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:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	ORG-0003203
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Marie Grimes McGrath
Person in charge:	Ellen Tighe
Lead inspector:	Julie Hennessy
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	1

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 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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 May 2014 09:00	07 May 2014 18:00

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This report sets out the findings of an announced one-day monitoring inspection. The inspector met with residents, staff members, the person in charge and the provider.

The centre provides residential and respite accommodation and services for adults with intellectual disabilities.

The premise is one of four dormer bungalows that comprises a designated centre. The bungalow may accommodate a maximum of eight adult residents and this comprises seven residential places and one respite place. The seven residential places were full on the day of inspection and the respite place, which is filled one week in four, was vacant.

The inspector found evidence of a person-centred approach. Residents were engaged in meaningful activities appropriate to their interests, needs and preferences. Residents appeared very content and well cared for. Staff knew the residents very well and interacted with residents in a kind, warm and appropriate manner.

The inspector identified two major non-compliances relating to fire safety that were brought to the immediate attention of the provider and an immediate action plan was issued. First, adequate arrangements were not in place to ensure that all

persons would be safely evacuated in the event of a fire within an acceptable time-frame. Second, the provider was unable to confirm or demonstrate on the day of inspection that there were adequate fire safety arrangements in place for the first floor of the centre. The provider responded to the identified issues within the time-frame allocated in the immediate action plan. The inspector found that the proposed actions and action taken in the immediate action plan were satisfactory and appropriate.

The provider demonstrated commitment to the regulatory process, for example, a number of key policies had been identified as requiring development during monitoring inspections of other parts of the service, and these policies had since been developed and approved.

The inspector found evidence of good governance and management in a number of key areas including, medication management, infection control and the management of restrictive practices.

Improvements were required in a number of other areas including, needs assessment, personal planning documentation, audits, the premises and arrangements relating to the workforce and person in charge.

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:

Findings:
Overall, the inspector found that residents were supported in achieving their needs, wishes and interests and resident's participated in meaningful activities. However, improvements were required relating to needs assessments and personal planning.

The inspector found that residents appeared very content and well cared for. The inspector spoke with staff and observed staff interactions and found that staff knew the residents very well and interacted with residents in a kind, warm and appropriate manner.

The inspector found that residents were engaged in meaningful activities appropriate to their interests, needs and preferences. Residents attended day services run by the provider and availed of activities such as music, sensory stimulation and hand massage. On the day of inspection, one resident had been to the park and another had been horse-riding. Family contact was encouraged, supported and facilitated and there was documentary evidence of ways in which family links were maintained.

The inspector found that a comprehensive assessment of needs, with multi-disciplinary input, had not been completed for each resident, as required by the Regulations. The house manager outlined clear plans that were proposed to address this gap.

The inspector found that each resident did have a personal plan, which was developed and reviewed with multi-disciplinary input, as required by the Regulations.

All of the residents in the centre were non-verbal and personal plan development and review was in accordance with the nature of his or her disability. A record of the level of participation of the resident was maintained.

Each resident had a personal plan that was in an accessible format. The inspector reviewed a sample of personal plans. The personal plans contained relevant information and were person-centred. Relevant information contained in the personal plans included information relating to likes, dislikes, mobility and people important to the resident. Assessments needed to inform the personal plan were available, for example, relating to communication and these will be discussed further under Outcome 11: Healthcare Needs. Goals and actions for each year were outlined and a monthly review of goals was completed. Each action named the person responsible for pursuing objectives in the plan within specific time-frames.

However, personal plans did not meet all of the requirements of the Regulations. For example, the services and supports to be provided to residents to realise their goals were not detailed. There were also gaps in the documentation, for example, one resident had specific preferences in terms of who would be involved in his intimate care yet staff were unable to locate this information in the personal plan. The format of the plan was somewhat unwieldy and personal plans were not clearly informed by an assessment of the residents' needs, risk management plans and health plans.

Personal plans were reviewed on an annual basis, which involved the multi-disciplinary team and included the person in charge, the key worker and relevant allied health professionals. Staff described how family members were invited to participate in the annual review of the personal plan. Where family members attended, this was documented.

