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-0011637
Centre county:	Dublin 15
Email address:	sandra.nelson@docservice.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Mary O'Toole
Person in charge:	Sandra Nelson
Lead inspector:	Michael Keating
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	13
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 July 2014 10:00	07 July 2014 18:00
08 July 2014 10:00	08 July 2014 14:00

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

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

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of the centre were also sought.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider, for the purposes of application

to register were found to be satisfactory. The nominated person on behalf of the provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.

The centre was purpose built and opened in May 2013 with the aim of meeting a specific need for people with intellectual disability who were living with mid and advanced stage dementia. The mission of the centre is to promote hope, dignity, purposeful living and a dignified and peaceful death for persons with dementia.

A number of relatives' questionnaires were received by the Authority prior to and during the inspection. The opinions expressed through the questionnaires were broadly satisfactory with services and facilities provided. In particular, relatives commented on the excellence of the accommodation provided and they praised the excellence of care provided by staff.

Evidence of good practice was found across all outcomes with 14 out of 18 outcomes inspected against deemed to be in substantial compliance with the Regulations. Outcomes judged to be fully complaint included the communication supports to residents', admissions and contracts for the provision of services, maintaining family relationships, healthcare needs and social care needs. Three outcomes were judged to be moderately non complaint, which related to the provision of mandatory training to staff, fire evacuation management practices and the auditing of medication. A minor non compliance was found in relation conflicting information within policies concerning charges applied to residents.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

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 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

Judgement:
Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

Findings:
The inspector found that residents' rights, dignity and consultation were supported by the provider and staff. Residents' were supported to make decisions about their lives in accordance with their ability, by staff that were well known to the residents and were trained specifically in communicating with people with dementia. However, some improvement was required in relation to the management of residents' finances as there a discrepancy found in relation to policies and guidelines which provide direction to staff on the management of residents' finances.

There were three guidance documents aimed to provide guidance and clarity on the management and expenditure of residents' finances. These were the Long Stay Charges Policy, the Patient's Private Property Account Policy and recently revised guidelines in relation to managing service users monies. This recent guidance documented stated that residents were charged €150 per week from their social welfare payment as a long stay charge. However, figures provided to the person in charge (PIC) on behalf of the provider and reflected within residents contracts of care stated residents were charged €155 if they were in receipt of disability allowance and €175 if they were in receipt of an old age pension. The long stay charges policy referred to residents being charged €155 per week 'in most cases'.

All residents had a capacity assessment in place which determined their level of knowledge in relation to money management. All residents were assessed as not having basic monetary skills. Therefore the provider took responsibility for the management of their monies and held their savings in a residents' account. The balance of residents'

savings was provided to the person in charge on a monthly basis, along with a breakdown of their expenditure. Additional charges to residents for additional services such as hairdressing, beauty treatments and meal outings were listed within the contract of care and referred to within the relevant policy. Residents' were also charged costs relating to staff expenses while supporting residents on an outing such as the cost of the staff meal or coffee. As the residents were out of the centre very infrequently, this charge rarely applied.

Overall though significant effort was made to involve residents in decision making. Consistency of staff and the involvement of family was seen as an essential element in this process as residents capacity to be involved in decisions impacting upon them varied greatly from person to person but also on a daily or hourly basis for many individuals. Residents relied significantly on staff who were aware of their needs and wishes to advocate on their behalf. An effective key working system evidenced through good care planning documentation ensured that residents were provided with consistent supports.

There was a complaints policy in place and a staff nurse was identified as the complaints officer. There were no complaints logged, although the complaints officer had met with a number of families recently to advice them of the policy and encourage them to communicate their satisfaction or concerns relation to any elements of the service provision. She had also met with each of the residents' individually and tried to identify elements of the service that could be enhanced from their perspective.

Staff were observed interacting with residents' in a respectful and courteous manner at all times. Staff spoke passionately about the residents' and it was clear from the responses of many residents that they identified with individual staff. For example, residents with significant disability and advanced stage dementia were witnessed opening their eyes when they heard a staff member's voice, or smiling, acknowledging their presence.

