of a sample of records pertaining to residents finances showed that the systems were transparent, all transactions recorded and there was oversight of these. One resident was the subject of a court order for treatment

purposes. The provider had procured the necessary documentation of the relevant order in relation to this to ensure it was adhered to.

There was a regional advocacy group where one resident represented the views or wishes of the others, and where residents could not make their views known staff acted on their behalf.

Privacy and dignity was seen to be respected with staff seen to always knock before entering a bedroom and bathroom doors were closed when personal care was being given. Staff were seen to interact with the residents warmly and in a respectful manner.

**Judgment:**  
Compliant

### **Outcome 02: Communication**

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

**Theme:**  
Individualised Supports and Care

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

No actions were required from the previous inspection.

#### **Findings:**

Some improvements were required to ensure that residents who could not communicate verbally were facilitated to do so through appropriate assessment and the development of personal plans in relation to this.

Staff were however very familiar with the residents non verbal communications and were seen to be attentive and responsive to this.

Pictorial images were seen to be used to help with sequencing of events for the residents and the complaints process, daily living schedules and safeguarding systems were outlined in a very suitable format. One resident used the computer for internet access and others had access to the local papers.

**Judgment:**  
Substantially Compliant

**Outcome 03: Family and personal relationships and links with the community**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Inspectors saw evidence from records reviewed and from speaking with residents and information received from family members that familial and significant relationships were respected, maintained and supported. There was evidence of regular communication with families who were involved in all decisions and planning with the residents. Relatives confirmed this.

There was ample room in the centre for visits to take place in private. Holidays and visits home were regular where this could be facilitated and there was evidence that staff ensured residents were able to attend and be present at all special family occasions.

There was evidence that families were quickly informed of any incidents or changes in health status. Residents had regular access to the local community via activities, shopping, and attendance at local events or religious ceremonies. Some residents attended a local group for older persons and other organised events where they did activities such as baking.

**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 policy was detailed and outlined a formal assessment and decision making process. It was also informed by the need to ensure residents could be



protected from abuse and were compatible to live together.

A review of a recent admission indicated that this process had been followed.

The contract for services was available and outlined the services and facilities to be provided. In one instance inspectors saw that a resident was paying significant sums each month to have repairs done to a "therapeutically prescribed garment" due to behaviour presented. This was contrary to the contract and once brought to the regional manager's attention the decision was taken to the provider to discontinue the practice.

**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):**

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

### **Findings:**

Inspectors reviewed the personal plans, medical records, daily and multidisciplinary reports of five of the residents and found good practice in the systems for the assessment and monitoring of residents needs. The actions from the previous inspection were therefore addressed.

However, there was an inconsistent approach to the development of the required support plans stemming from these assessments. These were noted in relation to mental health, dementia care and end of life care. In one instance the dementia care plan did not correlate with the guidelines defined by the multidisciplinary review. An end of life care plan which was required had not been devised in a timely manner.

The documentation available to provide information to, for example, acute services, while very lengthy did not include the crucial information on intellectual disability or medical condition to ensure consistency of care. As on some occasions staff may not be available immediately to accompany a resident to hospital, for example at night time, this could present a risk.

There was evidence of good multidisciplinary assessment and a range of evidenced based assessment tools used. There was significant involvement of and prompt access to allied services including psychiatry, occupational therapy and speech and language therapy.

Multidisciplinary reviews were held annually or more often as required. Each resident had a personal plan which outlined their individual wishes and preferences and these were completed with the participation of the resident and or relative. These were very detailed on a range of domains including, health, nutrition, safety, communication, family supports and social inclusion. They included timeframes and named persons responsible for implementation. It was possible in most but not all instances to confirm that the plans had been implemented although in some instances such as ongoing access to sensory supports this was not evident.

There was evidence that each resident was reviewed internally on a three monthly or more frequent basis if this was required based on changes in health or behaviour.

Resident's wishes and preference for social activities were very well supported. The capacity and preferences of the residents differed greatly for social activities and daily routines and support needs. These were individually planned but not rigidly prescribed and inspectors saw that during the days of inspection residents could make choices as to their activities and these were facilitated. Some went to local GAA matches, horse riding, and walking, musical events and also had good social interaction with staff within the units. There were staff and transport available to ensure these could take place.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The premises is suitable in size, lay out, design and accessibility for the needs of the residents. It is comprised of two spacious detached bungalows in close proximity to the local town and all services.

