

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003948
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 April 2015 10:30	14 April 2015 18:00
15 April 2015 09:00	15 April 2015 15:30

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 report sets out the findings of an announced inspection of Group E St. Anne's Residential Services following an application by the provider to register the centre.

This was the second inspection of this designated centre. The first inspection was a triggered 'single-issue' inspection carried out on 19 December 2014 relating to 'Outcome 8: Safeguarding and Safety'. That inspection was carried out in response to an anonymous complaint received by the Health Information and Quality Authority (the Authority) on 17 December 2014. The anonymous complaint related to allegations of poor practice and practices that could constitute the abuse of residents in three designated centres, including this designated centre. Inspectors did not find

evidence either on this inspection or the previous inspection that the allegations of poor practice as specified in the anonymous complaint were currently being practiced in this designated centre.

The designated centre comprises two residential houses in a community setting. Over the course of this inspection, inspectors met with residents, staff members, the person in charge, one house manager, the assistant chief executive officer (A/CEO) and the quality and risk officer. While all residents did not communicate verbally, inspectors communicated with a number of residents and observed staff interactions. Staff demonstrated that they knew the residents well and were observed to interact in an appropriate manner with residents. Staff demonstrated a positive approach to behaviours that challenge over the course of the 2-day inspection.

Inspectors reviewed questionnaires that had been completed by one resident and a number of relatives in relation to their experience of the service. The feedback from the resident and from relatives in relation to the care received by staff was positive. However, the gender mix in one house was raised as an issue in a feedback form and supported by other evidence.

A major non-compliance was identified in relation to social care needs as the provider had not satisfactorily ensured that the designated centre met the assessed needs of all residents. Three residents had been identified as requiring alternative more suitable accommodation. There was documentary evidence that this was having a negative impact in some ways on individual residents' quality of life. While the provider had taken some steps to try and resolve this, the situation remained unresolved. This was discussed with the A/CEO at a meeting following the inspection.

Other non-compliances were identified in relation to personal planning, arrangements to meet residents' training and education needs, measures to ensure privacy and dignity and notifications to the Authority. Also, not all staff had received mandatory training in relation to the management of behaviour that challenges, the protection of vulnerable adults or fire safety. Non-compliances are discussed in the body of the report and outlined in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

There was a complaints policy on display in a prominent position and it was also available in an easy to read format. Inspectors reviewed the complaints log in one of the houses and found that there had been four recorded complaints in 2014 which ranged from clothes being too tight, shoes missing and residents being upset following an incident. There were details of corrective action being taken in all cases. However, the complaints log didn't record whether or not the complainant was satisfied with the outcome of the complaint.

Records of house meetings with residents were maintained. In one house for example, meetings had taken place monthly since the beginning of the year. Minutes demonstrated that staff checked that residents were happy with how the house was being run.

There was an advocacy committee in place in the service. However, minutes of such meetings were not available in the centre and it was not clear how the committee was representative of all residents. The person in charge outlined arrangements in place for residents to access external advocacy if required.

Most bedrooms were single rooms with the exception of one shared double room which, for privacy reasons, had screening arrangements in place. However, MDT minutes identified that this arrangement did not meet the assessed needs of the residents.

Inspectors saw complete records were maintained of all financial transactions involving residents' finances. In relation to day-to-day expenses; two staff members were signing for all transactions involving a resident's finances. There was an audit system

undertaken by finance staff of the organisation to review residents' finances. Inspectors reviewed the audit results of five residents which reviewed whether a receipt was available for each transaction involving a resident's money, if a staff signature was available and if the amount recorded matched the amount on the receipt. Records showed that compliance was in most cases above 90%.

There was adequate space for clothes and personal possessions in all the bedrooms. Inspectors found that all bedrooms were tastefully decorated with residents' own items of furniture and lighting. Residents were supported to clean their own clothes or bring their clothes to the laundry area and there were adequate laundry facilities in the house.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Inspectors found that residents' communication needs were met by staff.

In the sample of healthcare files seen by inspectors each resident had a communication profile completed as part of their health and social action assessment. This outlined how residents communicated verbally, non-verbally and their receptive language. Staff with whom the inspectors spoke were aware of these individual communication needs, and were observed communicating appropriately with residents during the inspection. One resident used lámh communication which is a manual sign system used by children and adults with intellectual disability and communication needs. A lámh communication book was available for staff for reference in the kitchen. One resident had a picture schedule available which helped the resident to have certainty around activities during the day.

Each resident had an acute hospital communication booklet which was available in case a resident had to be admitted to hospital. It outlined key information about the resident that would inform hospital staff in the event of such an admission.

Television and stereo systems were provided in the main living rooms. In one of the houses the television was enclosed in a secure casing. The person in charge said that the reason for this was related to the risk of injury. Incident report forms seen by inspectors supported that reason.

Judgment:

Compliant

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

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

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that positive relationships were supported.

There was a policy on visiting and residents said to inspectors that families were welcome and were free to visit. A log was maintained of all visitors. There was adequate communal space in the houses to receive visitors with a kitchen/dining rooms and a separate living rooms.