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

Judgement:
Compliant

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

Findings:
The inspector found that the person in charge and staff had responded very effectively to the communication support needs of residents. Information was provided throughout

the centre in an accessible format. For example, 'way finding' photographs were used throughout the centre to assist residents to navigate their way around. In addition, memory aids were used to stimulate memory; all residents had life story books using photographs and text in hard copy format. Three residents were also supported through the development of life story books on ipads' which was being piloted with a view to rolling it out to all residents. A clinical nurse specialist in assistive technology was assisting in this pilot, and was available to support residents and staff in additional assistive technologies.

All staff had received training in ways to communicate with people with dementia such as exploring ways of capturing life stories, encouraging reminiscence and considering ways of obtaining consent. Specific quality dementia care standards had also been developed to guide practice within the centre. One of these Standards entitled 'communication and behaviour' aimed to ensure that the personhood and well-being of the person was maintained through effective communication approaches. This approach also recognised that the development of non-cognitive symptoms could possibly cause distress and lead to behaviour that challenges. This was a focus of the training provided to staff and all residents were offered an assessment at an early opportunity to establish generating and aggravating factors. Each residents' care plan identified their usual means of communication.

Staff records and rosters reviewed suggest that there has been a stable staff force in place since the opening of the centre and this was recognised as crucial in providing consistency in the care provided to residents. It was clear that residents identified with specific staff and responded to individual voices.

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Judgement:
Compliant

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

Findings:
Families were encouraged to be involved in the residents lives and residents were supported to maintain friendships and links with their past. The inspector had the opportunity to meet with relatives during the inspection and spoke with one family who had arrived to the centre unannounced. This was the family's first visit to the centre after their relative had been admitted in the previous week. They spoke of being hugely impressed with the service and were amazed by the design of the centre and the fact that all residents were provided with single rooms.

The inspector spoke with the person in charge and a clinical nurse specialist in dementia care in relation to the involvement of families in the admission procedures. It was explained that once there was a consensus diagnosis established, families were called to a meeting, a focus of which was to ensure that the family understood dementia as a palliative illness and recognised where on the continuum their relative was. In addition, family were shown the centre and the two parts of the centre were explained. Families were involved along the trajectory of the illness and were involved in the full admission process that happens again when it was felt that the resident needed to move into the advanced care side part of the centre. It was also recognised that as all residents were admitted from other parts of the service, their contact with these residential services should be maintained. The people who the residents used to live with were described as a 'second family' and this social connectedness was maintained. Evidence of all of this was found within each resident's care plan. The inspector observed this in practice and saw one resident being visited be a lady she used to live with in a very natural and unplanned way and there was clearly a close bond between both people.

Resident's were also encouraged to go out with family when possible. One resident had recently returned from the Special Olympics in Limerick, where she was supported by family members and a chaperone who was a staff member from the previous centre she used to live in.

Facilities were also available for the use of families. A family room with a sofa bed and washing facilities was available for use at any time. This had been availed of twice in the past year used by families of residents as they approached end of life.

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

Judgement:
Compliant

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

Findings:
There was an admissions policy specific to the centre and it clearly set out the arrangements for admitting new residents. The inspector reviewed the file of a resident who had been recently admitted to the centre. This resident had moved from another part of the service in the previous week. A full multi disciplinary support team were involved in the decision making process. Clinical nurse specialists in dementia care provided a lead in this regard as they were involved in assessing all residents within the

broader service who were susceptible to acquiring dementia or were suspected of having dementia. For example, baseline tests were carried out on all residents from the age of 35 who have down's syndrome. Early diagnosis and intervention was viewed as key to managing the illness and in supporting people to stay in their own homes as long as possible. However, there remains a significant demand for places in the centre who cater specifically for people with mid-stage and advanced stage dementia care. This ongoing engagement with the nurse specialist places them in a unique position to be able to identify priority need in consultation with other multi disciplinary team members.

