Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Group C - Community Residential Service Limerick
Centre ID:	OSV-0003941
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Geraldine Galvin
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
27 February 2017 09:15	27 February 2017 19:00
28 February 2017 09:15	28 February 2017 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
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 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This inspection was the third inspection of the centre by The Health Information and Quality Authority (HIQA); (an additional monitoring inspection had taken place in one house).

The last inspection was undertaken in April 2016; this current inspection was undertaken to follow-up on the actions arising from that inspection and to monitor on-going regulatory compliance so as to inform a registration decision.

How we gathered our evidence:
The inspection was facilitated by the person in charge, the nominated provider and frontline staff on duty in the two houses.

Prior to the inspection the inspector reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the

original and amended application for registration of the centre, the previous inspection findings and action plan, updates on the action plan and notice received of any incidents that had occurred in the centre. During the inspection the inspector reviewed records including policies and procedures, fire and health and safety related records, and records pertaining to staff and residents.

The inspector met with all of the residents living in the centre at the time of this inspection. The inspector found residents to be engaged and they spoke freely of their plans for the day, their interests, the support they received from staff, their background and the importance of family and home, friendships and community links. Residents had an understanding of HIQA and the work of the inspector and also discussed matters of concern to them and the impact of this on them and their quality of life.

The inspector observed that residents and staff mixed easily with each other.

Description of the service:
The provider had in November 2016 reconfigured the centre so that it now consisted of two houses that accommodated eight female residents. The two houses were a short walk from each other and from the main campus where the management team and facilities and supports such as the day service were located. Residential services were provided to a maximum of eight female residents on a full-time basis.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The statement had been reviewed in March 2017 and reflected changes such as the reconfiguration of the centre and other changes such as staffing levels; the inspector found that the service to be provided was as described in that document.

Overall Findings:
Of the 12 Outcomes reviewed the provider was judged to be complaint with nine, in moderate compliance with one and in major non-compliance with two; Outcome 7 Health and Safety and Risk Management and Outcome 8 Safeguarding and Safety.

There was evidence of good practice and evidence of an ethos of care that supported respect for and facilitated resident independence and autonomy and that wished to demonstrate compliance with regulatory requirements.

However, notwithstanding this overarching statement, the quality of life and the quality and safety of the care and supports provided to all residents were negatively impacted on by the ongoing failure to provide an appropriate placement for one resident based on their assessed needs. This failing has been identified and acknowledged by the provider, measures had been taken and continued to be taken by the provider in an attempt to manage the situation but ultimately the situation was unresolved; residents assessed needs were not being adequately met and residents were not protected at all times from physical and psychological harm.

Because of the requirement to prevent and manage behaviors that challenge there were restrictions on the extent to which all residents had control and choice over

their living arrangements and their routines.

There was a perceived unidentified barrier on behalf of some residents to raising their concerns and dissatisfaction.

In the days just prior to this inspection records seen by the inspector confirmed a serious and concerning breach by staff in the receipt and management of an allegation of physical abuse received by them. The actions taken by staff were in clear breach of local and national safeguarding policy and guidance.

Some but not all fire safety upgrading works recommended by a fire safety audit in 2014 had been completed.

Residents did lead full and active lives outside of the centre and were clearly engaged with family, peers and society; residents spoke of ability rather than disability. Residents were supported to enjoy good health and wellbeing and had access to required healthcare.

Improvement on the last inspection findings was found in relation to the assessment of and planning for resident's needs and supports and facilitating residents to achieve their personal goals and objectives.

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:
While there was substantial evidence of good practice there were restrictions on the extent to which all residents had control and choice over their living arrangements and their routines. There was a perceived barrier on behalf of some residents to raising their concerns and dissatisfaction.

The inspector saw that further to the last inspection bedroom and bathroom doors had been fitted with privacy locks; residents highlighted these to the inspector and the additional privacy that they afforded.

The inspector noted positive interactions between staff and residents and the records created by staff were noted to be respectful and tempered in content, tone and language.

The inspector saw that residents lived full and active lives, were busy and engaged and had plans throughout the inspection process. Residents were observed to engage freely with staff and went about their daily routines with enthusiasm; there was ongoing consultation and discussion between staff and residents on all matters pertaining to the daily routine. Formal house meetings were also convened; the required frequency was monthly.