The inspector reviewed the files of a respite resident, who was in hospital at the time of inspection. The inspector found that up-to-date information and communication relating to the planned admission and impending discharge was well documented.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Findings:
The inspector looked at a number of aspects of this outcome during the inspection. The inspector found that all of the requirements of Schedule 6 of the Regulations had not been met.

The inspector observed that the physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, a number of the bedrooms were significantly limited in size. Given the level of physical needs of the residents in the centre, the bedroom sizes presented significant challenges in terms of meeting the resident's needs, in particular and as further discussed under Outcome 7: Health and Safety and Risk Management, the safe moving and handling of residents by staff in such confined spaces.

The inspector observed that the shower room was also limited in terms of size and space and was in a poor state of repair. For example, the toilet seat was missing, the handrails in the shower were rusty, the grouting in the tiles at the base of the shower was stained beyond repair, there was a lip in the shower tray that could present a trip hazard and/or impede access of wheeled equipment and there was inadequate storage for commonly used items. The house manager confirmed that the shower was used by five of the seven residents in the centre. An assisted bath was used in a different bathroom by the remaining residents.

The inspector noted that the house manager had made improvements to the decor of the centre including to a number of bedrooms and the communal space. The remaining bedrooms were due for an upgrade. The house manager told the inspector that a plan had been submitted to upgrade the shower-room.

The inspector found that there were inadequate or inappropriate storage facilities in the centre. A wheelchair was stored in the narrow downstairs corridor. Excessive amounts of paper, folders, incontinence wear and some unused equipment were stored in the upstairs laundry room, as further discussed under Outcome 7: Health and Safety and Risk Management. Chemicals and paint tins were stored on open shelving upstairs, although residents did not have access to the upstairs area. Incontinence wear was stored in the same room as the freezer upstairs. Folders, bags and some items of clothing were stored openly underneath the staircase leading to the upstairs area.

The inspector observed that there was suitable equipment available to meet the residents' needs as outlined in Outcome 7: Health and Safety and Risk Management including, ceiling tracker hoists, profiling beds, electric wheelchairs and an assisted bath.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Major

Outstanding requirement(s) from previous inspection:

Findings:
The provider had not ensured that adequate arrangements were in place in relation to fire safety in the centre. The inspector identified two major non-compliances relating to fire safety that were brought to the immediate attention of the provider and an immediate action plan was issued.

Adequate arrangements were not in place to ensure that all persons would be safely evacuated in the event of a fire within an acceptable time-frame. The most recent fire drill on 30/1/2014 took 30 minutes to complete. The previous fire drill on 23/12/2014 took 36 minutes to complete. Key issues identified during the most recent fire drill related to the fact that a number of residents were being evacuated using hoists and another resident refused to leave the premises during the practice drill. Although a report was produced by the fire officer identifying problem areas following the fire drill, which was good practice, the inspector was not satisfied that appropriate progress had been made to ensure that residents would be evacuated within a safe time-frame in the event of a fire and that suitable equipment to aid such evacuations was available.

The provider was unable to demonstrate that there were adequate fire safety arrangements in place for the first floor of the centre, where the laundry and a sleepover room used by staff were located.

The inspector observed that in this area there were sources of ignition, including a drier, area along with sources of combustion, including chemicals and large amounts of paper and, sources of oxygen, including via a lift shaft or attic window if left open. This arrangement posed a potential risk of fire. There was no risk assessment of the laundry room and the risk of fire in this area had not been identified in the monthly fire checks that were being completed.

The inspector viewed the sleepover room, which was also situated upstairs. There was no risk assessment of this room. The provider was unable to confirm that this area had been assessed and deemed to be in compliance with relevant building and fire safety legislation relevant to its current use. The provider submitted satisfactory documentary evidence of compliance with relevant legislation within the time-frame allocated in the immediate action plan.

The inspector reviewed a number of other arrangements relating to fire safety and health and safety; many were satisfactory while others required improvement.

There was a prominently displayed evacuation plan and evacuation procedure for emergency situations that outlined arrangements in place in the event of evacuation of the centre. The mobility status of residents had been documented but the mobility needs of residents were not. The cognitive needs of residents were not documented where applicable.