A respite bed was also maintained for short term use and this benefited future residents by introducing them to the service and also as a way of staff and other residents' to get to know them. The admission policy stated that each admission was considered on an individual basis, and evidence within care plans reflected a slow transition into fulltime living within the house, for some residents this was a slow integration taking place over months. For others who moved in more quickly, a process of 'staff handover' was used where staff from the previous living environment accompanies the resident for a number of days, usually between 3 and 7 days. This was evidenced within the care plan for the most recent admission, who was supported in this way for 3 full days, before reducing this support over an additional two days. It was explained that this was done in order to capture the 'nuances of people's personality that could not be handed over in a file'. It was also noteworthy that the admissions criteria had been changed to meet the needs of siblings who live in the centre. While one had a consensus diagnosis of mid stage dementia, the other did not. However, it was determined that as these siblings had lived together all of their lives and had a huge reliance and dependency upon one another it would be hugely distressing for both to separate them at this time in their lives. They have separate bedrooms with their own sitting room, these residents were spoken with several times by the inspector and it was evident from their interactions that they derived support and comfort to one another.

Each resident was also provided with a contract for the provision of services which detailed the support, care and welfare of each resident and included the details of the services to be provided and the fees to be charges. Residents' representatives were also provided with a copy of this contract.

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

Findings:
In general, the inspector found that residents were involved in the development of their personal plans and that staff provided a good quality of social support to residents. Each resident had opportunities to participate in meaningful activities, appropriate to their interests and preferences.

A 'slow care' model of service delivery was adopted in the centre, reflective of the needs of the residents. This meant activity was completed at the pace of the resident and was very much dependent on the responses of that resident at any particular time. Structured activities were also timetabled and residents could participate by choice. For example, a volunteer came in and baked or did gardening with the residents every Monday morning and a number of residents were involved in baking on the first morning of the inspection. Opportunities for meaningful activity was provided to residents and care plans and the activity log documented activity from weekly swimming classes for one resident to bed side activity for others.

Person centred care plans were maintained which demonstrated that a good standard of care and support was provide to offer stimulation to all residents and to provide them with meaningful activity. Other regular activity provided included music therapy, spirituality, walks, reminiscence groups, art, going for drives, as well as ordinary activity of living such as filling the dishwasher and shopping.

Social care plans were being reviewed regularly in response to changing health needs. Plans were also in place to revise the format of the care plans in line with the 'Quality Dementia Care Standards' which had been developed specifically by the specialist who had been involved in setting up this service. These standards had been developed to support and enhance the quality of life throughout the continuum of dementia and formed the cornerstone of care provision within the centre. They were developed under six separate standard principles. One of these standards linked directly to 'social care needs' which aimed to promote well-being and social connectedness. This standard sought to maintain relationships, meet preferences and lifelong interests and provide suitable activity across the continuum of dementia. There was evidence provided within existing care plans that this was being achieved however, the inspector formed that view that direct linkage between the care plans and these standards would establish clearer evidence base to ensure residents desired social care needs were identified and met.

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:
Compliant

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

Findings:
The inspector found that the centre was bright and airy, well maintained and adequately met the residents individual and collective needs in a comfortable and homely way. Each resident had their own en-suite bedroom and there was sufficient communal space provided within each bungalow. Some residents showed the inspector their bedrooms which were nicely decorated and of suitable size to meet their individual needs. Each room was personalised, with family pictures framed on walls and posters reflecting music and/or personal achievement of residents.

The two bungalows comprising the designated centre were purpose built and future proofed in order to support residents' current or emerging needs, considering the profile of residents. For example, ceiling hoists were in each bedroom and bathroom. One of the units is an eight bedded bungalow for persons who have an intellectual disability and mid stage dementia. The second unit is a six bed bungalow for persons with intellectual disability and advanced stage dementia with a focus upon end of life care needs. The centre had also developed a brochure on achieving quality environments for person centred dementia care which reflected the effort that when into the design and development of the environment and reflects the best research evidence in creating environment for dementia care delivery. The design of the centre had also won an award at the recent health care words as the most innovatively designed care centre in Ireland.

All matters to be provided within the premises were provided for as per Schedule 6 of the Regulations.

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 - Moderate

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

Findings:
Overall it was found that the health and safety of residents, visitors and staff was promoted and protected. However, non compliances were identified in relation to the fire evacuation and firs safety management procedures.