Records seen indicated that residents engaged with this process, signed the minutes and discussed matters including staying safe, fire safety and complaints with staff in addition to matters pertaining to the routine of the house. However, while records seen

indicated an established monthly pattern of meetings in one house there had been no house meeting held in one house between October 2016 and February 2017.

There were policies and procedures for the management of complaints and a complaints log was maintained in each house. It was clear that residents understood what a complaint was; there was documentary evidence that on at least two occasions' staff had supported residents to create a record of matters of concern to them to be forwarded to the provider; the resident's wishes had been respected. The provider had also facilitated access for residents to an independent advocacy service.

However, the complaints log was empty and there was clearly an ongoing matter of concern to residents in one house; this was known and accepted by the provider. On speaking with residents the inspector noted that some residents were clearly reluctant to "complain" and were "afraid" of the consequences of complaining; one articulated feared consequence was the fear of being requested to move from the house if they complained. It was not evidenced where this fear originated from, whether it was intrinsic or extrinsic but it was brought to the attention of both the person in charge and the provider nominee at verbal feedback.

All staff spoken with clearly understood and articulated that some strategies implemented for safety in response to behaviours of concern and risk had become routine in the house and were impacting negatively on the right of residents to exercise reasonable control and choice over their basic daily routines in what was their home. Limitations included (some of which were observed by the inspector) the time that residents got up at, when they could have their breakfast, the time they could have their evening meal and how they choose to spend the evening and weekend.

Two residents were required to spend time in their bedrooms to prevent an incident of behaviour of concern and risk. While there was an element of thought that these particular residents had always chosen to spend time in their rooms, the evidence was irrefutable that this was also required for their personal physical and psychological safety when another resident was in the house.

The providers own review of the centre in December 2016 had concluded that while there was assurance of a good quality service there was a clear negative impact on the quality of life for residents in one house as a consequence of behaviours of concern and risk.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Staff spoken with generally had a good understanding of each resident's means of communication and of the supports required to ensure effective communication. Some residents had good verbal communication ability while other residents required support be that staff knowledge and understanding of their needs or the use of assistive devices.

Communication assessments had been completed and where necessary residents had been referred to and reviewed by the speech and language therapist. There was evidence of recommended interventions in practice such as the use of communication passports, PECS (picture exchange communication systems), graphics to establish and facilitate expressions of emotion and the introduction of electronic devices and communication applications.

Staff spoken with had a clear understanding of the effectiveness or not of these interventions and the importance of the maintenance of existing verbal skills and respect for resident choice; for example if a resident choose at times not the use the PECS.

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:
Based on the sample of personal plans for residents reviewed by the inspector significant improvement was noted.

The inspector saw that each resident had had a detailed assessment of their holistic needs from which plans of support were developed; the assessments and plans had

been reviewed within the previous twelve months or later.

There was evidence of the resident's participation in the plan; some residents had signed off the plans of support. The accessibility of the plan was enhanced by graphic and photographic supports.

Having spoken with the person in charge, frontline staff and residents themselves, the inspector was satisfied that the assessments and support plans reflected the resident, their needs, choices and preferences.

Assessments and support plans were seen to incorporate the findings and recommendations of members of the multi-disciplinary team. The provider nominee and the person in charge confirmed that each personal plan had been the subject of a multi-disciplinary review in November 2016 but the minutes of some of these reviews were awaited at the time of inspection.

Based on the records seen improvement was also noted in the process for identifying, agreeing and progressing residents personal goals and objectives. Timeframes and responsible persons were identified and clear records were maintained of the actions taken by staff with residents to progress the achievement of their goals. The identified goals were individualised to each resident and reflected personal, social and developmental themes.

Judgment:
Compliant

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:
Since the last inspection the provider had made a decision to reconfigure the centre and remove one house from the centre and establish that house as a stand-alone designated centre.

The designated centre now comprised on two houses within a short walk of each other and from the main campus. The inspector saw and residents confirmed that the location of the houses offered residents a high level of independence as they could walk to the

other house, to the services and facilities on the main campus and to the local facilities such as shops and restaurants.

The design and layout of both houses was suited to the needs of the residents; both houses presented as welcoming, comfortable and well-maintained. All accommodation and services were provided on the ground floor in one house and residents confirmed the comfort and independence that this afforded them compared to previous accommodation where they had to negotiate a stairs.

