**Health Information and Quality Authority Regulation Directorate**

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

<table>
<thead>
<tr>
<th>Centre name</th>
<th>St Joseph's House for Deaf and Deafblind Adults</th>
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<tr>
<td>Centre ID</td>
<td>OSV-0002090</td>
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<td>Centre county</td>
<td>Co. Dublin</td>
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<td>Type of centre</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider</td>
<td>Catholic Institute for Deaf People</td>
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<tr>
<td>Lead inspector</td>
<td>Helen Thompson</td>
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<tr>
<td>Support inspector(s)</td>
<td>Louise Renwick</td>
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<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection</td>
<td>27</td>
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<td>Number of vacancies on the date of inspection</td>
<td>11</td>
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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 renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 07 September 2017 09:30
To: 07 September 2017 19:40
From: 08 September 2017 14:15
To: 08 September 2017 19:30

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

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Summary of findings from this inspection
Background to the inspection
This was an announced inspection to assess the centre’s compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. It was conducted as part of the provider’s assessment of application to renew the registration of this centre. This was HIQA’s fifth inspection of the centre and was conducted by two inspectors over two days. The required actions from the previous inspection in December 2016 were also followed up as part of this inspection process.

How we gathered our evidence
The inspectors met with a number of the staff team which included nursing staff, care staff, a chef, the person in charge, the provider nominee and the chief executive officer.
Inspectors, met and spent some time with residents that were present on the days involved and spoke with four residents. Where required, this process was facilitated with the support of an interpreter who joined the inspectors on the afternoon of the first inspection day. Notably, at the time of inspection 13 residents were away on their annual trip to Lourdes. Feedback on the quality of the service provided was also garnered from questionnaires completed by residents and their representatives. Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement and interactions with residents.

As part of the inspection process the inspectors spoke with the aforementioned staff and reviewed various sources of documentation which included the statement of purpose, centre data sets, self-monitoring documentation, staff files, training records, residents' files and a number of the centre's policy documents. The inspectors also completed a walkthrough of the centre's premises.

Description of the service
The service provider had produced a statement of purpose which outlined the service provided within this centre. The statement of purpose stated that the centre provided services to residents who were deaf or deaf/blind. Residents' other support needs included mental health needs, clinical needs, behaviours that challenge and intellectual disability.

The centre comprised a main building and two adjoining units situated within a cul-de-sac in a suburban residential area. There was also access to a large garden area. It was close to a variety of amenities including shops, pubs, restaurants and public transport. There was capacity for 38 residents and on the day of inspection the centre was home to 27 residents over 18 years of age. This included residents that were availing of respite.

Overall judgment of our findings
Fourteen outcomes were inspected against and overall the inspectors found that some improvements were required in a number of core regulatory outcomes. These primarily related to residents' social care and safeguarding needs. The centre's workforce also required further training and competency building to more effectively support residents' needs. The inspectors did acknowledge that residents' healthcare and medication needs were generally found to be well assessed and supported in the centre.

In summary, the pervasive theme observed across a number of regulatory breaches related to a lack of assessment, facilitation and support of the resident's skills/competency enhancement with regard to promoting living in a more independent manner. Additionally, some residents' safety and security needs weren't assessed correctly from a risk perspective. Whilst the de-congregating process was planned for by the provider, in the interim some improvement was also required with the residents' environment through the addressing of non-compliances with the centre's premises.

The centre's governance and management, though improved from the last inspection, still required improvement in its systems to underpin the addressing of gaps in the delivery of a quality service for residents.
The inspectors observed that the primary reason for residents to avail of the service provided in the centre, was the opportunity to live with other people with a sensory disability which was acknowledged by all. This clearly facilitated communication and socialisation opportunities, but the institutional style of living was observed to be a challenge to some residents being supported to achieving their possible full potential. Feedback received from residents was in the main complimentary of the service, especially with regard to the opportunity to communicate with other people that were deaf or deaf/blind. However, residents also highlighted their desire for increased independence, skills acquisition, more opportunities for community participation and for premises improvements. Residents and family members also highlighted queries and some concern regarding possible future plans.

Inspectors noted that the coming years are a time of change for the centre with the sale of the premises and future planning for decongregation from this location in line with the HSE policy. The provider had commenced this process, which included the appointment of a project manager and communication/consultation with other centres that had recently undertaken a similar journey.

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

Theme:
Individualised Supports and Care

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

Findings:
As part of the inspection process, the inspectors were supported by an interpreter to more effectively communicate with a number of residents. Observation of staff practices and discussions with staff also informed the inspectors' judgements. Overall, inspectors found that residents who consented to having a conversation expressed their general satisfaction with the service they received. However, inspectors observed that some improvement was required with the facilitation of some residents' participation and execution of choice and control in their day to day lives.

Residents were consulted with through regular resident meetings, where issues could be discussed and heard.

There was a complaints policy and process in place, which residents appeared to freely access. Any issues or complaints were recorded and reviewed by the person in charge. Efforts were made to seek satisfaction from the complainant following action taken by the staff team to address and rectify issues.

However, some improvements were required in relation to the language used in care planning documentation and in approach, to ensure that it was person-centred, rights-based and respectful. For example, describing residents as "non-co-operative" and "non-compliant" with their care when they were demonstrating their right to refuse and to make a choice.