Family relationships were supported by staff in various ways as applicable to each individual resident. Residents were supported to visit their family members, to stay overnight or for weekends in their family home and to go out on day visits with family. Residents were able to tell inspectors when they were due to go home. Family were invited to attend personal planning review meetings if appropriate.

Where access to community based activities had been curtailed due to concerns regarding behaviours; appropriate referrals had been made. Recommendations arising from such referrals were implemented to address such needs and resume such access.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Each resident had a written contract of care. However, improvements were required to such contracts.

Inspectors reviewed a sample of resident contracts of care and found that two hadn't been signed either by the resident or their representative. The sample contracts seen by the inspectors included for example: how personal effects are managed; staffing arrangements; provision for family contact; assessment/care planning; medication management; comments/complaints and insurance.

In relation to admissions to the centre; there was an organisation wide Admissions Transfer and Discharge Committee chaired by the assistant chief executive officer. The person in charge outlined that the last admission had been approximately four years ago and had been on an emergency basis. However, this person was still living here and it had been recorded at multi-disciplinary case meetings that this resident was inappropriately placed. As a result, the contract of care did not provide for this resident's assessed needs.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors found that quality of care delivered to residents' was of an acceptable standard. However, the designated centre did not meet the assessed needs of all residents. While overall, the personal plan and review process was detailed and person-centred, some improvements were required which are outlined below.

The inspector found that the designated centre did not meet the assessed needs of all residents. Three residents had been identified as requiring alternative more suitable

accommodation. There was documentary evidence that this was having a negative impact in some ways on individual resident's quality of life. Examples of impacts on the residents included residents living in a more restrictive environment than they required, lack of individual space and privacy and the impact of the behaviours of other residents' in the house on their ability to integrate as fully as they could in the community. In addition, the unsuitable accommodation, a shared bedroom arrangement and number of residents in the house had been identified as contributing to behaviours amongst the residents themselves. Also, the gender mix of residents was identified as an issue in one house. The inspector found that these issues had been identified and documented since September 2014. While the issues had been discussed at MDT and referred to the Admissions, Discharges and Transfers (ADT) Committee; there were no concrete plans in place to resolve the issue. The inspector found that this was at the level of major non-compliance due to the negative impacts on individual residents of the unsuitable living environment.

A specific tool was used to document each residents' assessment of their health, personal and social care needs, abilities and wishes. Where needs, supports or risks were identified, other specific plans had been completed including health plans, risk assessments and behaviour intervention plans.

Each resident had a written personal plan. Personal plans were individual and person-centred and contained information such as key people in the resident's life, special events, favourite outings or places and a range of likes and dislikes. Information was in an accessible format, for example, a resident's personal preferences were displayed in pictorial format. Some plans were maintained in a format of the resident's choice, including DVD or computerised format.

Each resident had a timetable that outlined what he or she did on a daily and weekly basis. Information included both day services and activities that the resident participates in and enjoys. Activities included swimming, special Olympics practice, baking, computers and going for walks. However, inspectors found that in one house, activity logs were not consistently maintained and the range of activities at weekends were limited. For example, for one resident, the weekly timetable did not outline any activities outside of the house at weekends. The inspector spoke with staff who said that residents would be offered an outing or activity outside of the house at some point over the course of the weekend; however records were not maintained to evidence this. Activities in the second house were varied and meaningful and based on the individual wishes of the residents.

However, some improvements were required to personal plans to ensure that they fully met the requirements of the Regulations, in particular in relation to the setting of residents' personal goals. For example, goals were not both short- and long-term; the supports needed for residents to achieve their goals were not specified and it was not clear how goals contributed to improving residents' quality of life. In addition, goals that related to training, education, employment and skills development were not based on an assessment of the residents' capabilities and wishes. This will be further discussed under Outcome 10: General Welfare and Development.

There was a system in place to review personal plans and there was evidence of some

multi-disciplinary input into this review process. However, the range of multi-disciplinary input was limited into the review process, meaning that not all of the professional input required was available at such review meetings to review each resident's progress, assess the effectiveness of the resident's plan and propose changes to the personal plan as required. This was discussed with the house manager and A/CEO who agreed that the full range of MDT input was not readily available.

In addition, not all personal plans had been reviewed annually (or more frequently if necessary), as required by the Regulations. For example, one plan viewed was 4 months outside of its annual review date.

A record of the review of the personal plan and any challenges to meeting goals was maintained for each resident. Any challenges to achieving such goals was documented as was progress made in relation to challenges encountered. Resident and family involvement in personal planning was documented.

Finally, while files overall were detailed and person-centred, they required stream-lining to ensure ease of access and retrieval. For example, a care plan was required to outline personal care needs for one resident and a risk assessment was required for another resident to ensure the resident's safety in the kitchen. This information was available in other formats within the file but there was a risk that such key information would be missed due to the number of different formats and locations in which information was maintained.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall, the design and layout of the centre were suitable for its stated purpose.

Overall, the premises was in reasonable condition and clean. However, some there was evidence of wear and tear in some areas, including the main bathroom in one house and the lino in the TV room in another house. A socket in use was damaged. Some areas required further cleaning, such as areas behind the sink in the bathroom and corners.