Four evacuations had taken place within in past six months. Of these four, two were held to simulate a night-time evacuation of the premises when residents were in bed. The first of these happened on the 14 March 2014. The evacuation report identified that it took ten minutes to evacuate, although the residents had not been able to be evacuated to the assembly point. This was stated as because not enough staff had responded from other centres on the campus and because two staff were required to hold doors open. The evacuation report also stated that another drill was required 'before the next scheduled one'. While there was no way of knowing when the next scheduled one was due, the subsequent drill bid not happen for three months, taking place on 19 June 2014. The evacuation in March was supervised by the night sister (who provides management cover across the campus) and a member of maintenance staff however, it was only signed by the night sister. The evacuation report also stated that a copy must be sent to the fire safety officer, who was identified on the report if he was not in attendance. The fire safety officer who was also the head of maintenance has been coordinating all fire drills and had a member of his staff coordinating the simulated night-time drills which took place early morning. The inspector spoke with this fire officer and he stated that he had not been made aware of these issues by his member of staff, and had not seen the form. In addition, the evacuation forms used in all four drills did not provide a section for learning outcomes or to ensure any required action had been carried out. This was shown to the fire safety officer who stated this would be rectified. However, later during the inspection the inspector was shown an updated fire safety policy that had been in place since 21 May 2014. The fire safety officer had no knowledge of this policy; in addition this policy had updated the evacuation recording form to include learning outcomes and provided copies of it within the appendices. These had not been used by the fire officer who had coordinated the subsequent drills in June 2014.

A certificate of compliance relating to fire safety and building control was submitted to the Authority as part of the registration process. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergence lighting. A general fire evacuation plan identifying an adequate number of exits was posted at prominent positions throughout the centre. Staff told the inspector they were now confident in their ability to evacuate the centre at all times since recent involvement in evacuation drills and the completing of training for all staff within the centre completed in May 2014. All residents also had detailed risk assessments outlining their specific evacuation requirements in the event of an emergency.

The inspector read the centre specific safety statement which was combined with relevant health and safety policies and procedures including risk assessments. In addition, a comprehensive risk register had been developed and implemented throughout the centre which simply and effectively covers the identification of risks, measures in place to control risks and outlined the arrangements in place for identifying, recording and reviewing all risks with a view to minimising any identified risk. A member

of staff had also been identified as the organisations health and safety representative and he was carrying out regular audits to identify and review risks and hazard identification. An organisational health and safety committee met once every six weeks to review all health and safety related accident and incident report forms. This identified staff member as well as the person in charge, and provider attended this meeting.

Individual risk assessments had been carried out for all residents to ensure that any risks were identified and proportionally managed. There was evidence that they were regularly being updated by staff following ongoing review.

There was a policy on and control measures in place to mange any outbreak of infection. Household staff were employed and the premises were clean. Cleaning records were observed by the inspector.

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:
Compliant

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

Findings:
Generally, there were arrangements in place to safeguard residents and protect them from the risk of abuse. There was a policy in place which had been reviewed and updated in May 2014 which provided guidance to staff on how to manage and report any concerns in relation to the protection of vulnerable adults. Staff spoken with were competent in their knowledge regarding reporting mechanisms within the centre and in how they would deal with any incidence of abuse. However, not all staff had completed training in the area of adult protection. Training records indicated that four staff were due to complete this training in July 2014, however, for other staff who have not had training as far back as 2003 there was no plan in place to provided revised and updated training for this group. This non compliance is actioned under Outcome 17: Workforce.

A restraint free environment was promoted within the centre. Any possible restrictions had been recorded/ risk assessed and the use of any interventions to reduce likelihood of injury to any resident had been reviewed and reduced. For example, the use of lap straps and padded bed rails had been risk assessed and protocols were in place in care

plans regarding the use of slings and hoists, bed transfers and the use of an angel clip when transporting one resident to prevent them from opening their seat belt whilst using the centres bus.

Intimate care plans were implemented for each resident and had been reviewed in May 2014. These considered all relevant areas of personal care including the level of ability to self care, communication preferences, medical needs, equipment required and social and environment issues. Training had been provided for staff on issues of consent for people with dementia. Staff spoken with stated the process of gaining consent was seen as continuous where residents were supported and encouraged through the use of visual aids to reassure them in relation to areas such as intimate care. For example, a towel of face cloth was used to inform the resident of a need for personal care and this was seen as a way of developing residual capacity and consent. If a resident refused at that time, the process of 'slow care' allowed for this and staff would try again later. This was accommodated by providing a continuity of staff and ensuring staff were well know to residents, and could therefore make a determination to meet the residents care needs in the residents' best interests.