On reading care plans and speaking with some staff, inspectors found that at times, residents were perceived by their disabilities and medical needs, in place of seeing their abilities, their attempts to maintain their independence and their individual capacity to
be in control of their own lives.

Some practices and caring interventions in the centre had resulted in restrictions being placed on some residents' rights. Inspectors found that advocacy services had not been adequately encouraged or promoted for residents who had restrictions placed upon them. The ability, capacity and capabilities of some residents was not always considered as a given, and there was evidence that the resident's views and opinions had not been actively sought regarding certain choices. This had resulted in some residents displaying unwanted or risky behaviour to exercise their opinion or views. This had not been considered by the management team as a communication by the resident to have their opinion heard and their rights promoted.

Residents all had their own private bedrooms in the designated centre, with sufficient space for their personal belongings and furniture. A number of residents managed their own finances themselves with limited support required. Other residents had support from family members. There were systems in place to monitor and safeguard residents' finances where it was required, with ledger accounts maintained and secured.

**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):**
No actions were required from the previous inspection.

**Findings:**
In general, inspectors found that given the statement of purpose and the needs of residents that were catered for in the centre, the provider had ensured that the service was supportive of residents' communication style. However, improvement was required with ensuring that communication assessments were completed for some residents, and that all possible alternative augmentative communication options were explored.

Inspectors observed interactions between staff and residents, and residents and their peers, and found that staff could effectively communicate with residents. As a given, staff needed a certain level of training in Irish Sign Language to work in the centre and it was evident that the majority of residents could express themselves freely and engage in meaningful conversations with the people around them. The provider and wider staff team promoted residents' communication by seeking staff, allied health professionals, alternative therapists and priests attending the centre that could communicate using Irish Sign Language.
While all residents living in the centre were deaf, or deaf/blind and required a signing environment, there had been no assessment of some residents' communication needs beyond this requirement. For example, some files reviewed highlighted that residents found it difficult to express their needs, but had the potential to indicate when they required something at times. This had not been explored further to enhance their expressive communication abilities. According to some resident's behaviour support plan, they could become upset or aggressive at times as they required physical hand over hand contact to communicate, which was a known trigger in upsetting them. Overall, inspectors found there to be limited access to assessments, or to alternative and augmentative communication tools that would further enhance some residents' ability to communicate effectively.

Residents were observed to have access to a variety of media formats which included television and written materials.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:
Effective Services

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

Findings:
Inspectors viewed a sample of written agreements in place for residents living in the centre, as well as residents who were availing of respite and reviewed the policies around admissions, transfers and discharge.

Inspectors found that residents had written agreements in place outlining the facilities and services on offer in the centre, along with information on any fees. Some residents or their representatives had signed these written agreements, and some had not.

On review of a sample of financial records, inspectors found that residents were paying fees in line with what was described in their written agreements. Residents availing of respite had this covered by the Health Service Executive (HSE).

There was an admissions policy in place, and the process was included in the written statement of purpose. Inspectors found that there was a clear criteria for admission to the designated centre, with the main criteria being that the person's primary
communication is through Irish Sign Language, and someone who is deaf or deaf/blind. Inspectors found that while the criteria was clear, the policy was not guiding practice in relation to the admission of residents on a respite basis, and was not fully followed. For example, two residents availing of respite did not have comprehensive assessments completed by the provider as outlined in the policy. Information on the needs of residents attending for respite was limited, and not ensuring that all care and support and potential risks could be adequately provided for during their stay.

**Judgment:**
Non Compliant - Moderate

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**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

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

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

**Findings:**

Whilst residents were living in a signing environment which promoted their ability to be social and interact freely with staff and peers, improvements were required in relation to the assessment, planning and review of residents' personal and social care needs in order to ensure residents were afforded opportunities for new experiences, and the skills to maximise their independence and personal potential. Some improvement was also required with the accessibility of residents' plans.

In addition, residents' move and transition to the centre needed to be supported in a more robust and systematic manner.

Inspectors found evidence of good practice regarding social care supports for residents living in the centre. For a small number of residents with higher support and staffing needs, assessments and plans were more comprehensive and person-centred. This included residents with more complex healthcare and sensory support requirements. Information recorded gave a sense of the individual person, their dreams and aspirations and what was meaningful and important to them. Required supports were clearly outlined in plans, and as such could be fully implemented and systematically reviewed to ensure they were effective.
However, the documentation and the supportive interventions available to residents who were more independent required review and significant improvement to ensure that they comprehensively supported the person. The care and support in place regarding a number of residents' social care needs was not based on clear assessments. The inspectors sampled residents' files and found this to be the case for five of them.

In the absence of comprehensive assessments, arrangements to support the residents' needs and wishes were not clearly captured and outlined. Plans present were also not reviewed in a systematic outcome focused manner. In addition, some individuals more recently admitted to the centre had not had a clear comprehensive assessment of need completed. Improvements required with the centre's care planning system were also reflected in the provider's most recent visit and in other inspection feedback mechanisms. The provider reported that staff training was planned regarding this area of need.

From reviewing a sample of residents' documentation and in speaking with staff, inspectors found that the supports in place were centred on the health or clinical needs of residents, and lacked a focus on personal development, skills teaching and maximising residents' independence and potential. This was contrary to the service provision aims as outlined in the centre's statement of purpose. Inspectors noted the challenges facing residents who were deaf and deaf/blind in participating fully in the wider community, due to a variety of societal issues. However, inspectors found that improvements were required in the facilitation of supports by the provider to ensure that residents had the opportunity to gain valuable skills and independence to allow them participate in the wider community to the best of their abilities.