Suitable fire equipment was provided. Fire exits were unobstructed. Monthly fire safety inspections were taking place. The inspector viewed servicing records and found that the fire alarm was serviced on a quarterly basis. The annual servicing records for fire safety equipment and emergency lighting were not available in the centre as they were held centrally. The provider forwarded documentary evidence of the records the day after the inspection and they were up-to-date.

The inspector viewed individual staff training records and found that fire safety training had taken place recently for most staff, with the remaining staff scheduled for training by the end of the month.

There was a safety statement in place that was up to date. The risk management policy did not meet the requirements of the Regulations, however, the inspector noted that a new risk management policy was approved by the Chief Executive Officer (CEO) on the day of inspection.

Health and safety hazard inspections were not being completed, for example of different work areas, which is necessary to ensure that new or changing sources of harm are identified. The inspector found a number of hazards that had not been identified, for example, a wheelchair was stored in the narrow corridor downstairs and could impede evacuation in the event of an emergency and there was inappropriate and insufficient storage of items as mentioned in Outcome 6: Safe and Suitable Premises.

The inspector viewed risk assessments and found that a range of risk assessments had been completed for work areas and work activities including manual handling, infection control, hot water, administration of medications and slips, trips and falls. Those completing risk assessments had received training in this area. Risk assessments identified who was responsible for and a specific time-frame for completing actions.

However, the risk assessment system was not sufficiently robust in that not all risks had been assessed. For example, the manual handling risk assessments did not include the moving and handling of residents in severely restricted bedroom spaces and the risk of fire had not been adequately assessed as previously mentioned.

There were incident reporting guidelines in place that were in date. Incidents were being recorded and reported. There was evidence of learning from incidents and each individual incident was reviewed. Incidents were collated for statistical purposes on a monthly basis; however trending of incidents did not take place.

Inspectors reviewed staff training records and found that staff had received up to date training in the moving and handling of residents. The person in charge had recently attended training in completing mobility risk assessments and the inspector viewed comprehensive individual risk assessments in residents' files. There were measures in place to assist with residents' mobility including ceiling tracker hoists, profiling beds, electric wheelchairs and an assisted bath. However, the inspector found that a number of bedrooms and the shower room provided inadequate space to ensure that staff could move and handle residents safely. The inspector spoke with staff who confirmed that they could not apply a number of the techniques taught to ensure safe moving and handling due to space constraints.

The inspector found that there were a range of arrangements in place to ensure effective infection prevention and control. The inspector reviewed staff training records and all staff had recently received training in relation to hand hygiene. Facilities were available to enable good hygiene practices. The inspector viewed detailed cleaning instructions and guidelines relating to environmental cleaning, the kitchen and the management of laundry. The inspector reviewed cleaning logs in the kitchen and bathrooms and found that they were being completed.

Inspectors spoke with staff who were aware of the principles of infection prevention and control, for example, the importance of hand hygiene, the use of different mops and buckets for different areas and the management of potentially contaminated laundry.

Infection control audits were carried out annually by the CNM2 (clinical nurse manager in infection prevention and control) and findings were reviewed with each staff team. There was evidence of learning from audits. Findings of hygiene audits were reviewed by the infection control and quality committees.

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

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that the provider had put in place appropriate measures to protect residents from suffering from abuse.

The current organisational policies in place for the protection of vulnerable adults, intimate care and behaviour that challenges were outside of their review date. The inspector noted that new policies governing these three areas were approved by the CEO on the day of inspection. An abuse management sub-committee was in operation in the organisation and this was overseen by a Quality and Risk Officer.

The inspector viewed training records that confirmed that staff required up-to-date training in relation to responding to incidents, suspicions or allegations of abuse and in

the management of behaviour that challenges including de-escalation and intervention techniques.

The inspector spoke with staff and found that they were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse.

There was a nominated person to manage any incidents, allegations or suspicions of abuse and staff were able to identify the nominated person.

The inspector reviewed restrictive practices in the centre and found that practices in the centre were good. For example, a risk assessment of any bedrails in use had been completed for the residents who had bedrails, assessments were completed for other types of restrictive practices, a clear rationale for the use of any intervention was documented, interventions were developed and reviewed with input from relevant medical and health professionals where necessary, and alternatives had been considered. Staff were knowledgeable about restrictive practices and ensuring the safety of residents when in use. Improvements were required in relation to the documentation required to support such practices; although the safety of residents with bedrails were regularly checked at night-time, the checks were not being documented.

