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:	Cairdeas Services Kilkenny
Centre ID:	OSV-0005054
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Julia Kelly
Lead inspector:	Noelene Dowling
Support inspector(s):	Declan Carey
Type of inspection	Announced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 August 2017 09:30	01 August 2017 19:30
02 August 2017 09:00	02 August 2017 13:00

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 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 Inspection:
This was the third inspection of this centre which forms part of an organisation which has a number of designated centres in the region. The inspection was undertaken as a result of the providers application to vary the conditions of registration, namely, to reduce the number of residents from ten to eight and a reconfiguration of the centre by removing one unit and including another unit from a different designated centre.

This was part of the providers overall development and improvement strategy to ensure units within the designated centres provided services to residents with compatible needs and were managed by a suitable person in charge with responsibility.

Both units within this revised current configuration had been inspected in December 2016 and January 2017 respectively as part of their previous designation. Registrations were granted in September 2015 and April 2017 respectively.

The inspection found that the configuration of the units and arrangements made for the variation of the conditions of registration were satisfactory.
The inspectors reviewed the actions from both previous inspection of which there were ten in total and eight of these had been satisfactory resolved. Actions not resolved satisfactorily included risk management fire safety and governance. Although actions had been taken on both.

How we gathered the evidence:
The inspectors met with all residents and spoke with four and they allowed the inspector to observe some of their daily life and routines. Residents who could communicate told the inspector they were very happy living in the centre, it was their home, they could do the activities they enjoyed and their staff managed any problems for them.

Inspectors also reviewed a number of questionnaires completed by family members or by residents with staff support. The questionnaires indicated a good deal of satisfaction with service, good communication and consultation, open visiting and being able to approach staff or managers with any concerns. The inspectors also met with staff members and the person in charge

Description of the service:
The revised statement of purpose describes the centre as providing care to 8 residents, both male and female with moderate to severe intellectual disabilities and physical care needs. To this end the inspector found that the care provided was congruent with the residents' needs.

The centre comprises two units located some miles from each other in the community. Both premises are single story suitably equipped ,spacious and laid out to meet the needs of the residents. They are very comfortable with space for privacy and or also for the use of specialised equipment necessary.

Overall judgement of our findings:
The findings of this inspection are influenced by the changes to the governance structures which have taken place recently and had not as yet been embedded in practice. The person in charge was appointed in April 2017.

• The duties and arrangements for the post of person in charge required further development and review to ensure the role could be carried out in a manner which reflects the regulatory requirements and responsibilities for the delivery of care.
Some other improvements were required in the following areas to improve the overall outcomes for residents;
• risk management systems which could impact on residents safety (outcome 7)
• oversight and review of restrictive practices to ensure they comply with national guidelines (outcome 8)
• specific healthcare support plans were not consistently available (Outcome 11)
• availability of staff to ensure residents can consistently access their chosen activities(outcome 17)
• protection of residents private information (outcome 1)

In other respects the inspection found that the provider was in substantial compliance with a number of regulations which had positive outcomes for the residents;

Good practice was observed in the following areas;
• residents had good access to healthcare, multidisciplinary specialists and good personal planning systems were evident which resulted in a positive and supportive experience for them (outcome 5)
• residents activities were based on their own preferences which ensured they had interesting and varied experiences which suited their needs (outcome 5)
• medicine management systems were safe (outcome 12)
• numbers and skill mix of staff were suitable which provided good levels of support and continuity for the residents (outcome 17)

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The action required from the previous inspection had been addressed as they applied to this centre. The unsuitable audio alarm had been removed from the resident's bedroom and a more suitable alternative sourced which was effective for its purpose but afforded the resident greater privacy. However, two issues were identified which could potentially impact on residents' privacy and dignity.

The annual report seen by inspectors included detailed personal information on a resident which could identify the individual concerned and some systems of communication required review.

Residents who attended at day-service were required to take their own files which included personal plans, multidisciplinary reviews minutes, support plans and considerable other personal information with them. This was explained to inspectors to ensure the staff in the day service had full access to all information and could record daily progress notes and other care information.