The inspectors acknowledged that some residents did attend day care service options and some were attending community activities. However, the resident's desire for increased socialisation and independence was highlighted on feedback questionnaires.

Inspectors found that the system to underpin a resident's move to this residential centre required improvement to ensure that it was supported in a clear, standard and systematic manner. File reviews demonstrated that there was a lack of transitional planning, assessments and plan development to ensure that residents' needs were met.

Judgment: 
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

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

Findings:
Inspectors found that the centre's premises required improvements to ensure that it optimally met residents' individual and collective needs in a homely manner. This included improvement in the maintenance and decoration of the centre and with the provision of some schedule 6 matters.

This finding was concluded from observations, a walkabout of the premises, a review of centre data sets and of the centre's self-monitoring documentation. In reaching this judgement the inspectors were also acutely aware that the number of residents was significantly reduced over the course of the inspection days as 13 people were away on an annual trip to Lourdes.

While the inspectors acknowledged that the provider has a long term plan to de-congregate and move from this setting, on the day of inspection there was a lack of interim measures identified to improve the physical environment. In addition, there was a large office space situated on a corridor where residents' bedrooms were also located. The inspectors observed this created increased traffic and activity to the residents' personal space.

The layout of the building, particularly regarding access to the bathroom facilities meant that some residents had to transition from one side to the other through the main dining room to use their preferred option. The inspectors noted that one of the bathrooms was laid out in an institutional manner with a number of cubicle type toilets present.

The inspectors found that there were inadequate facilities for the residents to personally attend to their own laundry requirements. This was highlighted during feedback on a recent provider visit, and it was noted that some residents were choosing to use a private community facility. Inspectors noted that there was no bath option available for residents. This observation and resident's desire to have their own toilet and shower was highlighted on residents' feedback questionnaires.

The dining accommodation available to residents was of an institutional nature and not conducive to promoting an optimal mealtime experience. Inspectors noted that it was often the setting where incidents occurred. In addition, though there were some small kitchenette facilities in the building, these were not adequately equipped and fitted out to promote residents' usage and skills development.

Storage was observed to be an issue with equipment being inappropriately left in residents' living areas, for example, a bath tray left in a room where a resident liked to watch television.
Overall, the function/usage of some of the residents' areas was unclear and thus lacked homeliness. The inspectors also observed an unpleasant odour in a number of areas of the premises.

Some areas required care, attention and improvement in their upkeep. This included
painting in several rooms, doors frames and skirting boards needed to be repaired and carpets were worn/scuffed. These issues had been identified on the provider’s self-assessment and were also acknowledged during the inspection walkabout with members of the management team.

Suitable equipment, aids and appliances were available to support residents' assessed needs.

The inspectors acknowledged that the provider had plans underway with regard to the de-congregation of this centre, and were assured that this should in the future address the cited issues.

**Judgment:**
Non Compliant - Moderate

### 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:**
Inspectors found that while the health and safety of residents, staff and visitors was promoted, significant improvements were required in relation to risk management, incident review and oversight in the designated centre.

Since the previous inspection, the provider had ensured a programme of vaccination was available for all residents to protect them against a healthcare associated infection. This addressed the failing identified in the last report regarding infection control.

There was a risk management policy in place dated January 2017 and the provider had a written risk register. Overall, inspectors found a disconnect between the risk management policy, practices and approach within the designated centre. Risk management practices were not consistent with the guidance of the centre's policy. For example, the risk register was not inclusive of all known risks in the centre, and known or potential risks that had been identified were not formally risk assessed, documented and managed. Overall, risk management documentation for the centre required improvement.

Inspectors found that health and clinical risks for residents were well documented, assessed by the nursing team and discussed at regular clinical governance meetings. On review of these health risks, inspectors found that they were well managed.
However, in contrast, for some residents who were outward in making their own decisions and more independent in their actions, they were not found to be supported by a risk management framework that ensured all necessary supports, skills teaching and interventions had been exhausted to empower the resident to manage their own risks, and be responsible for possible consequences.

Inspectors found that there was a system in place for the recording and review of accidents, incidents and adverse events in the centre. Quantitative data was recorded monthly on the number and nature of incidents occurring in the designated centre and discussed at governance meetings. However, inspectors found that this review did not seek to identify trends or emerging patterns, and some incidents of concern had not triggered a risk assessment and management process to prevent the likelihood of it occurring again. For example, a staff member had to extinguish a fire on the grounds where leaves had been set alight. This had not resulted in a clear risk process or documented control measures or supports to prevent it from happening again. Similarly, for known risks that were discussed at meetings (but had not been formally documented) there was a lack of oversight of the implementation of control measures. For example, on the days of inspection cigarette butts were in ashtrays in the smoking area and in ashtrays on the grounds, when it was indicated that they should be routinely emptied.

Inspectors found that there was a fire alarm and detection system in place, emergency lighting and suitable fire fighting equipment in the designated centre. These were all evidenced as serviced and checked by professionals on a routine basis. There were fire doors throughout the building, which were automated to close if the alarm sounded. Some doors appeared to require repair. There was no documentary evidence available in the centre to indicate that all fire doors had been checked in this regard. Post the inspection process, confirmation of review of the doors and the provider’s assurances were forwarded to the inspectors.