Inspectors reviewed arrangements in place for managing residents' monies and found that a robust system was in place for the logging and checking of all monies spent. Oversight of the system was by the person in charge and the accounts department.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that residents' healthcare needs were met and they had access to appropriate medical and allied healthcare services.

The inspector found that each resident had a healthcare folder that contained up to date information relating to all aspects of the residents' health needs including referrals, assessments, medications, appointments and reports. A range of risk assessments had been completed using validated tools including, nutrition, pressure sores, pain and continence.

The inspector reviewed residents' files and found that residents had regular access to a General Practitioner (GP). There was an out-of-hours GP service available. Assessments and reports from medical professionals were available, including from neurology, psychiatry, orthopaedics, surgery and in relation to the review of blood results.

Residents' healthcare folders contained evidence of residents' access to a range of allied healthcare professionals including dietetics, speech and language therapy (SALT), occupational therapy (OT), physiotherapy and dentistry.

Input from medical and allied health professionals was documented in residents' care plans and informed practice. For example, detailed information relating to residents' mobility and communication needs were documented and informed practice.

Daily records and checks were maintained including those relating to the residents' weight, height and bowel movements.

One to two residents at any one time had a Percutaneous Endoscopic Gastrostomy (PEG) tube. Guidelines relating to the management of PEG were in place. Recent instruction had been provided by a CNM within the service in relation to stoma care. The inspector observed good practice in relation to the management of a resident with a PEG tube on the day of the inspection by nursing staff. However, the inspector found that training or instruction for all staff in the centre in relation to the care of a resident with a PEG tube had not taken place and was required. This will be further addressed in the action related to Outcome 17: Workforce.

Staff were able to demonstrate how they ensured that residents' who could eat were offered choice at mealtimes. Residents were supported to access snacks and drinks throughout the day.

Menu planners were maintained and a wide variety of foods, including fresh fruit and vegetables were included. The fridge was well stocked. The residents' weights were closely monitored by the dietician and oversight of residents' weight and health status was by the Clinical Nurse Manager.

Advice relating to dietary needs was available for each resident from the dietician and speech and language therapist. Advice was documented in the residents' healthcare folders and relevant information contained in a folder in the kitchen.

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

Theme:
Health and Development

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that there were safe systems in place in relation to medication management.

The inspector found that while there were policies in place relating to the ordering, prescribing, storage and administration of medications to residents, they were outside of their review date. The inspector noted that a new medication management policy was approved by the CEO on the day of inspection.

The inspector found that the system for ordering medications on the day of inspection was safe. Medications were ordered on a specific form from the local pharmacies on foot of a written prescription by the GP.

There were clear processes in place to ensure that residents' prescriptions were up to date. Prescriptions were reviewed regularly by the GP.

Medications were stored safely in a locked cupboard. Medicines were clearly labeled and in their original packaging.

The practice around the transcribing of medications was safe and was completed by the CNM (medication management coordinator) and signed by the GP before use.

All medications to be dissolved or crushed were prescribed by the GP.

The person in charge confirmed that there were no controlled medications and no residents who self-administered medication at the time of inspection.

Inspectors found that the system in place for returning unused or out-of-date medicines was safe and involved the logging and recording of all returns. Used or out-of-date medicines were segregated from other medicinal products, as required by the Regulations.

Oxygen was in use in the centre. There were guidelines in place relating to its use and regular checks were completed of the cylinders.

Medication errors were being recorded appropriately. The inspector reviewed a sample and found that an action plan was included for any errors to aid learning.

Inspectors found that there was a system in place for reviewing and monitoring safe management practice. A monthly log of all PRN ("as required") medications and a quarterly self-assessment sheet were completed at centre-level. The results of such checks and medication errors were reviewed by the medication management coordinator. Quarterly checks of each residents' medications took place, including checks of their prescription. Annual audits of the system were taking place and were reviewed

by the provider (and other relevant bodies). The inspector reviewed the most recent audit (29/9/2013) and found that it was comprehensive.