The person in charge had purchased large suitcases to transport these files in each day. While communication between day and residential services was very good this practice required review as there was a potential risk to the confidentiality of this volume of residents' private information should any untoward event occur while travelling to and from the day service.

The inspector found that residents were supported to participate in the life of the centre and to make choices and decision with the support they required to do so.

It was apparent that staff understood and responded to resident's needs and preferences in their daily lives. Residents confirmed that they choose their activities and work and enjoyed these. Regular day-care services were not open during the inspection but a schedule of activities and trips out had been agreed with the residents which they were participating in.

Residents' meetings were held weekly in each house. Where these systems were not suitable for the residents it was apparent that staff individually and in consultation with relatives sought to ensure they were included and were happy with their routines and plans.

The records of the meetings indicated that they considered residents views on activities and routines. They were also used as a medium to develop communication and understanding between residents of their rights as individuals who lived closely together. An external advocate had been sourced and was supporting a resident with a private matter at the time of the inspection.

Management of residents' finances were transparent. An assessment for capacity was undertaken in regard to residents managing their own monies. Residents were being supported by staff to manage their finances and all had a personal bank account. A review of a sample of records pertaining to residents' finances showed that the systems were transparent, all transactions recorded and regular oversight of such spending evident.

Inspectors saw that where a where a resident had been overcharged inadvertently for services these had been refunded by the provider once this was discovered. Resident personal belongings were twenties. It was also apparent that where residents could not maintain their own personal dignity staff were observant of this and supported them to do so.

The inspector was informed that no resident was the subject of a court order for treatment purposes or financial support at the time of this inspection.

The complaint policy was in accordance with the regulations with systems for oversight evident. There were two complaints recorded on behalf of residents. They had been managed effectively with one made by staff on resident behalf. This was processed via the social work team who were monitoring the outcome.

Judgment:
Substantially Compliant

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

Theme:

Individualised Supports and Care

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

Findings:
The action required in relation to this outcome had been resolved. The personal plans held detailed communication guidelines which were seen to be person-centred and individualised. It was apparent that the staff understood the resident's non verbal expression very well and responded appropriately to this.

All communication with residents was observed to be respectful and supportive.Pictorial images were used to help with sequencing of events for some residents which included their activities. Skype was used by some residents and all had access to phones which were used frequently to maintain family contact.

A specialised digital communication system was being trialled for another resident. Television and other media systems were available and seen to be used based on residents preferences.

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:
The actions required from the previous inspection had been addressed with regard to re-assessments undertaken to reflect changes in residents care needs. Also, comprehensive annual reviews of residents' personal plans were taking place consistently and changes reflected in personal support plans. Necessary support plans were also available and reflective of needs for residents. This was a matter which has been addressed from the previous inspection.

Overall, inspectors found that the social care needs of each resident was being supported and facilitated in the centre. Daily activities and social care goals were found to be meaningful and supported the residents to have valued social roles in the community.

Inspectors found that the care and support provided to the residents was to a good standard and from a sample of files viewed, each resident had comprehensive health, personal and social care plans in place.

Residents' comprehensive assessments carried out by a multidisciplinary team were in place and reviewed on an annual basis, as required by Regulations. The review meetings were carried out and attended by residents, staff, family members and an advocate, if required to support residents.

Residents had an annual health assessment, contained within a 'Best Possible Health' folder. Should a healthcare need be identified for residents by staff or the multidisciplinary team, a support plan was put in place for each need. For example, some residents had support plans for epilepsy, nutrition, sight, mobility and oral hygiene. These support plans had input from a health professional, care plan to support residents, some had a risk assessment and specialist review in a hospital setting, as required. However, inspectors found some support plans for wound care did not have sufficient detail and this was discussed further in Outcome 11.

Plans were informative of each resident's key information including personal details, important people in their lives, independent living skills, meaningful activities, community interactions and their likes, dislikes and interests.

Plans identified social goals that were important to each resident and from the sample viewed by the inspectors, it was observed that goals were being documented and a plan of action in place to support their achievement. Each resident was allocated a key worker and these goals were reviewed at meetings with residents, staff, family members and people that support residents on a regular basis.