There were sufficient furnishings, fixtures and fittings in each house. Residents' photos and artwork were displayed in the house. There was suitable lighting, heating and ventilation. Overall, the centre was clean although some areas required attention. It was suitably decorated with adequate communal space. There was a kitchen in each house that was equipped with the necessary equipment. Some individual residents had access to their own space in the garden or in an annex.

As previously discussed in Outcome 1: Residents Rights, Dignity and Consultation; there was one shared bedroom in the centre. According to documentation from the MDT and an individual advocate; this presented difficulties for one of the residents who needed individual space and this was not provided in the centre.

Residents had access to equipment that promoted independence and comfort such as shower chairs. Records were available for equipment that required servicing.

Each house had a large secure rear garden and a resident told inspectors that they used the outdoor space when weather permitted.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

While arrangements were in place in relation to health and safety and risk management, a number of improvements were required. These related to the risk management policy, risk assessments, hand hygiene facilities and fire evacuation arrangements.

There was a risk management policy which set out the procedure for identifying hazards including checklist, judgement based on experience, flow charts, brain storming and systems analysis. However it did not include incident reporting which was used as the main tool to identify hazards.

Records were maintained in relation to incidents. In the first house from January 2015 to April 2015 records included 42 incidents of violence and aggression, 8 incidents of violence and aggression when medication was administered and 4 medication adverse events (errors).

In the second house inspectors reviewed 97 incidents from May 2014 to April 2015 with over 80% of reported incidents relating to a violent or aggressive incident. In that period one resident had received medication to manage a violent/aggressive episode on 28 occasions and a second resident had received medication on 8 occasions in response to an incident of behaviour that challenges. The system in place to ensure oversight of medication is described under Outcome 12: Medication Management.

An inspector met with the quality and risk manager for the organisation. She outlined that all incidents were reviewed initially in the centre to try to prevent an incident happening again. A copy of the incident report form was then sent to the risk management department where the incidents were inputted onto a database and any trends analysed. The quality and risk manager also provided training on risk assessments and advice in relation to development of safety statements.

Each resident had participated in identifying specific hazards relating to their lives. These were called individualised risk assessments and each included an analysis of what the issue was, the controls in place to manage the issue and what further controls were required. There was evidence that this process was effective in that additional staffing had been provided in one house at night time as a direct result of a need identified during this process. For residents who displayed evidence of behaviours that challenge; risk assessments were available which were up-to-date.

Inspectors reviewed the safety statements for each house. They were the organisation safety statements with some specific risk assessments relevant to each house. It included measures to control specified hazards including unexpected absence of a resident, accidental injury, aggression and resident self harm. However, these specific hazards had not been included as part of the risk management policy itself. However, the risk management system was not sufficiently robust as a hazard relating to locating a smoking area next to the home heating oil tank had not been identified.

Personal emergency evacuation plans were available for each resident and were on display at each fire exit door. There were records to show regular fire evacuation drills. However, where it had been repeatedly found that a resident refused to exit the building during these evacuation drills; there was no specific plan in place for this resident in the event of a fire.

Inspectors saw evidence that the vehicles owned by the centre, and used to transport residents, were roadworthy, regularly serviced and insured.

The inspector saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained. Servicing records were up to date for both houses. There were daily checks of the fire panel and weekly fire alarm activations. There were weekly visual checks of fire doors, fire safety equipment and emergency lighting. However, agency staff told inspectors that they had not received fire training in either of the two houses. This will be addressed under Outcome 17: Workforce.

Inspectors saw evidence of audits of control of infection and there was access to specific advice on the management of infection. Staff had access to infection control advice as

required. However some required facilities had not been provided as the downstairs bathroom in one house did not have hand washing or hand drying facilities available.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A number of measures were in place to protect residents from abuse. There was evidence of a positive approach to behaviour that challenges. Improvements were required in relation to ensuring that all alternative measures are considered before a restrictive procedure is used. Also, not all staff had received training in relation to the protection of vulnerable adults and behaviours that challenge. The inspectors further followed up on anonymous information received on 17 December 2014 relating to allegations of poor practice and practices that could constitute the abuse of residents. The anonymous complaint concerned three designated centres; one of the two houses in this designated centre was included in the anonymous complaint received. Inspectors did not find evidence either on this inspection or the previous inspection that the allegations of poor practice as specified in the anonymous complaint were currently being practiced in this designated centre.

The person in charge told inspectors that all staff had received mandatory training, including in relation to the protection of vulnerable adults and behaviours that challenge. However, inspectors spoke with regular agency staff on duty at the time of the inspection and found that they had not received training in relation to behaviours that challenge and one staff member had not received training in relation to the protection of vulnerable adults.

Relevant policies were in place, including in relation to the protection of vulnerable adults, restrictive practices, behaviours that challenge, the provision of personal intimate care and residents' personal finances and possessions.

The inspector spoke with the house manager and a number of staff on duty 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.