There was a clear system in place for the oversight of safe medication management; a medication management committee met four times a year and oversight of PRN medications, psychotropic medications and audit results was by the Drugs and Therapeutics Committee.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Findings:
Overall, the inspector found that there was an effective management system in place and clearly defined management structures. There was evidence of good governance and management in a number of key areas including, medication management, infection control and restrictive practices. However, the post of the person in charge was not full-time, formal arrangements were not in place for the management of the designated centre during the absence of the person in charge and formal systems were required to carry out audits, reviews and unannounced visits.

The provider demonstrated commitment to the regulatory process, for example, a number of key policies had been identified as requiring development during monitoring inspections of other centres operated by the provider, and policies had been developed and approved in response. A training plan was in place to implement the new policies.

Inspectors spoke with staff and found that they were clear in relation to lines of authority and were able to identify the person in charge. Staff confirmed that the house manager, the person in charge and the provider were approachable and responsive to any issues raised.

The person in charge was the person in charge for two designated centres. The person in charge had the necessary experience and qualifications to manage the designated centre, as required by the Regulations. However, the role of the person in charge was

not full-time, as required by the Regulations. The person in charge works 32.46 hours a week, four days a week.

There were sufficient arrangements in place to manage the service out-of-hours and at weekends, with four area managers available to do on-call on a rotating basis and back-up by the provider nominee and manager of the day services. However, formal deputising arrangements were not in place in the event of the planned or unexpected absence of the person in charge, as required by the Regulations, to ensure continuity of arrangements in place.

A number of audits were being carried out, including hygiene audits, medication management audits and self-assessments against the National Standards for Residential Services for Children and Adults with Disabilities. The inspector reviewed an annual audit checklist of the service completed in January 2013, signed by the provider, which included an action plan to address outstanding issues. The audit was due for completion for 2014. Also, the inspector did not find evidence of specific health and safety audits, including fire safety audits that were completed for the centre.

The provider outlined specific plans in place to meet the regulatory requirements relating to the annual review of and biannual unannounced visits to the designated centre.

While there were robust reporting and supervision arrangements in place, some improvement was required to improve the documentation of meeting minutes. The provider outlined the types of arrangements in place relevant to the designated centre that ensured staff were facilitated to discuss issues and exercise their responsibilities relating to the safety and quality of care that they delivered. These included 6-weekly house meetings that the person in charge attended and the inspector viewed minutes of such meetings. However, minutes did not detail what discussions took place and any required actions arising from the meetings. The person in charge and the provider nominee confirmed that there were formal monthly meetings between the person in charge and the provider nominee and that they were in daily contact on an informal basis also. The provider nominee in turn meets formally with the Assistant CEO on a monthly basis and with the CEO and executive management team every two to three months. Additional meetings and forums are also in place to facilitate shared learning that the person in charge can attend that occasionally involve external input to provide training or advice on relevant topics such as risk assessment or finances.

The provider told inspectors that staff appraisals were completed on an annual basis. Records of staff appraisal were maintained on staff files and were held centrally in the Dublin office. The inspector was informed that staff were recruited centrally and that the recruitment policy and staffing files were also held centrally in the Dublin office. These files were not reviewed at this inspection.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that staff were experienced and knowledgeable about the needs of the residents. Improvements were required in relation to increasing the formal skills level of care staff in the designated centre and also in relation to the completion of mandatory training.

The provider told the inspector that a number of nursing posts (three whole time equivalent posts) were unfilled and that steps were being taken to ensure a greater skills mix amongst the staff team. Although previous attempts to fill the positions were unsuccessful, the posts have been re-advertised, subject to approval by the Health Service Executive (HSE).

The provider identified an area for development in that a number of care staff did not possess a formal recognised qualification relevant to the role of care assistant, such as the FETAC Level 5 Healthcare Assistant course or equivalent. The provider demonstrated that the organisation has been very proactive and is taking steps to address this gap, including applying for funding from the HSE and ensuring that all new care assistant entrants have already completed a FETAC Level 5 course, or equivalent. Care staff had received in-house training relevant to their role, including hand hygiene, epilepsy awareness and manual handling. The inspector did not find any evidence of negative outcomes for residents due to identified gaps in formal training of carers on the day of inspection.