With the exception of one bedroom that was shared by two residents, residents were provided with their own bedroom. The shared bedroom was not an issue for the two residents that occupied it and the provider is committed to and has reduced the prevalence of shared bedrooms when possible. Bedrooms were personalised and afforded sufficient storage space.

Adequate sanitary facilities were provided for the numbers of residents accommodated; one bathroom had been refurbished and refitted to promote universal accessibility.

Each house had a fully fitted and appropriately equipped kitchen; adequate dining space was provided and facilities were available for personal laundry.

Each house had an additional pleasing and bright communal area to the rear with access to a mature garden. One resident was looking forward to spring and doing some light gardening.

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

Findings:
The inspector saw that each house was now fitted with emergency lighting; an automated fire detection system and fire fighting equipment were also in place. Escape routes were clearly indicated, unobstructed on the days of inspection and had been fitted with easily released internal thumb-turn devices.

Staff undertook and recorded daily, weekly and monthly visual checks of these fire safety measures. Staff also undertook with residents, simulated evacuation drills and

discussed with residents the importance of participation and co-operation with these drills. The records seen indicated that good evacuation times were achieved and drills were undertaken to simulate different scenarios including hours of darkness.

However, certificates of the inspection and testing by a competent person of the fire safety systems were not consistently maintained in the fire register that was kept in each house and therefore did not evidence that these inspections had been undertaken at the prescribed intervals.

In July 2014 the provider had commissioned an external competent person to undertake a fire risk assessment of the premises; recommendations assigned either a medium or high priority were issued; all were to be completed in a 12 month timeframe. The provider confirmed that all of the required works were still not complete; these works included the installation of fire resisting doors to protect evacuation routes.

A comprehensive re-assessment of risk assessments was required. The inspector reviewed a sample of risk assessments particularly as they pertained to the safety and welfare of individual residents in the context of behaviours of concern and risk. The risks were identified as were the consequences, the controls in place and any additional controls required. However, based on these inspection findings the impact of the hazard (and to a degree the impact of some required controls) was underestimated and therefore the level of residual risk was inaccurately calculated.

This was discussed with frontline staff, the person in charge and the provider nominee who all agreed that the impact when taking into consideration psychosocial as well as physical impact was underestimated. It was also discussed at verbal feedback that while the impact was acknowledged and clearly articulated by residents and staff spoken with, it was poorly evidenced in records seen such as daily narrative notes.

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:
There were measures in place to protect residents from harm and abuse. These measures included local policies aligned to national safeguarding policy, staff training, the availability of a designated safeguarding officer and on-call support for staff for guidance and direction.

The inspector reviewed the providers policy on safeguarding residents from abuse dated 2014 and reviewed in June 2016; the policy outlined clear guidance, reporting procedures and reporting timeframes for staff in receipt of any allegation of abuse. Staff spoken with confirmed their attendance at safeguarding training and were familiar with the reporting procedure.

However, in the days just prior to this inspection records seen by the inspector and staff spoken with confirmed a serious and concerning breach by staff in the receipt and management of an allegation of physical abuse received by them. The actions taken by staff were in clear breach of local and national safeguarding policy and guidance and did not demonstrate a robust understanding of abuse or staff responsibilities that was sufficient to provide assurance that allegations were always appropriately responded to.

In one house, since the time of the first HIQA inspection in March 2015 there has been an identified and unresolved failing in relation to safeguarding and safety as the provider has not satisfactorily ensured that all residents were protected from injury or harm by their peers.

Over the course of HIQA inspections a number of steps have been taken by the provider in an attempt to address this situation; measures taken included: staffing levels had been increased at key times of the day and were due to be increased again in the days following this inspection; regular access to psychiatry and psychology input; the review of the behaviour support plan by a clinical nurse specialist in behaviour support; workshops for staff; on-going regular MDT review; alternative accommodation had also been explored but this had not progressed.

Staff providing direct supports to residents with behaviors that challenge or posed risks to others and themselves demonstrated and articulated insight, understanding and skill in supporting residents. There was evidence that staff implemented the strategies outlined in the behaviour support plan.

However, the issue was clearly not resolved as the fundamental issue was the inappropriate placement of a resident. It was clearly stated in a needs assessment for residential placement that one resident required accommodation with a smaller group of peers of similar ability and functioning. It was clearly stated that the resident was challenged when accommodated with peers with good verbal and social skills and hence this personal challenge manifested in behaviours that were a risk to these particular residents and to the resident themselves.