The inspector spoke with a resident who confirmed that they were happy in the centre. Staff were observed to interact in an appropriate manner with residents.

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

The inspector reviewed documentation pertaining to behaviour that challenges and restrictive practices, observed practices and spoke with the person in charge, the house manager and care staff. The inspector found evidence of a positive approach to behaviour that challenges with supports provided to manage these behaviours. Supports included behaviour management plans, supervision guidelines, risk assessments, restrictive practice guidelines and guidance on PRN ("as required") medication. During displays of behaviour that challenges; staff were observed to support residents in an individual and positive manner using appropriate strategies.

In the house named in the anonymous complaint received, the house manager had extensive experience supporting residents with behaviours that challenge and outlined work that had taken place since she commenced working in that house in November 2013. This included training for staff, support for the staff team by the psychologist, the development of behaviour management plans, the focus on proactive strategies to support residents and the use of reactive strategies where necessary in an appropriate way. Staff said that their understanding and awareness of how to positively support residents had increased as a result of such interventions and support. Inspectors found that incidents of challenging behaviour, although still significant in number, had notably decreased during the preceding months. The inspector spoke with the house manager and staff members who attributed this decline (at least in part) to a more positive approach to supporting residents with behaviours that challenge.

There were a number of restrictive practices in the centre and these were documented and subject to on-going monitoring and also review by a restrictive practices committee. Any practices in place were found to be accurately recorded, with a clear rationale provided and approved by the restrictive practices committee.

While overall measures were in place in relation to the management of behaviour that challenges and the use of restrictive procedures as outlined above, improvements were required. Where possible causes of residents' behaviour had been identified; they had not always been alleviated. Specifically, documentation from the MDT and an independent advocate identified the unsuitable placement of residents and the number of residents in the centre as being contributory factors to individual residents' behaviours. This had yet to be resolved.

Also, all alternative measures had not always been considered before a restrictive procedure was used nor was the least restrictive procedure used. For example, in one house, two en-suite bathrooms were locked when residents were in the house to restrict access to toiletries without full consideration of less restrictive alternatives.

The inspector reviewed arrangements in place for managing residents' finances and found a clear system in place that involved the logging and tracking of all day-to-day transactions at centre-level. An auditing system was in place.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the incident book and notifications received by the Authority.

A record of all incidents occurring in the centre was maintained. Incidents were reviewed by the person in charge and the quality and risk officer. Incidents were discussed by the house manager at staff team meetings.

Quarterly reports were submitted to the Authority and those submitted to date contained the required information.

However, the inspector found one incident that should have been notified to the Authority and had not been notified as required. The inspector reviewed the details of the incident in question and found that the internal processes to manage and follow up on the incident had otherwise been followed in accordance with the organisation's policy and procedures.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that residents participated in training and skills development. However, not all residents were attending suitable programmes. In addition, a formal assessment was required of each resident's educational, employment and training goals.

There was no policy in place in relation to access to education, training and development. A formal assessment of each resident's educational, employment and training goals had not been completed in the centre to ensure that residents participated in suitable programs and that each resident achieved their full potential.

All residents attended a day service. The inspector reviewed a sample of day service timetables in one house and found that residents had a varied and busy timetable. A number of residents communicated to inspectors that they enjoyed their day service.

While the day service provided for most residents was appropriate to their abilities and needs; not all residents were availing of a suitable day service. Where it had been identified by MDT and independent advocacy that a resident would benefit from an alternative more appropriate day service 5-days a week, this was only currently being provided 1-day a week. This recommendation had been identified in September 2014 and had yet to be implemented in full. MDT minutes reflected that the failure to provide a full day service to meet the needs of that resident was due to lack of funding available for transport to the alternative day service.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents healthcare needs were met by timely access to medical and allied health services. Residents nutritional needs were also met.

Inspectors reviewed a sample of resident healthcare files. Each resident had access to a general practitioner (GP). The person in charge outlined that residents could see the GP in his surgery or he would attend the centre if required. There was evidence in the healthcare records that residents had timely access to GP services. There was also regular blood testing for residents on particular medications to ensure that the levels were within recommended ranges.

The GP requested review of residents' healthcare needs by consultant specialists as required. There was correspondence on file from consultant specialists following appointments and reviews. There was evidence that families were consulted with and kept informed following healthcare appointments. There was evidence that residents had access to specialist care from the psychiatry team led by the consultant psychiatrist. In the sample healthcare files seen by inspectors the psychiatry team reviewed residents' medication at regular intervals.

There was evidence that residents were supported to access allied health professionals including a psychologist, physiotherapist, speech and language therapist, an optician and occupational therapist.

There was a policy on nutrition and hydration. Inspectors saw evidence of reviews by the speech and language therapist with reports detailing safe swallow recommendations and advice on food consistency. Where residents required further evaluation of swallow, this had been undertaken in an acute general hospital. Detailed reports and x-ray imaging from these investigations were kept in the healthcare record. Current nutritional assessments which were completed by a dietician were available for a number of residents. Recommendations from these assessments were in a communication book in the kitchen in one house. Meal planning and maximising physical activity were included as recommendations for some residents. Residents could choose when to take their meals and inspectors observed this to be the case. Staff outlined to inspectors that the main meal was prepared by staff when residents returned from day service. Inspectors saw that the food was properly and safely prepared. The food as prepared by staff appeared wholesome and nutritious.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There were systems in place for medication management. Some improvements were required in relation to transcription practices.