The accommodation is comfortable and spacious with all residents having their own bedrooms and sufficient shower and bathroom facilities some of which are en suite. While currently a number contain baths the inspector was informed that it is the intention to remodel these into wet rooms which will better serve the residents as their mobility decreases. The living areas are comfortable and spacious seating with an additional sitting room for space and privacy.

Bedrooms, bathrooms and corridors were of suitable size to facilitate the use of the assistive equipment. There was a suitably equipped laundry room.

The kitchen and dining areas were spacious and suitably furnished while domestic in style. The premises were well maintained, bright and homely. Bedrooms were very personalised with the residents' possessions, photographs and records of achievement. The heating and ventilation was suitable and the standard of cleanliness was notably good. The location was in close proximity to transport, shops and the local village. There were easily accessible and very pretty gardens which had suitable seating and as the front gate was seen to be kept closed residents could walk and spend time outside safely. Inspectors saw evidence that the equipment necessary including the hoist, specialized bed, wheelchairs and the transport was serviced regularly.

**Judgment:**

Compliant

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

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

**Theme:**

Effective Services

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

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

**Findings:**

There were 9 actions from the previous inspection and inspectors found that in relation to the two units in the revised configuration of the centre all actions had been addressed. Fire safety management systems were found to be good with evidence that equipment including the fire alarm, extinguishers and emergency lighting installed were serviced quarterly and annually as required.

Fire doors which were identified as being wedged open had been fitted with Magi locks to prevent this occurring. The provider was in the process of having a window replaced with a door to provide an additional escape route for one dependant resident. Personal evacuation plans were available for one resident and regular fire drills including deep sleep drills had taken place. Where two staff were required to evacuate this had been addressed by the provision of an additional night staff.

There were risk assessment and management plans for manual handling and the safe use of the hoist. Infection control measures were satisfactory. Staff were able to tell inspectors of the manual handling and hoist procedures.

Systems for identifying and responding to risk were found to be proportionate and balanced. For example, residents had full and free access to the gardens and front of the house with the front gate closed to prevent injury. Residents who smoked had safe smoking areas and precautions were taken such as removal of the lighters.

There was a signed and current health and safety statement available. A number of safety audits of the environment and work practices had been undertaken and were updated regularly. The risk management policy was current and complied with the regulations including the process for learning from and review of untoward events. A centre-specific risk register was maintained. There were measures in place to manage identified risks such as falls, choking episodes or residents going absent inadvertently. Risks identified included both environmental and clinical in accordance with the residents' needs and there were controls in place to mitigate against these.

Individual risk assessments were completed for residents to address issues pertinent to their assessed needs. Inspectors found that the policy was implemented in practice. There were systems for the review of all accidents and incidents with the service managers overseeing the immediate and follow up actions. Such incidents were not a significant feature of the service.

There were policies in place including a detailed emergency plan which contained all of the required information including arrangements for the interim accommodation of residents should this be required. Emergency phone numbers were readily available to staff.

There was evidence of learning from accidents or incidents. This is demonstrated by the provision of additional night staff and nursing support for the residents. Auditing systems are discussed under outcome Governance.

**Judgment:**  
Compliant

### **Outcome 08: Safeguarding and Safety**

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

**Theme:**  
Safe Services

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

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

**Findings:**

There were seven actions required following the previous inspection. Most had been satisfactorily resolved. One action which was not fully resolved was in relation to the use of restrictive practices. This was specific to the wearing of a garment which impacted on the resident's movement and dignity. The garment was not of a material to be suitable for warm weather or comfortable enough for night time. There was evidence that a full review of this restriction was now planned and both psychiatric and psychology services were scheduled to undertake this.

However, this matter had required review for over one year. The methodology for decision making and evidence that there remained a valid need for the use of this garment or that alternatives had been tried was not evident to inspectors. The documented period of release of the garment for personal care did not indicate if the behaviours of concern were still evident.

The use of restrictive practice was not in this instance based on national guidelines or the centres policy.

The provider had satisfactorily addressed a second restrictive practice with the provision of additional staff which ensured other residents' safety and the resident in question was not unnecessarily confined to a small space due to staff shortages. The rationale for the practice had also been clarified to ensure it remained valid.

Other restrictions such as bedrails or lap belts were assessed for safety and rationale and where relevant overseen by the relevant clinician. The inspector was satisfied that these were proportionate and reasonable actions.