The revised behaviour support plan was therapeutic in its approach and informed by a functional analysis of behaviours. However, in reality because of the failure to provide the resident with a placement suited to their needs, two other residents were an

identified trigger for the behaviours exhibited; this resulted in a pattern and routine of segregation in the house.

For example records seen and staff spoken with confirmed that these two residents could not get up and have their breakfast until the other resident had left the house; that resident was taken after breakfast to another house until it was time for them to go to the day service (there were no reported incidents in this house or the day service). Likewise in the evening there was a routine for the residents return to the house; the resident did not return to the house until the other residents had completed their evening meal; the resident returned then and on their return the other two residents either left the house if they had a planned activity or if not went to their bedrooms.

In the days prior to this inspection there was an intense episode of behaviours of concern and risk and a further episode over the course of the inspection; the recorded trigger was the presence of one of the aforementioned residents.

The impact of this enduring situation on all residents was clearly and respectfully articulated by both staff and residents. Descriptors used by staff to describe the house included "tense", "unpredictable", "always on edge", "restrictive" and "not right" and did not provide to all residents the "security" that they deserved and required. All staff spoken with said that two residents in particular spent a significant amount of time upstairs in their rooms for their safety, that it had become routine in the house.

At their invite and with their consent the inspector spoke to residents; residents described the situation in the house as "up and down"; residents described how they felt "hurt", "sad and lonely" when the behaviours were directed at them, that they cried sometimes but also felt angry at times; they felt they now "lived their life" around the requirement to avoid triggering a behaviour.

There was a lack of clarity amongst staff as to the training they had received in responding to behaviors that challenge, including de-escalation and intervention techniques. There was one confirmed gap in facilitating any such training for one staff; training records indicated that another staff had not received training since 2007.

Judgment:
Non Compliant - Major

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:
Over the course of the inspection the inspector saw, records seen indicated and residents spoken with confirmed that they were supported to lead full and active lives. There was consistent evidence of independence, autonomy, maintaining strong family contact, contact with peers and friends, community inclusion and integration. This was facilitated on an individualised basis based on each residents assessed needs, ability and preferences.

Residents communicated to the inspector how they planned to spend their day, their evening and their week and it was clear that they looked forward to what was planned. All residents spoken with confirmed their participation in activation, education, training and/or employment. Records seen indicated that residents always had plans some supported by staff; others with family, friends and peers. There was a good balance struck between what activities were facilitated by the provider and what was accessed in the local community.

Many of the events and activities enjoyed by residents (as shared by them with the inspector) included their holiday last year as a group of peers, social events with family and friends from outside of the service, music groups, returning to swimming, sports including planned trips abroad and paid employment.

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):
No actions were required from the previous inspection.

Findings:
The inspector saw that residents including residents with established chronic illness looked well; residents reported feeling well and enjoying good health.

Detailed healthcare related records were maintained. All staff monitored general health and wellbeing. Access to healthcare personnel and services and the monitoring of required healthcare was seen to be largely facilitated by the person in charge (who was a registered nurse) and other members of the nursing team, for example supporting residents to attend scheduled appointments. There was a formal system of communication between nursing staff and frontline staff where feedback on findings and

any clinical changes were communicated.

The inspector saw that as appropriate to their needs residents had access to regular review by their General Practitioner (GP), to psychology, psychiatry, neurology, speech and language, dental care, optical review, chiropody and specialist healthcare services such as cardiology. Records of each referral and review were in place.

There was evidence of health promoting interventions implemented on a regular basis including annual influenza vaccination, monthly monitoring of body weight and vital signs (temperature, pulse and blood pressure), access to national screening programmes and regular blood-profiling.

From the records seen residents had a good understanding of the importance of these interventions to their general well-being and were practically and emotionally supported by staff as needed, for example while in the acute services or undergoing procedures.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Staff confirmed that medicines were dispensed and supplied to residents by a community based pharmacy in a compliance aid or in the original container as appropriate.

There was a centre-specific medicines management policy that had been reviewed in May 2016 to reflect the requirement for all prescriptions generated to be legible to staff administering medicines.

Staff spoken with articulated an understanding of medicines management and adherence to guidelines and regulatory requirements to ensure safe practice. Staff said that on delivery medicines were checked for accuracy against the prescription; the inspector saw that this check was documented.

The inspector noted that medicines were stored securely and there was secure restricted access to the keys of the medicines storage facility.