There was an up to date policy on medication management.

A nurse prescriber had recorded the list of required medication for each resident. The original prescription had been received from the general practitioner (GP) and written by the nurse prescriber to the current medication administration record. However while the the administration record had been signed by the GP, it had not been signed by the nurse prescriber which was required to prevent the possibility of error. In addition there was no audit of transcribing practice as recommended by An Bord Altranais agus Cnámhseachais. This is addressed under Outcome 18: Records and Documentation to be kept.

Medication was dispensed from the pharmacy in a monitored dosage system. The medication was checked by nursing staff on delivery from the pharmacist. It was kept securely in a locked cabinet in a locked office. Residents' medication and administration record sheets were brought by the resident to their day service.

As outlined in Outcome 7: Health and Safety and Risk Management; a number of residents had received medication in response to incidents of challenging behavior. These incidents were being separately recorded by the centre and there was evidence that the psychiatry team were being asked to review residents' medication if it was being administered in response to incidents of challenging behavior.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose contained a statement of the aims, objectives and ethos of the centre. However, it did not meet the requirements set out by Schedule 1 of the Regulations. For example, the specific care needs, facilities to meet those care needs and services to be provided by the centre were not clearly set out nor were the arrangements for residents to access employment. In addition, the number, age range and gender of the residents for whom it is intended that accommodation should be provided was not sufficiently detailed. The admissions criteria was not specified. The total staffing compliment was not completed in full. The description of the rooms was not sufficiently detailed, nor did it include their size and primary function. Other areas required amendment also and these were discussed in detail with the person in charge.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that there was a clearly defined management structure in place in the designated centre.

While the management structure in place was clearly defined, the provider had

recognised the need to strengthen the governance and management arrangements at organisational level. As a result, three new clinical nurse manager (CNMs) were in the process of being recruited.

The provider had ensured that unannounced visits to each house within the designated centre had been completed. An annual review of the quality and safety of care of the service had been completed by the Quality and Risk Officer and was reviewed by the inspector. The inspector found that aforementioned reviews contributed to improving the quality and safety of the service as areas that required improvement in the service had been identified.

Other audits took place within the service including in relation to medication management, fire safety, health and safety and hygiene.

Staff were clear in relation to lines of authority and were able to identify the person in charge.

The person in charge was full-time and was the person in charge for three designated centres. The person in charge was present for the first day of this 2-day registration inspection. The person in charge was a registered general nurse and had completed a diploma in first line management.

However, the deputising arrangements in place in the event of the absence of the person in charge for 28 days or more were not clear.

There were systems in place to support the person in charge, including a house manager in each of the two houses that comprise the designated centre. One house manager was on leave at the time of inspection. Inspectors found that the second house manager was very aware of the capabilities and any needs of all residents. Staff confirmed that the house manager and person in charge were supportive and approachable.

Regular house meetings took place and minutes were kept of such meetings. Inspectors viewed such minutes and found that included discussion of issues relevant to the quality and safety of care provided to residents. Monthly managers meetings were held that included the person in charge, provider nominee and which were attended by other persons depending on specific topics under discussion. A structure was not in place however for regular meetings attended by all house managers as is the case in other parts of the organisation.

There was a system in place for the completion of annual staff appraisals. Inspectors spoke with staff who confirmed that such appraisals took place.

Inspectors found that the systems for accountability required improvement. This was evidenced by a number of key and as yet unresolved issues that had been referred to the MDT and Admissions, Discharges and Transfers (ADT) Committee. In addition, the A/CEO confirmed that there is no dedicated MDT support to St. Anne's Service. These issues were described in more detail under Outcomes 5 and 10.

Judgment:

Non Compliant - Moderate

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

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

No actions were required from the previous inspection.

Findings:

Where the person in charge had been absent for a period of 28 days or more, the Authority had not been notified as required either of the absence of the person in charge or the arrangements for the management of the designated centre during that absence. However, suitable arrangements had been put made for that absence.

Judgment:

Non Compliant - Moderate

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

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

No actions were required from the previous inspection.

Findings:

The facilities provided were in line with the statement of purpose. However, sufficient resources were not provided to fully meet all of the residents needs in the centre in line with the statement of purpose. The statement of purpose outlines that the centre will ensure that "appropriate accommodation / environment is provided". As previously discussed under Outcome 5; three residents required a more suitable placement and/or an alternative day service to meet their needs.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector found that overall, the number and skill mix of staff was appropriate to the number and assessed needs of the residents on the day of inspection and that the staff rota was properly maintained. However, not all staff had received mandatory training.

The A/CEO acknowledged a previously identified 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. A funded plan is in place to address this gap. Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to hand hygiene, safe moving and handling and food safety.