Inspectors noted that fire drills were done regularly and residents were supported to evacuate in the event of an emergency with individual personal evacuation plans which had been updated since the previous inspection. Feedback from fire drills was discussed with residents at their meeting forum. Additional equipment and tools had been provided to assist residents in the event of a fire or evacuation. For example, vibrating pillows and balls, and flashings lights to alert residents to the alarm sounding.

Staff had all received training in fire evacuation and/or fire warden training which was evidenced as being up-to-date and refreshed periodically.

**Judgment:**
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
Whilst inspectors found that there were measures in place to safeguard and protect residents from abuse, significant improvement was required. This related to the provision of support to residents to develop skills for self protection, the provision of staff training, the management of restrictive practices, and the assessment of some residents' behavioural support needs.

Inspectors reviewed any current safeguarding issues in the designated centre and found that where necessary, the Health Service Executive (HSE) national policy for safeguarding vulnerable persons at risk of abuse had been followed by the person in charge. There was a safeguarding register in place to ensure all allegations or concerns were appropriately followed up in line with this policy. For example, preliminary screenings were completed and interim safeguarding plans put in place. There was a policy in place for the prevention, detection and response to abuse as per the regulations.

On review of residents' information and incidents that had occurred in the centre, inspectors found that the area of self-abuse and self-neglect had not been considered as a safeguarding issue for residents displaying indicating behaviours. For example, refusing to attend to personal care and withdrawing from peers. These had also not been adequately captured through the risk management process.

A number of residents travelled independently and could access the community as it suited them. However, inspectors found that from a safeguarding perspective, there were some issues that were not being adequately managed and supported to ensure residents had the skills to protect themselves, make informed decisions on their actions and keep themselves safe. There was a lack of training and skills teaching to encourage residents to take control of their own self-care and self protection. For example, the provider and management were aware of certain activities that some residents engaged in that put them in compromising situations, but in the absence of a robust risk management system, supports had not been put in place to support the residents to manage this themselves.

Staff had all received training in safeguarding vulnerable adults, this was refreshed routinely. However, there were gaps in the provision of adequate training to ensure all staff had the skills and knowledge to positively support residents' behavioural needs and to respond to behaviour that may be challenging for them. This was linked to the lack of
a clear approach in a guiding policy to outline the model that the provider was going to use to support residents. For example, a selection of staff had done de-escalation training, a number had done a one day introduction to a positive behaviour support model, and others had been offered a different type of training on challenging behaviour. Records showed that some staff had attended none of these sessions. This was resulting in an absence of a clear approach and supportive interventions for residents to enhance their quality of life, and was in need of address by the provider. There was also a lack of cohesion around the responsibility for managing and recording incidents of behaviour between the different staff roles in the centre. For example, inspectors were informed that staff nurses did not complete behavioural incident records as this was the role of the care staff team.

On review of the incidents that had occurred in the centre, and residents' plans inspectors found that the triggers recorded for some residents' behaviour were not being viewed as unmet needs which required assessment. Patterns and trends of incidents between peers were looked at individually as challenging issues but were not appropriately reviewed in light of the environmental causes. For example, the mix of residents, the dining experience and the manner in which the centre was laid out and operated. This was resulting in the focus being placed on the resident being challenging, in place of ensuring the environment and the supports available were effectively meeting residents' needs. Improvements were required in order to ensure every effort was made to identify and alleviate the cause of the resident's behaviour.

The person in charge and representatives of the provider informed inspectors of the challenges in ensuring residents had access to appropriate multidisciplinary team members (MDT) due to residents' communication needs. At present, residents had access to a psychiatrist, if required and recently a psychologist had been sought to advise on residents' plans and interventions for the management of behaviour. However, this person was not available to provide face to face psychological services to residents.

Some residents had access to the community mental health teams. Residents were given information and supported to attend external counselling services. Some residents had independently sought the services of voluntary organisations to seek out supportive volunteers to visit them on a weekly basis. However, inspectors observed that these supports were not being actively provided by the designated centre nor included and documented in residents' support plans.

There was a policy in place on the use of restrictive interventions. Inspectors found that not all restrictions on residents' rights or liberty had been viewed as such. An environmental restriction had not been assessed on an individual basis but based on the sensory disability of the resident group. Exit doors throughout the building were alarmed apart from one access door to the garden due to the needs of residents who were deaf/blind.

On review of the use of other restraints in the centre, inspectors found there to be a low use of mechanical and chemical restraints, and these were used to enable residents' abilities. For example, lapbelts and bedrails which were assessed as part of clinical supports.
**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe Services

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

**Findings:**
A record of all incidents that occurred in the designated centre was maintained. However, the inspectors found that the centre had failed to notify the Chief Inspector of all incidents as required by the regulations, more specifically one that was required to be notified at the end of a quarter.

**Judgment:**
Substantially 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:**
Overall, the inspectors found that residents' healthcare needs and nutritional needs were supported. However, improvement was required with regard to facilitating the resident's skills building around their food and meal preparation.

The inspectors observed that residents' healthcare needs were recognised and appropriately responded to. There was evidence of these needs being assessed, planned for, supported and reviewed.

Residents' healthcare records were organised/co-ordinated through an on-line care
system with a suite of standard assessments tools incorporated into this system. Residents' palliative and end of life wishes were noted to be considered and assessed in an individual, sensitive manner.