For example, some residents as part of their personal plan wished to attend a number of music events and participating in swimming classes with the support of staff. Inspectors observed that all these goals had been achieved or were in the process of being achieved at the time of this inspection. However, inspectors found staffing was not organised around the needs of some residents to allow them to participating in these events. This is discussed further in Outcome 17.

Residents also attended a range of various day services where they had the option to engage in activities such as exercise programmes, social outings, walks, baking and a choir. It was found some residents decided not to participate in various day services and alternative arrangements were put in place to accommodate the residents’ wishes in the designated centre.

Staff of the centre also supported residents to frequent local amenities such as shops, parks and favourite restaurants on a weekly basis.

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:
One action from the previous inspection was partially resolved with regard to fire safety issues. However, this inspection found personal evacuation plans for some residents lacked detail to guide staff to ensure all residents could be evacuated in the event of a fire. Another action with regard to risk management was not adequately resolved, as it was found there were still not adequate measures in place to identify, assess and manage all risks in the designated centre, on the day of inspection.

The inspectors were satisfied that, for the most part, the health and safety of residents, visitors and staff was promoted and systems were in place for the management of risk in the centre. There was a Health and Safety Statement in place which was specific to the centre.

The risk management policy met the requirements of the Regulations. The centre also had a risk register which was made available to the inspectors on the day of inspection. This included risks for individual residents and risks for the designated centre.

The inspectors were satisfied that, for the most part, where a risk was identified it was appropriately addressed and actions put in place to mitigate it. For example, there were assessments in place for the risk of epilepsy, pressure areas, mobility and choking. Measures were in place to mitigate these risks.

Inspectors found staff in the centre responded to and learned from most adverse incidents occurring, as there was a system in place to review incidents or accidents. The person in charge outlined that incidents would be recorded in an electronic system, reviewed by a multidisciplinary team on a weekly basis and discussed with the staff team. The risk assessments would be generated from a review of incidents.

The person in charge outlined risk assessments would also be generated from within the centre from safety audits done on a quarterly basis. For example, risks assessments would be put in place or updated for some residents following incidents of falls in the centre.

However, inspectors identified a risk that had not been managed in line with the designated centre's policies and procedures. There was not adequate measures in place to identify, assess and manage a risk in relation to a trip hazard in the back of one unit of the designated centre. This trip hazard involved a lead in the back garden identified during this inspection.

It was observed and reported by a staff member they were close to tripping over the lead. Some residents had mobility issues in this centre and there were no adequate control measures in place to prevent residents falling from this trip hazard. The person in charge outlined there had been no adverse incidents involving residents regarding this risk to-date.

Inspectors found an audit carried out on behalf of the provider that identified an incident where a medication had gone missing on two occasions. While this incident was identified in the audit, measures had not been put in place following the adverse incident to prevent a re-occurrence in the centre or to satisfactorily examine the cause. There was no documentation found that this incident was followed up by the provider or the person in charge.

The inspectors found that that a fire register had been compiled for the centre which was up to date. Fire equipment such as fire blankets and fire extinguishers were installed, regularly serviced and had been checked by an independent fire consultancy company in 2017.

There were also fire doors, emergency lighting and suitable fire alarms in the designated centre. The installation of self-closing devices on doors had been addressed as recommended from the previous inspection.

Documentation reviewed by inspectors outlined that staff did regular checks on escape routes, fire alarm panels, manual call points, smoke detectors, emergency lighting and fire doors.

Fire drills were carried out on quarterly basis and all residents had individual personal emergency evacuation plan in place. However, inspectors found not all residents were part of fire drills in both units of the designated centre. The person in charge outlined some residents had not participated in fire drills.

Inspectors found, for the most part, residents' personal emergency evacuation plans did contain clear information to reflect the practice required to support residents in the event of fire. Staff spoken with, were knowledgeable around the supports required for all residents.

However, some residents' personal emergency evacuation plans were not clear on supports required for some residents in the event of an evacuation. The person in charge acknowledged some plans were not adequate evacuating some residents in the event of fire.