The inspector found that there was an accurate staffing roster showing staff on duty, which included the times that all staff were on duty.

The inspector spoke with staff who confirmed what training they had received and viewed a sample of staff training records that were held in the centre. Of the files viewed, records indicated that manual handling training was up to date and that staff had recently either received fire safety training or were scheduled to receive fire safety training. Outstanding mandatory training included the provision of up-to-date training in relation to responding to incidents suspicions or allegations of abuse and in the

management of behaviour that challenges including de-escalation and intervention techniques.

Nursing staff had completed other training relevant to their roles and responsibilities including, hand hygiene, tools for safe practice, diabetes, venepuncture and dementia.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	ORG-0003203
Date of Inspection:	07 May 2014
Date of response:	13 June 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 needs, with multi-disciplinary input, had not been completed for each resident, as required by the Regulations.

Action Required:
Under Regulation 05 (1) (b) 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

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

• All service users Global Health Care Assessments will be reviewed and updated.
• All service users Care Plans will be reviewed to include MDT input and will be reflective of individual needs and choices and will be completed by 28.07.2014.
• Each service User will have an annual MDT review, to commence from July 2014 onwards.

Proposed Timescale: 28/07/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not meet all of the requirements of the Regulations, for example, the services and supports to be provided to residents to realise their goals were not detailed, there were gaps in the documentation and the format of the plan did not demonstrate that the personal plan was informed by the resident's assessed needs and other plans.

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:
• The person in charge will review all the plans of care in line with the review of the individual Global Health Assessments will be completed by 28.07.2014.
• Personal plans (PCPs) commenced for the service users in the designated centres on 04.02.2014 and will be completed by the 17.12.2014.

Proposed Timescale: 17/12/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the requirements of Schedule 6 of the Regulations were not met. For example, some rooms were not of a suitable size and layout for the needs of residents, suitable storage was not provided and the shower room did not meet a suitable standard.

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:
• Shower Rooms will be refurbished as part of the service capital projects plan for 2014.

• Immediate repairs completed 14.05.2014.
• All Laundry rooms meet requirement of their function and all excess items in Laundry removed from the area on 09.05.2014.
• Copy of plan of the designated centre – attached to report.
• The director of logistics has been informed of same.

Proposed Timescale: 31/10/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management system in place was not sufficiently robust in that not all hazards had been identified and not all risks had been assessed. For example, a wheelchair was stored in the narrow corridor downstairs and could impede evacuation in the event of an emergency, the manual handling risk assessments did not include the moving and handling of residents in severely restricted bedroom spaces and the risk of fire had not been adequately assessed.

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:
• While we have monthly evacuations in the designated Centre a full fire evacuation took place on 16.05.2014 and actions of report completed 19.06.2014.
• All evacuation exits are kept clear and same monitored by the PIC (person in charge) and the PPIM (person involved in the management of the centre) for compliance.
• Full fire risk assessment completed of designated centre by Fire Manager and PIC 04.06.2014
• All fire risk assessments completed 19.06.2014.
• Repeat fire evacuation on 25.06.2014 @ 07.15am.

Proposed Timescale: 25/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was unable to demonstrate that there were adequate fire safety arrangements in place for the first floor of the centre, where the laundry and a sleepover room used by staff were located. For example, the provider was unable to confirm that this area had been assessed and deemed to be in compliance with relevant legislation relevant to its current use, there was no risk assessment of the laundry room

and the risk of fire in this area had not been identified in the monthly fire checks that were being completed.

Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
1. Safety arrangement for first floor laundry area:
Immediate removal of all stored items in the Laundry commenced 8.5.2014 and completed on 13.5.2014.
Risk assessment was reviewed on 15.5.2014 to include completion of action plans.
Risk assessment will be reviewed on 15.5.2014 to include completion of action plans.
Risk assessment submitted.
2. Safety arrangement for first floor staff bedroom:
Risk assessment completed on 8.5.2014 and with immediate removal of all stored items and risk assessment will be reviewed on 15.5.2014 to include completion of action plans. Risk assessment submitted.
3. Attached Fire Certification Ref No BR.10/33/93 North Tipp Col Council received on 8.5.2014 and inspected and authenticated by Director of Logistics D.O.C. on 8.5.2014. Please refer to email from Mr. Derek Tallant, Director of Logistics in respect of same.