The use of p.r.n. (administered as required) medication was carefully managed, clinically overseen, recorded and reviewed.

While staff had training in the management of behaviour that challenged some behaviour support plans had not been reviewed in 18 months and there was no evidence that the plans were being implemented. This was not a consistent finding however but was evident where needs were complex.

Inspectors reviewed the policies and procedures for the prevention, detection and response to allegations of abuse and the protection of vulnerable adults. The policy was in accordance with the revised Health Service Executive (HSE) policy to ensure satisfactory screening, implementation of safeguarding plans and adequate review of incidents.

The provider employed a dedicated social work service. There was a suitably qualified and experienced person nominated as the designated person to oversee any allegations of this nature. Records demonstrated that all current staff in the centre had received up to date training in the prevention of and response to abuse.

There was evidence that where a recent incident of potential neglect had been identified the provider took appropriate safeguarding steps and initiated a full investigation of the incident. Learning was evident in training needs being identified and duly scheduled as a result of this.

Inspectors was informed that no further allegations were currently being investigated in the centre. Staff were able to demonstrate their understanding of abusive behaviours and of the correct reporting procedures. They expressed confidence in their management to take the appropriate action in the event of such incidents.

Each resident had a detailed intimate care plan in place. There were also pictorial and easy read versions of safeguarding systems for residents. Residents who could communicate informed inspectors that they felt safe in the centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

A review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated that the person in charge was in compliance with requirement to forward the required notifications to the Authority. All incidents were found to be reviewed internally.

**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:**

The provider was in compliance with this regulation. There was evidence from observation, conversation and review of records that the residents' daily routines were driven by personal choices and appropriate to their stage of life. A number attended day care services managed by the organisation for varying periods and this was carefully planned and pertinent to their individual needs. One resident was doing money management as part of this programme.

By virtue of choice, health and age a number of residents did activities in the house including games, small tasks with staff, foot massage and all had regular outings including trips to the seaside, horse riding, therapeutic sensory input or walks. Trips to the pub, concerts and local evens were seen to take place regularly.

It was noted that while in the house there was constant and very good communication and interaction with staff and they had full access to music and television of their choice. Personal plans provided details as to the level of personal support necessary with tasks.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found that resident's health care needs were supported in a timely manner and there was improved access to nursing care as required by the previous inspection. However, improvements were still required in the management of specific symptoms and the development of appropriate plans to guide practice and prevent deterioration.

Inspectors found that wound care plans did not provide sufficient guidance to staff. The documentation used to record the condition of the wound and intervention given did not ensure consistency of treatment and monitoring. The provider had recognised the need for training in this area and this was scheduled. However, given that this was previously

recognised as a risk, the training should have been sought for staff at an earlier stage.

A number of residents did not have specific healthcare support plans for assessed needs for example, significant breathing deficits. While staff were able to articulate the supports in place the lack of clear guidance could undermine the promotion and the consistent implementation of the best possible health for the residents.

There was policy on end of life care. Inspectors found that the provider had ensured that supports to meet the physical, emotional and spiritual needs at time of acute illness were made available. This was carried out in accordance with the resident's expressed wishes and palliative care was sourced and available.

However, the relevant care plans for the physical care needed had not been put in place in a timely manner. From a review of the daily records and other documentation inspectors were satisfied that the appropriate care was delivered at the time and a relative confirmed this to the inspector. This is actioned therefore under outcome 5 Social Care needs. The formal recording of advance decisions in regard to further hospitalisation or resuscitation was not completed in a timely manner. This could have compromised the resident's wishes being complied with.

There was timely and frequent access to residents' general practitioners and a number had maintained their own GPs which ensured consistency.

There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, mental health specialists, dieticians and physiotherapy, psychiatry of old age and geriatricians. The interventions of these clinicians informed the delivery of care on a daily basis.

Inspectors found that evidenced based assessment tools were used for dependency levels, and nutrition. These informed detailed management plans.

The inspector saw evidence of health promotion and monitoring with regular tests and interventions to manage health issues and specific issues such as, diabetes, seizures or medication usage. There were protocols in place for the management of epilepsy and emergency medication which staff were familiar with.

Residents' nutritional needs were being addressed and monitored. There was documentary evidence of advice from dieticians and speech and language therapists available and staff were knowledgeable on the residents' dietary needs. Inspectors observed that they received the correct consistency of food and fluids.