Residents were supported by a general practitioner (GP) of their choice, one of whom facilitated consultations in the centre twice a week. Residents had access to allied health services, for example, occupational and physiotherapy. Residents were also supported to access general community care services as appropriate to their individual needs. This had included the palliative care team and tissue viability nurse.

The inspectors noted that the resident's individual food and nutrition needs were assessed and supported. There was evidence in residents' files of the dietician, and speech and language therapist providing further assessment and recommendations as required. As evident from file reviews, observations and interviews these specialist recommendations were then incorporated into menu planning and the resident's daily support requirements.

Food was freshly prepared on site as the centre had its own catering facilities. Residents' individual choices and preferences were facilitated, with a selection of snacks and drinks available outside of mealtimes.

However, the inspectors noted that all meals were provided in a centralised manner, with no assessment or facilitation of the individual resident's skills building regarding food/meal preparation observed. There were some small kitchenettes around the premises but these were not noted to be comprehensively considered for utilisation by residents. This issue was noted on feedback questionnaires.

**Judgment:**
Substantially Compliant

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**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:**
Inspectors found that the centre has a medication management system in situ which ensured that the resident's medication needs were supported and protected. However, some improvement was required with regard to affording the opportunity for the self-administration of their medication with residents.

The inspectors found that residents who were self-administering their medication had
completed assessments as required. However, inspectors noted that this option was not automatically considered for new and current residents, though a high number of them required a low level of support. This finding was not in keeping with the promotion of self-development and independence as outlined in the centre's statement of purpose.

There were policies relating to the ordering, prescribing, storing and administration of medicines to residents. Medicines, including controlled drugs, in the centre were stored as required and residents' medication records were kept in a safe and accessible place. There was also a clear system with regard to the storage of unused, or medicines for return to the pharmacy.

Residents' medication needs were observed to be reviewed by their general practitioner and psychiatrist. A pharmacist of their choice was available to support residents' pharmacy requirements. Residents' medicines were supplied and administered from a blister pack system. In the centre, medicines were only administered by nurses through an electronic medication management system where the nurse is an authorised user. A staff signature bank with nurses correlating PIN numbers was also present. However in addition, to facilitate residents' on social outings, a small number of care staff had received training in the safe administration of medication.

The centre had an established system for the reviewing and monitoring of safe medication practices with random checks completed by the nurse manager.

**Judgment:**
Substantially Compliant

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

**Findings:**
Inspectors reviewed the centre's current statement of purpose dated August 2017 and found that it required some improvements to meet regulatory requirements.

The document did not:
- accurately reflect the current staffing complement, for example, CNM2 cited instead of CNM1
- contain all information as set out in the centre's Certificate of Registration
- outline supervision arrangements associated with therapeutic techniques.

**Judgment:**
Substantially 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:**

Overall, the inspectors found that to ensure effective oversight and accountability for the quality of service provision, further improvements were required with the centre’s management systems. In tandem, a system of effective performance management was required with the centre's workforce to ensure that each staff member was accountable for their role in service provision.

Inspectors found that there was a clearly defined management structure in operation in the centre. The person in charge who had been in the role for a number of years, was supported in her role by the provider representative and the chief executive officer (CEO). She was clearly involved in the governance and operational management of the centre. A nurse manager and care manager had in turn, particular responsibilities and reported to the person in charge through a regular meeting structure. All members of the management team were clearly identifiable to the residents and staff.

Subsequent to findings from the last inspection, there was now an established meeting process in place between the person in charge, provider representative and CEO. Inspectors reviewed minutes of meetings and observed that key operational areas were discussed and actions identified.

However, these management systems had failed to ensure effective oversight and governance as evidenced in the non-compliances found across a number of core outcomes including the centre's care planning, safeguarding and safety systems. For example, safeguarding issues for residents where trends of safeguarding concerns were not effectively monitored to ensure learning from them and possible causes identified,
i.e. patterns of incidents occurring in the dining room and the peer to peer mix. Ineffective risk management systems, with incidents not found to be effectively reviewed and learning implemented to bring about improvements.

In summary the inspectors found, quantitative analysis in place of qualitative with a lack of investigation and monitoring of reasons behind issues.

Inspectors also found that members of the workforce were not being supervised and performance managed to ensure that they were systematically accountable for the quality and safety of service delivery. Inspectors were informed that a new system was currently being trialled with the management team with a view to introducing it with all staff in 2018.

In response to regulatory breaches found on the last inspection, the provider was now found to be completing their six monthly provider visit requirement and inspectors observed the action plan developed from the most recent visit on the 22 August 2018. Some of the areas for improvement identified correlated with inspection findings.

An annual review, as required was also completed by the provider. However, inspectors noted that this review was very narrative in nature and lacked clear linkage to outcomes for residents. Also, the consultation process with residents and their representatives did not systematically reflect the process undertaken nor especially the questions posed to the participants to garner feedback.

**Judgment:**
Non Compliant - Moderate

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**Outcome 17: Workforce**

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

**Theme:**
Responsive Workforce

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

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

**Findings:**

Inspectors found that the number and skill mix of staff was appropriate to residents' assessed needs and service provision. However, improvement was required in the facilitation of staff training to ensure that they had the necessary competencies to comprehensively support residents' needs and wishes.
Inspectors reviewed the records of training provided to, and attended by staff members. Inspectors found that staff were up-to-date with their mandatory training requirements, which were routinely refreshed. For example, fire safety training, manual and patient handling and the safeguarding of residents from abuse. On review of further training records, inspectors found that 23 staff had been offered training in CPR and the use of AED.