Positive behaviour support plans were not required for any residents.

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

Judgement:
Compliant

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

Findings:
The staff were maintaining detailed records of all accidents and incidents in the centre. These were reviewed by the person in charge and health and safety committee. All incidents had also been submitted to the Authority as required by the Regulations. Quarterly reports had also been submitted as requested and copies of all notifications were maintained by the provider.

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Judgement:
Compliant

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

Findings:
The inspector found that residents' general welfare and development was being facilitated. All of the residents could attend a day activation centre within the campus, or were supported by staff from the activation unit and residential staff within their centre if they were unable to attend. Services provided to residents in this way included music therapy, art, Reiki, colonic massage, reflexology, spirituality groups, walks and bedside therapy's. A clinical nurse specialist in complementary therapies was available to support staff and residents in this regard.

Considering the primary focus of the centre in meeting convalescent and palliative care supports to residents, it was judged that residents were involved in activities deemed important to them. Maintenance of everyday living skills such as tea making and helping clear up after meals was encouraged and included in residents care plans. Attempts were made to encourage residents to do as much as they could for themselves, with recognition that if residents were not able to do something one day, this did not mean they could not do it the following day.

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:
Comprehensive care plans were provided within each residents file which considered long and short term health needs. Records highlighted significant input of medical specialists to support residents' needs. There was daily access to a general practitioner (GP) as well as access to opticians, dentists, chiropody, palliative care specialists, speech and language services, physiotherapy, psychology and psychiatry services and dietician services.

Health care plans identified current needs and also considered emergent needs and residents were monitored for potential additional medical complications. For example, associated medical issues relating to mid and advanced stage dementia includes epilepsy and depression and assessments in relation to these conditions were contained within residents' health care plans.

Residents' in advanced stages of dementia had specific advanced care plans in place. These were reviewed by the inspector and were noted to be developed in line with a local hospice guidelines. These plans detailed family awareness of diagnosis and prognosis of the illness, end of life multi-disciplinary meeting records, pain management and requests not to be transferred to an acute hospital as well as funeral and memorial planning. These plans also considered specific health needs in relation to residents' psychological and emotional status, eating and drinking, mobility, sleep patterns and oral care.

Residents' dietary and nutritional needs, as well as food preferences were also detailed in their health care plans. These were used to inform the catering staff of dietary and menu requirements. Residents were provided with modified consistency diets and most residents required the assistance of staff to eat their meals. Staff were observed providing this support in a discreet and sensitive manner, engaging with the resident at all times. Resident's diets were fortified as per assessed need and snacks were available in within the centre and pictorial menus showed a variety of choices for each meal.

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

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
Overall the inspector found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by qualified nursing staff. However, improvement was required in the auditing and checking of medication to ensure safe medication management practises.

The receipt of medication was being recorded and medication was being stored in a locked trolley in the staff office. The prescribing and administration of all medication was in compliance with the Regulations and in line with best practice guidelines. A pharmacist was available on site to provide guidance as required and also to audit

medication. All unused medication was returned to this pharmacist in a prompt fashion. Drug errors we recorded and reported using the organisation accidents and incident sheets and reporting mechanism. A drug error dating back to 2013 was reviewed by the inspector and this including learning from the incident to minimise the likelihood of recurrence. A fridge was available to store medication that needed to be temperature controlled and this fridge was kept locked with daily temperature checks recorded.

Receipt of medications was recorded in detail on a monthly basis and signed by the staff nurse who collected the prescription from the on site pharmacy. However, there were no checks in place to ensure that as prescribed and as required medication was counted and cross-checked against administration sheets to ensure the correct amount of medication was in stock and that the correct doses of medications had been administered as prescribed.

Residents' records also identified regular reviews of medication to ensure effectiveness and to assess if it was still required. For example, one resident no longer required the use of a sleeping tablet and her sleep pattern had been recorded which demonstrated that she generally slept well during the night without the need of a sedative.