They were also aware of residents' preferences and they had significant choices. Resident's weights were monitored regularly. The meal times as observed were relaxed social occasions and staff joined the residents for meals. Where assistance was required this was observed to be given in a dignified manner with good communication.

**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):**

No actions were required from the previous inspection.

**Findings:**

The policy on the management of medicines was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for medicines were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medicines.

There was good communication noted with the dispensing pharmacists who also undertook an audit of medication administration and usage. Where errors were noted actions were taken to minimise risk and remedy these.

Inspectors were informed that only staff who had undergone medication management training were administering medication and competency was assessed following the training.

Medication was reviewed regularly by both the residents GPs and the prescribing psychiatric service. No resident was assessed as having the capacity or wished to self-administer medication.

Protocols for the use of pro-re-nata (as required) medicine were in place and staff were aware of these.

**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:**

The statement of purpose was forwarded and found to be in accordance with the regulations. Admissions to the centre and care practices implemented were congruent with the statement as a service for residents with moderate to severe intellectual and physical disabilities and residents with age related care needs.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

There were five actions required from the previous inspection and there was evidence that the provider had satisfactorily resolved the issues.

There was clear and effective governance and reporting structures in place with evidence of improved systems to promote accountability.

There had been no person in charge at the time of the previous monitoring event. A fulltime suitably qualified and experienced nurse who was the team leader in the centre had been appointed to the post as agreed. This person was not available during the inspection but all documents had been forwarded to HIQA.

However, the arrangements for the absence of the person in charge were not satisfactory with no one person assigned responsibility for the duration of the current absence which was circa three months. This was however, mediated by the role of the services manager and the senior staff in both units and therefore there was no evidence that this impacted negatively on residents' care in this instance. This was discussed with the regional manager who agreed to make adequate arrangements in the future.

There was a clear and documented reporting structure with issues of concern and relevance forwarded to the services manager and then discussed with the regional manager as necessary. Regular meetings were also held with the Person in Charge.

The local management team included the regional services manager, service manager, human resources, social work and psychology department.

The provider nominee had commissioned an unannounced visit in June 2016 and a further visit was scheduled. Inspectors reviewed this report and found that it was comprehensive and focused with a detailed action plan issued.

Inspectors also found that significant work had been undertaken by the provider to address the actions identified in both the previous inspection report and the unannounced visit which included health and safety, environmental and clinical care issues.

The annual report for 2015 was available and while it was detailed it required further development of the framework to ensure a more robust evaluation of the service. The resident's and relatives views were included and very positive in regard to the service and care provided.

A number of audits were undertaken on medicine usage and administration, pro-re-nata (as required medication) usage, falls and challenging behaviour incidents. However, as with the annual report there was not sufficient evidence that the information collated was analysed sufficiently to inform practices.

The inspector was satisfied however, that these systems were part of an on-going developmental process and will when fully operational provide effective oversight of the delivery of care.

There was a satisfactory day and night time on-call system in place and staff confirmed that this was effective and responsive.

**Judgment:**  
Non Compliant - Moderate

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

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

**Theme:**  
Leadership, Governance and Management

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

**Findings:**  
While the provider had complied with the requirement to notify HIQA of any proposed absence of the person in charge for a period longer than 28 days the arrangements

outlined in the notification for the management of the centre were found not be correct. This is actioned under outcome 14 Governance.

**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:**  
Inspectors were satisfied that the service was funded and resourced to provide the staffing, facilities and services necessary to meet the needs of the residents.

**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:**  
There were two actions required from the previous monitoring event. While not entirely resolved, progress had been made to ensure there was sufficient nursing staff available to meet the assessed needs of the residents. The provider had increased the nursing staff availability to ensure that there was one qualified nurse available between both units during the day, evening and weekends. Recruitment had taken place and further

nursing staff were due to commence duty in September. This would ensure that there was also a nurse on duty and available to both units overnight.

From a review of the rosters over a sample period of time inspectors were satisfied with the actions taken to address this deficit. The additional staff also ensured that the person in charge had protected time to carry out management functions as opposed to primarily nursing duties.

However, an emergency clinical process which may be required for a resident required suitably trained staff and only one nurse currently had this training. This deficit required the resident's attendance at an acute hospital to have the procedure carried out. This was known to be very stressful for the resident. One further staff was scheduled to undertake this training but this would still require review to ensure the skill mix is satisfactory to meet the resident's needs.