The inspector saw and residents confirmed that they were supported by staff to management their own medicines; this practice was supported by a comprehensive and individualised assessment. Staff spoken with described appropriate safeguarding measures to monitor resident compliance.

There were formal records of the review of prescribed medicines by the GP or the psychiatrist on a quarterly basis.

Based on the sample of prescription records seen these records were now typed and were clearly legible; each prescribed medicine was signed and dated by the prescriber. Discontinued medicines were signed and dated as such and the maximum daily dose of medicines administered on a PRN (as required) basis was stated.

Staff maintained a record of each medicine administered by them. The medication administration record identified the medicines on the prescription and allowed space to record comments such as the withholding of medications.

Staff outlined the manner in which medications that were out of date or were no longer needed were stored in a secure manner, segregated from other medicinal products and returned to the pharmacy for disposal; a written record was maintained of the medicines returned to the pharmacy.

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 and function was kept under review by the provider and amended as necessary to reflect any changes made. The statement of purpose contained all of the information required by Regulation 3 and Schedule 1.

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 was a clear management structure consisting of the social care leader, the person in charge and the nominated provider. All staff spoken with were clear on this structure and confirmed the accessibility of the management team to frontline staff.

The person in charge confirmed that she worked full-time and that she was based on the main campus in close proximity to the centre. The person in charge worked weekdays but also participated in the provider's on-call system one weekend in every four; the inspector saw that this on-call rota was available to staff in each house.

The person in charge was suitably qualified and experienced; the person in charge was a registered nurse in intellectual disability nursing and had established management and supervisory experience in her capacity as a clinical nurse manager two (CNM2). The person in charge said and staff spoken with confirmed that she had daily contact with staff and residents either in person or by phone.

The person in charge reported to the provider nominee and both were seen to work in close proximity to each other and met daily. The provider nominee was clearly informed and had a solid understanding of regulatory responsibilities.

Systems that supported effective governance included quarterly meetings of the senior management team, fortnightly meetings of the local management team, quarterly meetings between the provider nominee, the person in charge and the social care leader and quarterly meetings between the provider nominee and frontline staff. This system supported communication and feedback from staff to senior management and vice-versa; the provider nominee said it was efficient and effective.

There were systems in place for the completion of reviews of the quality and safety of the care and supports provided to residents as required by Regulation 23 (1) and (2); the reports of both unannounced reviews and the annual review were available for inspection.

The annual review incorporated feedback from residents and relatives. Each review monitored both ongoing compliance and the implementation of the actions that had

emanated from both internal reviews and HIQA inspections. The inspector was satisfied that this process of internal evaluation was robust and transparent; good practice was acknowledged but so were failings; actions, timeframes and responsible persons were identified.

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

Findings:
Based on the information available to the inspector the staffing levels, skill-mix and staffing arrangements were adequate to meet the individual and collective needs of the residents. There was evidence that the provider kept staffing levels and arrangements under review; for example, the houses were not normally staffed by day but in response to changing and increasing needs one house was staffed for two days each week to support residents in "semi-retirement" and facilitating reduced attendance at day service. Also, in the days prior to this inspection and based on the providers own review of supports a decision had been made by the provider to allocate an additional staff member in the morning.

Relief staff were employed but the person in charge said and staff spoken with confirmed that while employed in a relief capacity they worked only in the two houses that comprised this centre so as to provide consistency and continuity for residents. Staff were clearly known to residents; the minutes of one residents meeting demonstrated how staff advised and familiarised residents of a new staff coming to work in the centre. During this inspection the inspector saw that newly recruited staff were inducted in a supernumerary capacity.

There was a planned and actual rota maintained and all staff spoken with confirmed the staffing arrangements and their adequacy including the sleepover arrangement in both houses.

There was a planned programme of staff training to be provided in 2017; individualised records of training completed by staff were maintained. From these records the

inspector saw that staff had attended mandatory training within the required timeframes in safeguarding, fire safety and manual handling. Other completed training included medicines management and first aid. Deficits were identified in training for staff in de-escalation and intervention techniques in response to behaviours of concern; this has been addressed in Outcome 8.
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:

Mary Moore
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-0003941
Date of Inspection:	27 and 28 February 2017
Date of response:	22 March 2017

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:
Strategies implemented to prevent and manage behaviours of concern and risk resulted in restrictions on the extent to which all residents had control and choice over their living arrangements and their routines.