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

Judgement:
Compliant

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

Findings:
There was a written statement of purpose that accurately described the service provided in the centre. It also included all of the information as required in Schedule 1 of the Regulations. The statement of purpose had also been provided to residents and their representatives.

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:
Compliant

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

Findings:
There were robust managements systems in place with clearly defined lines of authority and accountability. The provider had undertaken a number of audits and reviews of the quality and safety of the service. There were regular reviews of risk management arrangements and incidents and accidents. The inspector read a report of an unannounced inspection of the centre carried out on behalf of the provider which is a requirement of the Regulations. This report highlighted progress in relation to the last inspection carried out by the Authority, as well as identifying areas for improvement independently.

A review of polices had also been carried out and a number of policies had been updated or replaced including the policy of providing intimate care, safeguarding of vulnerable adults and end of life care and support and fire safety.

The provider had established a clear management structure and the roles of managers and staff were clearly set out and understood. The structure includes supports for the person in charge to assist her to deliver a good quality service. These supports included a service manager, clinical nurse managers and medical specialists. The nominee provider visited the centre regularly and was knowledgeable about the service. The person in charge also met with the nominee provider and others participating in management on a weekly basis and these meetings were recorded and minuted.

The provider had registered a person in charge (PIC) as well as a deputising person in charge with the Authority. The inspector dealt with the deputising person in charge throughout this inspection, as the person in charge had commenced long term leave in the previous three weeks. This has been reported to the Authority as a notifiable event under the Regulations. The deputising person in charge was deemed to be a fit person in charge and was suitably qualified, experienced and skilled. She had a in-depth knowledge of all of the residents and was extremely helpful to the inspector throughout the process.

Both persons in charge were due to commence maternity leave in the next month. In this regard the provider had transferred a Clinical Nurse Manger (CNM2) from another part of the service and begun her induction into this centre. However, this person had since left the organisation. The provider then advertised the position of person in charge and evidence was provided to the inspector that application had been received and the short listing process had begun. The provider was confident that a person in charge would be in place before the deputising person in charge commences maternity leave,

planned for four weeks time and that there would be time for a handover to take place between these persons in charge.

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
The inspector found that adequate arrangements were in place through the appointment of a deputising person in charge who was an experienced clinical nurse manager. In addition, the roster clearly identifies a staff nurse as being in charge on occasions when neither person in charge was on duty.

The person in charge had begun an absence for a prolonged period of greater than 28 days at the time of inspection. The provider had notified the Authority of this event.

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Judgement:
Compliant

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

Findings:
The inspector found that sufficient resources were provided to meet the needs of residents. There were sufficient staff on duty and the person in charge used staffing resources effectively to meet the support needs of residents. For example, extra staff had been provided to provide additional support to residents at end of life or to support residents who were admitted to hospital. Specific transport had been provided to enable

residents to travel and to use community facilities.

The centre was nicely furnished and equipped. It was also very well maintained and assistive equipment was provided for residents as required such as hoists, ceiling hoists and a shower trolley.

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

Findings:
The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with adults with disabilities.

Six staff files were reviewed subsequent to the inspection within the organisation central management offices and were found to contain all of the documentation as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Training records were held both centrally within staff files as well as locally within the centre. Training records provided by the person in charge identified that all staff had completely mandatory training in the areas of fire safety and manual handling. However, not all staff had completed up to date safeguarding of vulnerable adult training and there was no training plan to provide this to all staff who required it.

The inspector reviewed the proposed and actual rosters for the previous month and all staff were identified on the roster. The roster also clearly identified who was in charge at any given time.

Staff employed in the centre, observed and spoken to during the course of the inspection demonstrated an intimate knowledge of the residents they support. Residents were supported by two key working staff and the staff who were spoken to were familiar with the personal plans and goals set for their key clients.

Continuity of staffing was seen as key considering the profile of the resident group, as

has been detailed previously within this report. Staff spoken to felt well supported and loved working in the centre. Staff were observed to be extremely patient and supportive in their dealings with residents. It was judged that there was an appropriate skill mix of staff in place with nursing staff and care staff working together to support residents. Additional support and training was provided to staff including understanding dementia and intellectual disability, person centred dementia care, designing a home for person's with dementia, dementia and communication, end of life care, music therapy and diabetes care.