Deployment of staff was undertaken in a manner to ensure the required cover was available with a minimum of two waking and one sleep over staff between the units at night. It was also undertaken to ensure procedures such as the administration of emergency medicine could be carried out.

The training needs analysis undertaken by the provider had identified deficits in wound care and dementia as being necessary to meet the needs of the residents and this was scheduled.

From a review of the training records all mandatory training in manual handling, first aid, and safeguarding and fire safety was up to date and further training was scheduled. There was a good level of professional training evident with a number of staff qualified in social care and social care leaders in each unit.

There was a centre-specific policy on recruitment and selection of staff. A number of staff had been with the service for some time. There was an induction programme in place. A documented staff supervision /appraisal programme had commenced. Inspectors were informed that other mediums such as team meetings, and observations of practice would also be deployed and further formal supervision undertaken as required.

An examination of a sample of personnel files showed good practice in recruitment procedures for staff with the required documentation sourced and verified by the person in charge prior to taking up appointments. No volunteers were available. Staff were responsible for all ancillary duties such as preparing meals, shopping and cleaning of the centre.

**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):**

No actions were required from the previous inspection.

**Findings:**

All documentation required for the purposes of registration were provided and the required policies were available.

Schedule 2 documents in relation to staff were available and Schedule 3 records were substantially complete. Where improvements were required in residents records they are detailed and actioned under the relevant outcome.

**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:***

Noelene Dowling  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Action Plan

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

Centre name:	Dun Aoibhinn Services - Cashel
Centre ID:	OSV-0004726
Date of Inspection:	30 August 2016
Date of response:	12 October 2016

### Requirements

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

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

#### Outcome 02: Communication

**Theme:** Individualised Supports and Care

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

Residents communication needs were not assessed and outlined in their personal plans.

**1. Action Required:**

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

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

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

Support plans in relation to the communication needs of 6 of the 7 identified individuals are now outlined in their personal plans. The final individual has been referred for assessment by Speech and Language Therapist and will be reviewed by 24th October 2016.

**Proposed Timescale:** 24/10/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Some residents did not have personal plans to support assessed and identified need and some plans including those for end of life care were not implemented in a timely manner.

**2. Action Required:**

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Personal plans for the identified residents have now been updated to support their identified needs. Where end of life care plans are required into the future they will be implemented in a timely manner.

**Proposed Timescale:** 06/10/2016

**Theme:** Effective Services

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

A resident's personal plan did not reflect the decision and recommendations of the multidisciplinary review.

**3. 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:**

This individual's plan will be updated to reflect the decision and recommendations of the multidisciplinary review as of 10th October 2016.

**Proposed Timescale:** 10/10/2016



**Theme:** Effective Services

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

Documentation available in the event of transfer to acute services did not contain the pertinent information.

**4. Action Required:**

Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

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

Hospital Passports for all of the individuals are in the process of being reviewed and these will be completed by 25th October 2016.

**Proposed Timescale:** 25/10/2016

**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 restrictive practices were not sufficiently reviewed to ensure they were the least restrictive and proportionate to the risk or behaviour identified.

Clothing used as a restriction was not reviewed for suitability.

Some behaviour support plans were not reviewed or implemented.

**5. 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:**

A review of restrictive practices took place on 29/09/2016.

Alternatives to the clothing restriction are being sought and trialled with the individual – 28th October 2016 and ongoing.

Behaviour support plans are being reviewed with the psychologist as of 14th October 2016.

**Proposed Timescale:** 28/10/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

Some health support plans were not devised or sufficient to guide staff in the implementation of treatment for residents.

**6. Action Required:**

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

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

The health support plans for the identified needs are in the process of being devised and/or revised. These are due for completion on 20th October 2016.

**Proposed Timescale:** 20/10/2016

## Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

Arrangements for the absence of the person in charge were not satisfactory.

**7. 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 arrangements for any future absences of the person in charge have been revised to ensure the nomination of one identified person to replace the person in charge and this is outlined in our revised Statement of Purpose which has been forwarded to the Authority.

**Proposed Timescale:** 27/09/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

Some improvements were required to the provision of additional training for staff in a specific clinical procedure.

**8. 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:**

Three additional nursing staff were trained in this technique on 30th September 2016.

**Proposed Timescale:** 30/09/2016