However, based on the support needs of residents and in line with the centre's statement of purpose, some training gaps were evident in the designated centre, which had not been planned for or met by the provider. Training in supporting people with mental health issues had not been provided to staff members. This training deficit had been highlighted at the previous inspection as a barrier to effectively meeting some residents' assessed needs. Also, whilst some staff had received training in Dementia, 18 staff had not to date received training in this area. The need for care planning training and in a right based approach to service provision was also observed. Inspectors were informed that the provider was going to provide training to staff in facilitating a comprehensive assessment and life journey tool with residents. Preliminary dates had been set for this training.

Inspectors reviewed a sample of staff personnel files and found that they contained the requirements of Schedule 2. For example, proof of Garda Vetting was in place, a copy of their curriculum vitae and proof of identify. Inspectors found that the recruitment of staff was in line with best recruitment practices. For example, staff had to succeed at interview, have a predetermined level of experience and skills, and provide suitable references prior to employment. Volunteers had written agreements drawn up to outline what was expected of them.

Inspectors found there to be a good rapport between residents and staff, with some positive and joyful interactions observed throughout the inspection.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Findings:
Overall, inspectors found that improvements were still required with regard to some of the centre's policy documents and with the resident’s documentation to ensure that it optimally supported their needs.

As evidenced in the report, some policies and procedures in place in the designated centre required review to ensure they were clearly guiding practice and the approach that the provider was offering to residents. For example, a number of policies reviewed were generic in nature and were not centre specific. Others were not reflective of the model of care or the actual practices in place in the centre.

The use of both an online and paper based system was observed to challenge the optimal delivery of care and support in line with residents' needs. For example, a medical focus was directed by the online system which was only accessed by nursing staff, and residents' social and personal needs were recorded on a paper based system which was primarily led by other team members. This observation was discussed with the provider at the feedback meeting.
Also, some residents' records were not fully maintained. This issue was also identified during the provider's recent visit.

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:

Helen Thompson
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Catholic Institute for Deaf People</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002090</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>07 &amp; 08 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>13 February 2018</td>
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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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents were not encouraged and facilitated to fully exercise choice and control in their daily lives.

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**
Prior to the latest HIQA Inspection visit, the Board of CIDP formally adopted a ‘Social Role Valorisation’ (SRV) process for St Joseph’s House as outlined in the HSE Report entitled “Supporting People with Disabilities To Access Appropriate Housing In The Community” published in June 2016 and elsewhere. The ‘Discovery Process’ that is fundamental to SRV commenced in late October 2017 and is been undertaken with three residents and their families under the supervision of a national expert in SRV. The ‘Discovery Process’ will be undertaken with all residents and their families over the coming months. An initial information session on SRV was held recently for all family members and update sessions are planned for 2018. Based on experience elsewhere, we are confident that the adoption of the SRV approach will address the perceived shortcomings identified in this section of the HIQA Inspection Report.

**Proposed Timescale:** 31/12/2017

<table>
<thead>
<tr>
<th>Outcome 02: Communication</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Individualised Supports and Care</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Communication assessments had not been completed for some residents to determine what other communication supports they required to enhance their ability to more effectively communicate.

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

**Please state the actions you have taken or are planning to take:**
The CIPD Management is confident that all residents’ communication needs are met. While sign language is the first language of all deaf residents, hand-over-hand for all deaf-blind residents, other forms of communication (Braille etc.) are also used where required. In cases where care plans do not already contain this information, these will be updated to reflect each persons’ additional modes to effectively communicate with each other, and with staff, family members and others.

**Proposed Timescale:** 31/12/2017

<table>
<thead>
<tr>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Respite admissions into the centre were not in line with the written policy as outlined in the statement of purpose, and did not ensure that all potential needs and risks could be accommodated in the designated centre.

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

**Please state the actions you have taken or are planning to take:**
The admission policy and assessment form has been updated to reflect the statement of purpose and schedule 3 of the regulations. All future admission assessments will adhere to the updated policy.

The Management of CIDP acknowledges that, in the case of one resident on respite, the admission procedure was not followed for very specific reasons relating to that resident’s infrequent use of the service on a one day a week basis. Every effort is being made to ensure that a comprehensive assessment in line with current policy and the ongoing ‘Discovery Process’ will apply to all residents (including those on respite) into the future.

**Proposed Timescale:** 31/12/2017

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A comprehensive assessment of their bio psychosocial needs was not completed for some residents.

4. **Action Required:**
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
New admission assessment now captures all elements of bio psychosocial needs.

**Proposed Timescale:** 31/12/2017

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents did not have care plans developed and available to inform staff engagement, practices and support delivery of their needs.

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

Please state the actions you have taken or are planning to take:
All full-time residents have a care plan. These are reviewed and revised, as required, on an on-going basis.
In the case of one resident on respite, a care-plan had not been completed, principally due to their infrequent use of the service. All the staff are aware of the need to remain informed and up to date with respect to the residents’ needs and the practices required to support the residents’ care plans on an on-going basis.

Proposed Timescale: 28/02/2018
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An accessible format of their plan was not made available to some residents.

6. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
All residents are encouraged, and facilitated, to review both social and health care plans as and when they wish. Both Braille and Moon versions of care plans are offered and are available to residents as and when requested.

Residents are informed that accessible formats of their care plans are available in Braille, Moon, Large Print, or through an interpreter, if requested. As referred to in Action 2, the 'Discovery Process' will involve each resident, and their families as appropriate, reviewing their care plan and they will be actively encouraged to engage with information updates on a regular scheduled basis.

Proposed Timescale: 31/12/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' plans and goals were not reviewed in a timely and systematic manner.
7. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
A monitoring system was in place in response to previous inspection to ensure regular updates, however the observation that they were not outcome focused has been taken on board. We are currently implementing the Discovery process, which will identify opportunities to review goals and further enhance independence. The Clinical Governance Meeting will be reviewed to incorporate the bio psycho social needs which will ensure a more holistic approach this be in place by early April.

Proposed Timescale: 04/04/2018
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some resident's move and transition to the centre was not comprehensively supported.

8. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
The Management of CIDP acknowledges that, in the case of one resident on respite, the transition was not comprehensively documented. The updating of the admission process and input of scheduled reviews of possible placements is intended to mitigate the possibility of this recurring.
All recent transitions have case reviews scheduled or awaiting confirmation of dates, with the person and their advocate where required, to review their placement, ensuring that the resident is satisfied with the service they are receiving and all their identified needs are being met.
This is currently being carried out on a potential resident placement.

Proposed Timescale: 31/12/2017

Outcome 06: Safe and suitable premises
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
As identified in the body of the report, improvements were required with the maintenance and decoration of the premises.
9. **Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
St. Joseph’s House is of sound construction but it is an old building in need of periodic maintenance. As part of the ongoing maintenance programme, the Facility Manager in CIDP has completed the schedule of works for 2017 and there is another schedule for maintenance and decoration in place for 2018.

As part of this work, a review of soft furnishings and floor coverings is to be undertaken early in 2018. Painting and decorating has commenced in common areas, following consultation with Residents on colours.

**Proposed Timescale:** 31/12/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
As identified in the body of the report a number of Schedule 6 requirements were not provided for by the centre’s premises. This included:
- a lack of suitable storage
- laundry facilities
- issues with ventilation in an area
- adequate dining facilities

10. **Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**
The kitchen, dining and laundry facilities are currently being reviewed as part of the SRV Discovery process with a view to new arrangement being installed for use by residents in accordance with their needs, desires and abilities.
Small dining rooms to be set-up around the house to give Residents the option of dining in smaller groups if preferred. The trolley mentioned in the report is now in suitable storage and this will apply to all equipment going forward.
The ventilation possibilities in this area need to be explored further.

**Proposed Timescale:** 31/03/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory
requirement in the following respect:
The premises did not optimally support residents' individual or collective needs.

11. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
Cooking and laundry facilities for use by Residents who wish to avail of these facilities to be installed. These facilities will be accessible for wheelchair users and fully mobile Residents.

Proposed Timescale: 16/03/2018

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The risk management systems in place were not effectively identifying, assessing and managing risk in the designated centre as evidenced in the report.

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

Please state the actions you have taken or are planning to take:
A review of all risks and the format of the register began in September/ October and will be completed in line with CIDP policy. All department managers are now required to report weekly any incidents or adverse events within their department. The information, trends and actions from the reports will be discussed at in-house management meeting and monthly service provider meetings

Proposed Timescale: 16/03/2018

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:
Staff did not have the skills and knowledge to support residents to positively manage their behaviour.
13. **Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
CIDP will implement a programme of training that will further enhance these skills by resourcing training in Mental Health, Positive Behaviour Support and Dementia and rolling out in on a scheduled basis in 2018.

Proposed Timescale: Resourcing requests commenced 30 November 2017, will be booked as training is available. Schedule in place by January 2018. Training schedule to be finalised by 31st March 2018. Any staff member who has yet to complete Positive Behaviour Support training, will be scheduled for first available dates throughout 2018.

**Proposed Timescale:** 31/01/2018
**Theme:** Safe Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Engagement with, and consent from residents was not sought where restrictive measures had been applied for their health or safety.

14. **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:**
We have a practice whereby therapeutic interventions are only implemented with the informed consent of each resident, or consent is received through either them or their advocate. There are rare exceptions to this practice, which, are highlighted in a resident's medical notes, and the intervention is reviewed for the purpose of minimising these events further.

**Proposed Timescale:** 21/02/2018
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Assessments and review of incidents had not been completed, to ensure every effort was made to identify and alleviate the cause of residents' behaviour that challenged.
Alternative measures or supports were not considered before restrictive measures were applied.

Restrictions to the environment were not based on individual assessment, and as such the least restrictive procedure for the shortest duration was not applied.

15. **Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
As noted in the body of the report, the current arrangement in the dining room can become a factor/trigger behaviours in a small number of residents. These arrangements are under active review as per ‘Action 11’ above.
As part of each individual’s Care Plan Review, any supports highlighted as restrictions will be reviewed and discussed with the individual and ensure the least restrictive practice is in place for the shortest amount of time necessary.

**Proposed Timescale:** 31/08/2018

**Theme:** Safe Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Residents were not supported or assisted to develop the skills and knowledge to be in control of their own self-care and protection.