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

Judgement:
Compliant

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

Findings:
The provider had completed a recent audit and review of all policies and procedures across the broader organisation and had just recently re-issued revised versions of a number of policies including safeguarding of vulnerable adults the provision of intimate care and fire safety. Many changes within the centre since the last inspection such as intimate care planning and the reporting procedures relating to abuse were now reflected within these policies. All of the policies and procedures as requested by Schedule 5 of the Regulations had been developed.

Policies and guidelines specific to the needs of residents within the centre had also been issued. For example, care planning guidelines specific to people with intellectual disabilities and dementia. In addition, quality dementia care standards entitled 'supporting persons with intellectual disability and dementia' had been developed to guide practice, as has been documented elsewhere within this report.

The residents were also provided with a residents' guide, and efforts had begun to provide this in an accessible format. The provider had also developed a directory of residents with all of the information as required within the Regulations.

The inspector was provided with a copy of an insurance certificate which confirmed that there was up to date insurance cover in the centre.

Records were been maintained in a secure and safe manner. Staff records were stored within the organisations head offices which were provided to the inspector by a member of human resource staff. Residents' records were kept in the staff office in the centre. All records reviewed were accurate and up to date. Records were made available to the inspector as required during the inspection.

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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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	ORG-0011637
Date of Inspection:	07 July 2014
Date of response:	25 July 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 01: Residents Rights, Dignity and Consultation

Theme: DCAD10 Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Policy and guideline documentation relating to the management and expenditure of residents' finances provided inconsistent information relating to long stay charges.

Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
Guidelines for staff on managing service user's money have been amended and now

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

reflect the correct long stay charge rate. These charges now correspond to the financial assessment which was in each service user's care plan.

Appendices with current legislation have been included in the guidelines. The amount of the long stay charge is set out in schedule 1 of the 2011 Regulation.

Staff informed of above amendments to the guidelines.

Proposed Timescale: 29/07/2014

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 fire management system in relation to evacuations was not effective in ensuring that that all residents could evacuate the premises safely and ensuring that learning outcomes and actions required were carried out to protect all residents.

Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
A plan incorporating a response team is being developed for day/night evacuation of the centre.

This plan will be forwarded to each designated response area, together with a floor plan and read/sign sheet for staff.

Local Health and Safety representative to liaise with Fire Manager to schedule monthly fire drills.

Person in charge to receive feedback from staff member coordinating fire drill.

Fire Manager to carry out three monthly audits as per appendices of Fire Policy(DOCSO60)

Proposed Timescale: 06/08/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on fire safety management had been revised and published but was not informing practice in relation to the fire drill and evacuation procedures.

Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
All staff to read and sign Fire Policy (DOCSO60) dated 21/05/14.

All fire safety recording documentation from Fire Policy (DOCSO20) is now in practice.

Proposed Timescale: 06/08/2014

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:
There was no regular audit of medication to ensure that the correct amounts of medication were administered and recorded to ensure the medication in storage tallied with the amount of medication recoded as administered.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Each prescribed 'as required' medication will be labelled with the name of the service user, quantity dispensed and the date of dispensing. This facilitates counting of 'as required' medications and cross checking with the administration record in the MPARS.

Periodic checks of 'as required' medications will be in place. Medications with abuse potential e.g. Diazepam will be checked more frequently than other medication.

A local procedure for checking 'as required' medications will be developed.

Proposed Timescale: 06/08/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had been provided with up to date training in the safeguarding and

protection of vulnerable adults.

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 will have received training in Service User Protection and Welfare by 29th of July 2014.

Refresher training in Service User Protection and Welfare will commence on 17th of September 2014. Further dates provided for October/November.

All staff to familiarise themselves with the updated Policy for the Protection and Welfare of Vulnerable Adults and the Management of Allegations of Abuse(DOCSO20)

Staff to sign sheet when policy is read and understood.

The social work team have commenced information sessions to staff on the updated policy(DOCSO20)

Proposed Timescale: 31/12/2014