Inspectors also observed that there was an emergency response plan in place to provide

support, guidance and procedures on what to do in the event of an adverse incident should it occur.

However, as with personal emergency evacuation plans inspectors found emergency evacuation plans displayed did not contain clear information to reflect the practice, staff described to inspectors.

It was observed that there was adequate hand sanitizing gels, handing washing facilities and hot water available throughout the centre. It was found there were adequate arrangements were in place for the disposal of general and clinical waste.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There were no actions required from the previous inspection. Inspectors were assured overall that resident's safety and wellbeing was prioritised with effective monitoring systems evident. While some improvements were required in the development of behaviour support plans and clinical intervention in some instances this was not a consistent finding.

Overall, there was evidence of frequent mental health and psychological intervention to support the residents and provide guidance for staff. Behaviour support plans which had been implemented were very detailed and demonstrated an understanding of the resident's behaviours, identified triggers and gave directions to staff as to how to best support the residents. Incidents were then reviewed to ascertain if the plans had been implemented and were effective or not.

All staff had training in challenging behaviours including MAPA (a specific system for the management of challenging behaviours) where this was relevant and its use was strictly guided by a protocol and multidisciplinary review.
Restrictive practices in use had been reviewed there was a rational was evident for their

implementation .These included some locked external doors , locking of food presses at specific times and wearing of a specific type of discreet garment at times. There usage was recorded and monitored both to protect the residents and to ensure they were only used when necessary. The usage was then reviewed by the multidisciplinary teams.

However, the provider had taken the very appropriate safeguarding action of initiating a rights committee consisting of members of the organisation and suitably qualified members of the public. The purpose was primarily to assess interventions which may impact on residents rights and autonomy. The restrictions in use were reviewed by the committee at various intervals and they reverted to the managers with opinions or requests for further information or alternatives to be considered.

A number of such queries had been raised by the committee in April 2017. Inspectors found that there was a failure by local management to revert to the committee and provide clarity to the questions raised for a period of four months. This failure negated the value of the committee as an effective and neutral overseer of rights and safeguarding systems.

Individual safeguarding plans were implemented for residents where they were deemed at risk due to the behaviour of peers or other circumstances. The service manager oversaw these systems.

A dedicated internal social work service was available and inspectors saw that this department was actively involved where any issues of concern were noted. Records demonstrated that all current staff in the centre had received up to date training in the prevention of and response to abuse.

The policy on the protection of vulnerable adults was in accordance with the Health Service Executive (HSE) policy to ensure satisfactory screening, implementation of safeguarding plans, adequate review of incidents and reporting systems.

Residents who could communicate informed the inspector that they felt safe in the centre. Staff were able to articulate their understanding and responsibilities in relation to safeguarding and were very clear on what behaviours were not acceptable. They expressed their confidence in the management team to respond promptly to any incidents but also were clear on how they themselves would act in such an event. Detailed intimate care plans were in place which took account of resident's dignity, integrity and personal preferences.

All staff had training in challenging behaviours including in MAPA (a specific system for the management of challenging behaviours) where this was relevant and its use was strictly guided by a protocol and multidisciplinary review.

Judgment:
Substantially Compliant

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 the requirement to forward the required notifications to the Authority. All incidents were found to be reviewed internally.

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

Findings:
The action from the previous inspection had been addressed with resident nutritional needs detailed and support plans implemented. Inspectors found that the complexity of resident's healthcare needs were being well monitored and managed.

However, some support plans for wound care did not sufficiently detail the treatment to be provided to ensure this would be implemented consistently. While the records demonstrated that the issue had eventually been resolved there was no clarity as to the timing of treatment to direct both nursing and non nursing staff or at what point specialist intervention should be sought.

There was good access to general practitioners (GPs) and out of hours service was also used where necessary. There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, mental health specialists, neurologists and dieticians.

The inspector saw evidence of health promotion and monitoring with regular tests and

interventions to manage specific healthcare needs and gender needs were also monitored.

The residents daily records available were very detailed and indicated good observation and a timely response by staff to any changes residents heath status.