There was a training plan in place and the annual staff appraisal system facilitated the identification of staff training needs. Inspectors spoke with staff who confirmed what training they had received and records of training were reviewed. However, not all mandatory training required by the Regulations had been provided. Not all staff had received mandatory training in relation to fire safety. As previously mentioned under Outcome 8: Safeguarding and Safety: not all staff had received mandatory training in the protection of vulnerable adults or the management of behaviour that challenges.

The house manager described a clear system in place for new staff. Supervision arrangements were in place. The inspector reviewed an induction log that had been completed for all new staff members. This included centre policies, observation skills, incident reporting and the management of behaviours that challenge.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place.

Staff files were held centrally and reviewed by an inspector who found that they met the requirements of Schedule 2 of the Regulations.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

A record of each resident's assessment of need and a copy of their personal plan was available. The inspector found that a record of nursing and medical care provided to the resident including any treatment or intervention was maintained. However, as previously mentioned under Outcome 5: Social Care Needs, improvement was required to records in respect of each resident to ensure their accuracy and ease of retrieval. As previously mentioned under Outcome 12: Medication Management, residents' records demonstrated that the practice for the transcription of a prescription order was not in line with An Bord Altranais agus Cnáimhseachais na hÉireann guidance.

Records relating to money or valuables, other personal possessions, notifications and staff rotas were maintained, stored securely and were easily retrievable.

The majority of policies required under Schedule 5 of the Regulations were in place. However, there was no policy in place in relation to 'access to education, training and development' for residents. Also, while the risk management policy had been recently amended to fully address all of the areas outlined in the Regulations; the new policy had yet to be implemented. The complaints policy required amendment to outline how anonymous complaints are addressed in a satisfactory way.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Julie Hennessy
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 report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003948
Date of Inspection:	14 April 2015
Date of response:	21 May 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

It was not clear how the advocacy committee was representative of all residents.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

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

Staff and managers from the centre will attend the Advocacy training on 14/05/2015. All service users in the centre will attend a meeting/ information session in the centre, chaired by the house manager to share information on advocacy and its effectiveness. A service user representative will be invited to be a member of the service user advocacy committee, and will be supported if necessary by a staff to attend.

Proposed Timescale: 20/05/2015

Theme: Individualised Supports and Care

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

Where a bedroom was shared; it did not meet the needs of those residents.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

There is another service user in the centre having a placement review, when the appropriate alternative placement becomes available, the capacity of the centre will be reduced, ensuring all service users will have their own bedroom.

Proposed Timescale: 31/05/2016

Theme: Individualised Supports and Care

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

The complaints log did not record whether or not the complainant was satisfied with the outcome of the complaint.

Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

The Organisation has completed a pilot on a new complaints logging system. This will be implemented across the centres 01/07/2015. In the interim the draft document will be used for the recording of complaints and the satisfaction with their outcome in the centre. All staff in the centre will have received training on the complaints policy and

reporting and recording system by 15/06/2015.

Proposed Timescale: 01/07/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Not all contracts of care had been signed by the resident or their representative where appropriate.

Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

All contracts of care have been signed by their family/representative and the service user.

Proposed Timescale: 11/05/2015

Theme: Effective Services

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

The contract of care did not provide for the assessed needs of all residents.

Action Required:

Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

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

The contract of care will be reviewed by the nominee provider and the assistant CEO, and it will be amended to ensure that it allows provision for the individually assessed needs of each service user.

Any request for a service user to transfer to or from the centre will be recommended by a multi disciplinary team and referred to the service admissions, discharge and transfer committee.

Where a service user is admitted to a the centre a full assessment of their needs will be completed and plan of care and supports necessary will be put in place. A review of the individual and the suitability of the placement will be completed and additional supports or changes to the plan of care as necessary be implemented.

There is a resident in the centre who was admitted to the centre on an emergency

basis 4 years ago, and multi disciplinary review recommended that the service user was not appropriately placed in that centre. This service users placement will be referred to the service admission discharge and transfer team for review.

The service is currently in the process of completing a service user review of accommodation for the service users. The purpose of this review is to establish the suitability of placement in centres for the service users.

An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. The house will accommodate 5 individuals in total. The resident from this centre who was an emergency admission will be prioritised in the review process to determine if he could reside with others in the new centre. The review group will include participation from the service users and families and MDT members. The review group has commenced.

Proposed Timescale: 31/01/2016

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:

The persons responsible for pursuing actions was not always sufficiently specified

Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

All personal plans, recommendations and actions from meetings will have named responsible persons to action these points within an agreed time frame, these staff will be identified by the person in charge.

The house managers and person in charge will be responsible for reviewing these actions and establishing progress from the named responsible person.

Existing plans and recommendations will be reviewed by the house manager and person in charge to ensure that a named responsible person is identified for all areas.

The progress of the actions will be monitored and audited by the person in charge on a two monthly basis, or more frequently as actions will necessitate. Where actions are not being completed for and with a service user, support will be given to the staff where necessary by the person in charge to ensure they are achieved, reviewed and modified as necessary.