[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) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
All residents are supported to exercise control and choice over their lives. The placement of 1 resident which impacts on the other residents' lives has been forwarded to the service Admission, Discharge and Transfer team on 07/03/17, who have agreed that the a review on the provision of accommodation for this resident be sought from other service providers through the HSE.

Proposed Timescale: 30/06/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There had been no house meeting held in one house between October 2016 and February 2017.

2. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
The PIC has now scheduled house meetings to occur each month. A tracking system is now in place to track that the meetings have occurred.

Proposed Timescale: 17/03/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a perceived barrier on behalf of some residents to raising their concerns and dissatisfaction.

3. Action Required:
Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The PIC will ensure that all residents will be further supported to make their concerns and issues of dissatisfaction known and that they all feel supported in this process and that any perceived barriers that they have are ill founded.

Proposed Timescale: 15/03/2017

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 impact of the risk/hazard and to a degree the impact of the control measures was underestimated and therefore the level of residual risk was inaccurately calculated.

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

Please state the actions you have taken or are planning to take:
The risk rating and the impact of the control measure for the residual risk have been reviewed and adjusted to ensure the residual risk is rated higher with respect to the impact on the quality of life for each resident.

Proposed Timescale: 15/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider confirmed that all recommended fire safety works were still not complete; the works included the installation of fire resisting doors to protect evacuation routes.

Certificates of the inspection and testing by a competent person of the fire detection system and the emergency lighting were not consistently maintained in the fire register.

5. 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 Service has the highest standards in place regarding fire equipment, means of escape and building services.
We have reviewed the report by the fire consultant and confirm that of the nine risks identified six have been addressed in each of the residences including upgrading the fire alarm systems to L1 standard. The fire detection system and emergency lighting systems have been tested by a competent person for 2017. Works not yet completed are all related to fire containment/building fabric. Despite uncertainty regarding the

national Code of Practise and uncertainty regarding funding, the Service is committed to addressing the issues as outlined in the consultant's report. The Director of Logistics has developed a cost plan in relation to the necessary works for each of the centres involved and we are submitting this again to the HSE for additional resources with a view to completing the works as resources become available.

All fire equipment is adequately maintained. The fire detection system and emergency lighting system have been tested by a competent person for 2017 and the Provider Nominee has forwarded the certification of this test to the authority on 15/03/17.

Proposed Timescale: 29/09/2017

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:
There was one confirmed gap in facilitating training for one staff; training records indicated that another staff had not received training since 2007.

6. 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:
The staff in question has been forwarded to complete the respective training.

Proposed Timescale: 19/05/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Because of the failure to provide the resident with a placement suited to their needs, a pattern and routine of segregation had developed in the house. All staff spoken with said that two residents in particular spent a significant amount of time upstairs in their rooms for their safety.

7. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
All residents are encouraged to utilize all areas in the house and this will be reaffirmed

with residents. On discussing time spent in the respective 2 residents bedrooms, both residents have stated that they also like to spend time in their room.
The placement of 1 resident which impacts on the other residents' lives has been forwarded to the service Admission, Discharge and Transfer team on 07/03/17, who have agreed that the a review on the provision of accommodation for this resident be sought from other service providers through the HSE.

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an identified and unresolved failing (the fundamental issue was the inappropriate placement of a resident) in relation to safeguarding and safety as the provider has not satisfactorily ensured that all residents were protected from injury or harm by their peers.

8. 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:
Extra staff supports are in place to prevent any harm to the other residents and a full activity programme is place to support the resident in question. The placement of 1 resident which impacts on the other residents' lives has been forwarded to the service Admission, Discharge and Transfer team on 07/03/17, who have agreed that the a review on the provision of accommodation for this resident be sought from other service providers through the HSE.

Proposed Timescale: 30/06/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Actions taken by staff were in clear breach of local and national safeguarding policy and guidance and did not demonstrate a robust understanding of abuse or staff responsibilities that was sufficient to provide assurance that allegations were always appropriately responded to.

9. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The respective staff have been met by the Provider Nominee and the incident and

actions taken have been reviewed to ensure that all staff understand their obligation of reporting all safeguarding issues/ reports in accordance with service and national safeguarding policy. The staff in question will attend a safeguarding a refresher course to update their knowledge on the safeguarding of vulnerable adults.
Proposed Timescale: 31/05/2017