Proposed Timescale: 15/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place to ensure that all persons would be safely evacuated in the event of a fire within an acceptable time-frame, and a risk assessment detailing actions to be taken to address the unacceptable time-frame had not been completed.

Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
1. Villas Fire Marshall training completed on the 14.1.2014, training included the evacuation training, fire guidelines, risk assessment and mobility status of service users.
2. Instruction on completing fire guidelines completed on 15.1.2014 with home managers in residential service.
3. Hold opening of the doors has been addressed in the Villas and all objects are removed. This is being monitored by the area manager and managers on a daily basis for compliance.
4. Fire training on the 15.4.2014 and 6.5.2014 undertaken by 19 staff from the Villas. The remainder of the staff have been trained on the 13th and 28th of May 2014.
5. Practical trial on removal of bed from a service user's bedroom (via a door to an

external courtyard) as opposed to hoisting undertaken on the 8.5.2014. Result – 1 minute. The risk assessments for the service users are completed, this practice has been put in place for fire evacuations 16.05.2014 and 25.06.2014.
6. Individual risk assessments for the evacuation of the service users from the service user's bedrooms via a door to an external courtyard completed on Thursday 15.5.2014.
7. Dates for re-test of evacuation plan at the Villas Friday 16.5.2014 and 25.06.2014 at 8 a.m and 07.15 respectively.
8. Fire evacuation and re-test of evacuation plan were/will be attended by persons competent in fire instruction and fire safety.

Update:
• I can confirm that actions 1-8 have been completed by 28.05.2014.
• Unannounced Fire evacuation 16.05.2014.
• Feedback Meeting with staff that participated in unannounced fire evacuation completed on 19.06.2014.
• Retest unannounced evacuation on 25.06.2014

Proposed Timescale: 25/06/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A system for documenting checks when bedrails were in use was not in place.

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:
• A system for documenting bedrail checks commenced 09.06.2014
• All restrictive practices are documented in service user's plan of care and retained in the local Data base.
• Each service user's restrictive practice is also retained on the service restrictive practice governance committee Data Base.
• Bed rail assessment for relevant Service User is completed and will be discussed at the service Users restrictive practice meeting. To commence July 2014 and complete by 30.10.2014

Proposed Timescale: 30/10/2014

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 post of the person in charge was not full-time and formal deputising arrangements were not in place for the person in charge.

Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
The persons in charge will commence full time hours as per HIQA regulation 04.08.2014.

Proposed Timescale: 04/08/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of comprehensive health and safety audits, including fire safety audits was not available for the centre.

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:
• Safety certificates for all fire equipment have been sourced and are retained in the fire folder.
• Quality and Risk officer completed Health and Safety Audit on 06.05.2014.
• Fire safety audit discussed with fire manager and date for audit 23.07.2014

Proposed Timescale: 23/07/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

Some mandatory training was outstanding, including in relation to responding to incidents, suspicions or allegations of abuse and the management of behaviour that challenges including de-escalation and intervention techniques. Also, not all staff had received training or instruction in relation to the care of a resident with a PEG tube.

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 receives mandatory training as per Service Training Needs Analysis.
• Programme of training for all staff in the updated policy will commence August 2014 policy DOC 020 (Policy for the protection and Welfare of Vulnerable Adults and the Management of allegations of abuse).
• Training on Support Persons with Behaviours that Challenge DOC 011 commenced in June 2014 with scheduled training plan for 2014.
• Training for Staff Nurses in the Designated Centre in PEG feeding completed on 18.06.2014.
• Copies of revised policies have been issued to the HIQA inspector by the Quality and Risk Officer including:
DOC 015 Medication Policy
DOC 020 Policy for the protection and Welfare of Vulnerable Adults and the Management of allegations of abuse
DOC 011 Guidelines to Support Persons with Behaviours that Challenge
DOC 052 Risk Management Policy completed.

Proposed Timescale: 19/06/2014