Proposed Timescale: 15/06/2015

Theme: Effective Services

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

The range of multi-disciplinary input into the review process was limited.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The service has commenced the recruitment process for a psychologist to support residents in the centre. A review of the occupational therapist support required to support needs of residents is being completed by the service and this support will be contracted for service users in the centre as required.

These additional multi disciplinary team members will be included in the development of the person's personal plan, and will make recommendations where relevant. These team members will complete assessments for individuals where referrals have been made but not actioned to date. These assessments will have review dates and responsible staff to action same.

Proposed Timescale: 30/08/2015

Theme: Effective Services

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

Not all personal plans had been reviewed within the previous 12 months, as required.

Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

All person centred plans will be reviewed in the centre and will have review dates set in advance of the actual review date so as to ensure the plans are always in date. These will be planned by the person in charge and the house managers in the centre houses. There will be an audit completed by the person in charge of personal plans quarterly, with detailed action plans and people responsible following each audit. The person in charge is responsible to ensure that all plans are reviewed 12 monthly or more frequently as required.

There will be training delivered to the staff in house from a CNM3 from another part of the organisation in the area of care planning and documentation of changes to care needs, this will take place week commencing 11/06/2015

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Recommendations arising from reviews had not been implemented.

Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

All minutes of review meetings for each service user will be reviewed by the person in charge and the house manager. Where recommendations have not been actioned the person in charge and the house manager will identify a responsible person to follow through on this action for the service user. There will be a time frame given to complete these recommendations, with set review dates for short, medium and long term recommendations. The person in charge and the house manager will be responsible for monitoring the level of achievement, and where recommendations are proving difficult to achieve and additional support is needed the person in charge will arrange a full multi disciplinary meeting to review the recommendation. There will be an audit completed by the person in charge of personal plans quarterly, with detailed action plans and people responsible following each audit. The person in charge is responsible to ensure that all plans are reviewed 12 monthly or more frequently as required. The person in charge will monitor the effectiveness of the plans for each individual with the house managers, to ensure an improvement in quality of life for each service user in the centre.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

The designated centre was not suitable for the purposes of meeting the assessed needs of each resident.

Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

The service is completing a review of all service users and their accommodation needs, with the plan to facilitate alternate living accommodation for service users whose needs are not being met in the centre. Service users and their families will be involved in this process. Recommendations from multi disciplinary meetings will be also reviewed during this process.

The 3 service users in question will have completed multidisciplinary team meetings / residential placement review by week ending the 12/06/15. From these reviews, referrals will be made to the Admissions Discharge and Transfer committee of the Service, as per policy to identify a more suitable place of residence to meet the

residents needs.

The restrictive practices have been reviewed since the inspection and changes made to eliminate these restrictions, service users have now full access to the two ensuite bathrooms in the centre.

Proposed Timescale: 31/01/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There were signs of wear and tear in places and parts of the premises required further cleaning.

Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

The hygiene audit is completed in one of the houses in the centre, the second will be completed. Areas for action from the audit will be reviewed by the person in charge and the house manager and actions will be completed. A clinical nurse manager 3 from another part of the organisation will support the staff around completion of this audit, and support on how to make the necessary actions. Cleaning logs are in use in both houses in the centre, they will be audited and their effectiveness' reviewed and additional areas for attention will be included if necessary.

Proposed Timescale: 30/06/2015

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 was not sufficiently robust; a risk assessment was not available in relation to the location of the smoking area as this had not been identified as a potential hazard.

Action Required:

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

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

There is a risk assessment in place since the inspection in relation to the location of the smoking area and risk assessment specific to one service user that smokes.

The smoking area since the inspection has been relocated to a more suitable area.

A CNM3 from another part of the Service will support staff in the house with onsite training in relation to the identification of hazards and risks and control measures. This CNM3 will also support the staff in the completion of centre specific, and service user specific, risk assessments.

The Person In Charge and House Manager will also receive refresher supports, from the CNM3, on the weekly walkabout hazard inspection checklist.

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

Not all required facilities for the prevention of infection were provided. The downstairs bathroom in one house did not have hand washing or hand drying facilities available.

Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Hand wash dispenser and hand towel dispenser will be installed in the downstairs bathroom.

Proposed Timescale: 22/05/2015

Theme: Effective Services

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

A specific plan was not in place for all residents in the event of a fire emergency where one was required.

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:

For a service user where there is no specific evacuation plan in place in the event of a fire, the fire officer and the person in charge and staff team will review the needs of

this individual to establish the most effective and safe evacuation means for this individual, also the support of the multidisciplinary team will be utilised. The Director of Logistics, who is a Fire Engineer, will be involved with this review and sign off on the plan.

Proposed Timescale: 30/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Where possible causes of residents' behaviour had been identified; they had not always been alleviated.

In addition, all alternative measures had not always been considered before a restrictive procedure was used nor was the least restrictive procedure used.

Action Required:

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

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

A nurse from another part of the service who is a trainer in the "therapeutic management of aggression And violence" will facilitate in house training and support to staff in the development of behaviour support plans for service users, and in the identification and removal where possible of triggers to behaviour.