The inspector saw from records and speaking with staff that families were kept fully informed and involved in regards to healthcare issues and appointments.

Residents' nutritional needs were 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.

The specialist plans were seen to be implemented. Staff were aware of resident's preferences and residents helped staff to do the shopping.

The meal times as observed were very individualised and residents were supported in an unhurried and dignified manner.
There was a policy on end-of-life care.

This was not pertinent at time of this inspection but there was the capacity within the centre and organisation to maintain residents in their own home at such time if this was their preference.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
The inspectors found that the medicines management policies were satisfactory and that practices described by the staff member on duty were suitable and safe.

A medications management policy was in place to ensure safe administration of medication in line with best practice.

A locked medication press was in place and medication prescription sheets were available that included sufficient detail to ensure safe prescription, administration and

recording standards. However, inspectors found the packaging for one medication prescribed for a resident, was not labelled. A staff member outlined this would be addressed as a matter of urgency and the medication was in the segregated area for the resident within a locked medication press.

There were also appropriate procedures in place for the handling and disposal of unused medicines in the centre.

There was a system in place to record any medication errors in the centre. Inspectors found that if an error were to occur it would be reported accordingly to the person in charge and managed in line with policy and procedure. Inspectors found there had been a recent medication error on record in the centre and this had been managed appropriately, this incident was also discussed at a subsequent staff meeting.

Medications were audited in the centre on a regular basis, along with audits carried out by a pharmacist. From viewing a sample of these audits, inspectors found issues identified were addressed or in the process being addressed, on the day of inspection.

From viewing a sample of staff files it was also observed that they were trained in the safe administration of medication.

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:
A revised statement of purpose was forwarded for the application to vary which reflected the proposed changes to the centres numbers of residents and the current governance structures.

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

Findings:
The actions from the previous inspection related to the content and detail of the providers unannounced visits and the capacity of the then person in charge to effectively manage a large number of centres had been addressed.

As part of the reconfiguration and governance review a person with the required experience and qualifications and training had been appointed to the post of person in charge in this centre.

However, as observed in practice the arrangement did not provide assurance that the system as devised was providing sufficient oversight in both units.

This finding is influenced by a number of factors;

1. Although full time in post the post holder did not have a specific job specification and responsibilities outlined which differed to that of the previous team leader post.

2. As described to the inspector the use and availability of protected time, outside of nursing duty hours in the unit where the person in charge was based, was minimal.

3. The additional unit, which was the subject of the current application, was only visited by the person in charge for one and a half hours per week therefore direct support and oversight of this unit was limited. Regular team meetings had not taken place in this unit and there was a dependence on the team leader who worked limited hours to direct care .

There were however effective reporting systems evident. The regional management comprised the regional services manager, the service manager who was very involved in oversight and monitoring of the centre, human resources, social work and psychology department, training/ quality manager.

Systems for oversight and quality assurance were implemented. The provider nominee had commissioned two six monthly unannounced visits to the centre. On this inspection the reports were found to be focused and detailed on residents care needs. Any issues

identified were noted for action.

The service manger also undertook focused quality assurance and safeguarding reviews in each unit .Detailed action plans were identified and inspectors saw evidence that these were implemented.

The inspector reviewed the annual report for 2016 which was in easy read format suitable for residents and found that this covered a range of issues including data on accident or incidents, complaints, and included the views of relatives and residents which were very positive.

However the report required further information relevant parameters to adequately summarise the quality and safety of care. This was discussed at the feedback meeting.

Overall inspectors were satisfied with other quality assurance systems including auditing systems. 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 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):
No actions were required from the previous inspection.

Findings:
Inspectors found that there was adequate numbers of staff with the right skill-mix, qualifications and experience to support the residents living in the centre. There were issues identified in the area of deployment of staff at certain times and one staff file was missing one reference from a previous employer.

The staff team consisted of a person in charge (a registered nurse), staff nurses and health care assistants working in the centre. A multidisciplinary team also provided regular support that included a regional manager, social worker, psychologist, psychiatrist and speech and language therapist. There was one volunteer in the centre, once a month and the arrangements were in line with the regulatory requirements.