16. **Action Required:**
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

**Please state the actions you have taken or are planning to take:**
Every possible effort is made to support residents to develop their skills and knowledge to make the right decision. It will however, always be our intention not to infringe on the individual’s entitlement to make free choice. As part of the SRV Discovery Process, risks are being identified in order that appropriate skills training can be implemented. Residents will be encouraged to take positive risks following full information and risk assessment where appropriate; any training identified to ensure self-protection will be given.
St Joseph’s House risk register will have new risk of Resident’s managing their own risks following individual assessment, training and information. The approval for this risk will be sought from the service provider.
Proposed Timescale: 30/04/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the centre had failed to notify the Chief Inspector of all notifiable incidents as required by the regulations, more specifically the usage of restrictive procedures.

17. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
The Management of CIDP acknowledges that there was one quarterly review that was submitted late on September 14th 2017. Otherwise all reports were submitted on time and this will continue to be the case.

Proposed Timescale: 06/12/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents’ opportunities for participation and skills building with regard to their food preparation, were not systematically assessed, considered and supported in line with their individual wishes and abilities.

18. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
Based on experience elsewhere, we are confident that the adoption of the SRV Discovery Process will address the perceived shortcomings identified in this section of the HIQA Inspection Report.
Cooking and laundry facilities are currently being planned to include appliances that are accessible to all. A nationally approved external cookery course has been sourced; the course will include food preparation, nutritional awareness and budgeting.

Proposed Timescale: To commence following installation of facilities, expected March 2018.
Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not automatically considered for, and assessed with regard to the option of self-administration of their medication.

19. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
Based on experience elsewhere, we are confident that the adoption of the SRV Discovery Process will address the perceived shortcomings identified in this section of the HIQA Inspection Report. The authors of medication policy will be asked to review section on self-medication to ensure that it is consistent with the findings of the 'Discovery Process'.

Proposed Timescale: 31/12/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
As outlined in the body of the report, the centre's statement of purpose did not contain some of the information as required by Schedule 1 of the regulations.

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

Please state the actions you have taken or are planning to take:
Statement of purpose will be updated to ensure it meets schedule 1 requirements.

Proposed Timescale: 31/12/2017
Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The centre’s management systems failed to ensure that a safe quality service was provided as appropriate to some residents’ needs.

21. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Incident report trending and actions will be reported to the service provider at monthly meetings. A new departmental all department managers have been issued with weekly report templates covering all aspects relevant to their department.

Proposed Timescale: 16/03/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
As outlined in the body of the report, some improvements were required with the consultative aspect of the annual review process.

22. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The Management of CIDP acknowledges the valuable suggestion in the HIQA Inspection Report in relation to the CIDP Annual Report. Already being drafted, the 2017 report will include consultation from residents and their representatives on satisfaction levels and ideas and suggestions for improvements. The 2017 will also include relevant quantitative information as suggested.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Members of the workforce were not effectively performance managed to ensure that
they were accountable for the quality and safety of the service they delivered to residents.

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

Please state the actions you have taken or are planning to take:
All staff at St Joseph’s House are managed in terms of the job description and role responsibilities. There is an ongoing training needs assessment in place that applies to all staff. Supervisors and local management review these and any areas of non-performance are addressed in accordance with internal HR policies approved by the Board.
In line with best HR practice, the Management of CIDP is rolling out a formal structured performance management system on a phased basis over the next 12 months. In time it is intended that the majority of staff will be trained in respect of SRV and will participate in the associated ‘Discovery Process’ for residents and their families

**Proposed Timescale:** 31/12/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured staff were provided with training to meet residents’ needs. For example, training in mental health, training in dementia and in a rights based approach to service provision.

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

Please state the actions you have taken or are planning to take:
All staff at St Joseph’s House are managed in terms of the job description and role responsibilities. As part of this process, there is an ongoing training needs assessment in place that applies to all staff.

The Management of CIDP accepts that there are some deficits in respect of staff training but these are the result of a difficulty in sourcing suitable providers of training and is not related to an unwillingness to provide or undertake this training. We have contacted potential providers of the required training, and will continue in our efforts to identify others. Any specific guidance in this regard would be welcome.
In time, it is our intention that, the majority of staff will be trained in SRV and will participate in the associated ‘Discovery Process’ for residents and their families.

Proposed Timescale: Resourcing requests commenced 30 November 2017, will be booked as training is available. Schedule in place by February 2018.

**Proposed Timescale:** 31/12/2018

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

As outlined in the body of the report, some of the centre policies required review to ensure that they clearly guided and correlated with centre practices.

**25. Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

As part of our on-going three-year review, we are in the process of establishing a 'Policy Review Group' with an appropriate membership, to carry out systematic review of policies and update these in line with best practice in respect of deaf and deaf-blind adults in a residential setting. In carrying out this review, we are mindful of the need to further develop polices for the support of our residents in whatever new setting they may choose to live in the coming years. A further review and audit of policies will be carried out to ensure compliance with regulations and reflect practise.

**Proposed Timescale:** 31/07/2018

**Theme:** Use of Information

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

As outlined in the body of the report, residents' records were not comprehensively maintained to optimally support the resident.

**26. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
Work in relation towards a more integrated approach of record keeping is continuing but takes time. We are confident that integrated records for all residents will be in place by April 2018. In the meantime, all staff are aware of the two principal sources of information on each resident and have access to these records.

**Proposed Timescale:** 31/03/2018