There was an actual and planned rota in the designated centre.

Inspectors found that while there was enough staff to meet the assessed needs of residents, staffing was not organised around the needs of some residents. For example, some residents as part of their personal plans were to participate in evening events or activities in a local leisure centre. Some planned events with some residents were cancelled on a number of occasions, due to staffing arrangements in one unit of the centre.

Also in one unit of the centre, inspectors found some evidence of potential gaps in support in the evening times, where one staff member was rostered on duty to support four residents during a period in the evening/night-time before the night duty staff commenced. Inspectors observed feedback from residents' families or representatives noted staff had not been available around the same evening/night-time period.

The inspectors observed that residents received assistance in a dignified and respectful manner. From observing staff it was evident that they were competent to deliver the care and support required by the residents.

While staff were recruited, selected and vetted on an appropriate basis, and in accordance with Schedule 2 of the Regulations one member of staff did not have two written references from a previous employer as required.

A sample of supervision notes were viewed by the inspectors. It was found that the supervision process was adequate and supported staff in improving their practice on the day of inspection. The person in charge outlined as they had recently taken up the role, the frequency of formal staff supervision would be regular in the centre going forward. The person in charge had delegated this function to a staff nurse in another unit of the centre.

Inspectors reviewed training records, and found that staff were offered training regularly to ensure they were adequately skilled to carry out their duties. All staff had up-to-date training or training dates had been identified, on the day of inspection.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
Centre ID:	OSV-0005054
Date of Inspection:	01 August 2017
Date of response:	15 September 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:
Some practices impacted on residents' privacy and dignity.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability,

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

family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
•We will ensure that, in future, the Annual Report does not contain information which may impinge on the privacy of individuals.
•The current system with regards transporting individual files within a suitcase is currently being reviewed, this practice will cease.

Proposed Timescale: 01st October 2017 and ongoing

Proposed Timescale: 01/10/2017

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:
Some risks had not been identified or measures put in place to mitigate risks in the centre.

2. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
•All risks have identified and safe measures put in place to mitigate further risks.

Proposed Timescale: 01/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems for fire drills required review, as not all residents had participated in fire drills in the designated centre.

3. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
•Risk assessments have been completed in relation to individuals whom may choose

not to participate in fire drills- detailed plans are now identified in individual PEEPS and in the house evacuation plan.

Proposed Timescale: Completed

Proposed Timescale: 15/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found personal emergency evacuation plans and emergency evacuation plans displayed did not contain sufficient information to reflect the practice required.

4. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
•Individual PEEPS and house specific emergency evacuation plans now reflect greater detail to support staff in safely evacuating individuals.

Proposed Timescale: Completed

Proposed Timescale: 15/09/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for review and oversight of restrictive practises were not been used effectively.

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

Please state the actions you have taken or are planning to take:
•Follow up documentation as requested has been submitted to the Human Rights Committee.

Proposed Timescale: Completed

Proposed Timescale: 15/09/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some support plans for wound care did not sufficiently detail the treatment to be provided.

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:
•Wound care support plans have been amended to reflect the time specific treatment required.

Proposed Timescale: Completed

Proposed Timescale: 15/09/2017

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:
The duties, role and responsibilities for the person in charge had not been clearly defined and implemented in practice.

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

Please state the actions you have taken or are planning to take:
•Complete review of the role of P.I.C, has taken place with a revision of rosters which clearly identifies protected time. This will enable the P.I.C to have a more structured allocated time within both houses in the designated centre to ensure safe and effective practices are provided.

Proposed Timescale: Completed

Proposed Timescale: 15/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Information and documents as required in Schedule 2 of the Regulations, were not present in the personnel file for one member of staff in the designated centre.

8. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
•Human Resources will follow up with referees with regards signature on two references for one particular staff member.

Proposed Timescale: 01/10/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found staffing arrangements were not organised around the needs of some residents in the designated centre and required review.

9. 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:
•A team meeting will be held to discuss and review current staffing arrangements around social needs of individuals.
•A request has been submitted for a volunteer to support one individual to access further activities in the evenings.

Proposed Timescale: 30/09/2017