All restrictive practices in the centre will be reviewed by the restrictive practice committee, and the person in charge for the centre. These will be examined to ensure that the least restrictive measures are in place for the shortest duration. Where restrictions can be, and have been removed, this will be documented on the restrictive practice register for the centre.

The restrictive practices have been reviewed since the inspection and changes made to eliminate these restrictions, service users have now full access to the two ensuite bathrooms in the centre.

Training on the restrictive practice policy will be delivered to the person in charge, and staff in the centre.

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

Not all staff had received training in relation to the protection of vulnerable adults and

behaviours that challenge.

Action Required:

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

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

All staff within the centre will have the mandatory training in relation to the protection of vulnerable adults and behaviours that challenge. No staff will be placed in the centre without this training.

Proposed Timescale: 30/07/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

One incident that should have been notified to the Authority had not been notified as required.

Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

This notification has been made to HIQA since the inspection. All notifications will be made by the person in charge to the authority within a three day period of the allegation.

Proposed Timescale: 12/05/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

There was no policy in place in relation to access to education, training and development. A formal assessment of each resident's educational, employment and training goals had not been completed. Not all residents were availing of a suitable day service.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

The policy in relation to access to education and training is now in place. The centre team with the person in charge and the day service areas staff that support each service user will meet to develop a plan for each individual service user's education and training needs. There will be a separate, and designated, section in each care plan to ensure appropriate assessment of education, training and development needs of each service user. Out of each assessment, short, medium and long term goals will be developed with the service user to ensure that residents are afforded every opportunity available to them around education, training and employment.

There will be training for all staff in the centre to support them in the development process of suitable programmes for each service user in the centre.

Proposed Timescale: 31/08/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not meet the requirements set out by Schedule 1 of the Regulations.

Action Required:

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

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

The statement of purpose will be reviewed by the person in charge and nominee provider to meet the requirements set out by schedule 1 of the regulations, and submitted to the authority.

Proposed Timescale: 25/05/2015

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 deputising arrangements in place in the event of the absence of the person in charge for 28 days or more were not clear. In addition, the systems for accountability

required improvement.

Action Required:

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

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

The recruitment process for a full time Clinical nurse manager 2 has commenced, the appointed person will have experience at management level, have experience working with people with intellectual disability and challenging behaviour needs. This CNM2 will be the Person in Charge when appointed to the centre. This CNM2 is commencing in the centre 02/06/2015.

The recruitment process for 2 posts at clinical nurse manager 3 grades is complete. The first of these posts are in place since the 18/05/15, and is the deputy for this centre should the person in charge be on leave for 28 days or more.

The newly recruited Clinical nurse manager 3s will provide clinical leadership and support to the person in charge and staff in the centre. There will be a formal supervision, and mentoring system, between a named CNM3 and the person in charge.

Proposed Timescale: 30/06/2015

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

Where the person in charge had been absent for a period of 28 days or more, the Authority had not been notified as required either of the absence of the person in charge or the arrangements for the management of the designated centre during that absence.

Action Required:

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

The nominee provider has changed since this non notification. All incidents where the person in charge is absent for 28 days or more will be notified in the future.

Proposed Timescale: 12/05/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

Sufficient resources were not provided to fully meet all of the residents needs in the centre in line with the statement of purpose.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

The nominee provider, person in charge and director of human resources are reviewing staffing resources to the centre on 20/05/2015 to ensure needs of service users are being met. The recruitment process is in progress for staff for the centre to displace any external agency staff currently in the centre.

The service user review group will further identify where a more suitable accommodation would best meet the needs of service users, to include access to appropriate day service. Where current accommodation is identified as being unsuitable, service users will be referred to the Admissions, Discharge and Transfer committee.

Multidisciplinary team support will be assigned, or contracted in to support the service users needs in the centre.

Proposed Timescale: 30/07/2015

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 received mandatory training in the protection of vulnerable adults, the management of behaviour that challenges or fire safety.

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 within the centre will have the mandatory training in relation to the protection of vulnerable adults, behaviours that challenge, and fire safety training. No staff will be placed in the centre without this training.

Not all staff in the centre have a formal recognised qualification relevant to their roles

as care assistants. The service have funding sourced to address this and all staff will receive this training at FETAC level 5 over the next year.

Proposed Timescale: 30/07/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Not all of the policies required under Schedule 5 of the Regulations were in place. There was no policy in place in relation to 'access to education, training and development' for residents. Also, while the risk management policy had been recently amended to fully address all of the areas outlined in the Regulations; the new policy had yet to be implemented. The complaints policy required amendment to outline how anonymous complaints are addressed in a satisfactory way.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The policy in relation to access to education and training is now in place since the inspection in the centre.

The risk management policy is now available in the centre since the inspection.

The quality and risk officers in the service are reviewing the process for addressing anonymous complaints. This will be included in a policy and staff training will delivered on same.

Proposed Timescale: 30/10/2015

Theme: Use of Information

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

Improvement was required to records in respect of each resident to ensure accuracy and ease of retrieval.

Action Required:

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

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

The person in charge and house managers in the centre will review all service users' files. All information for each service user will be stored in the one file, in the area of the care plan relevant to the particular item of information. Information for archiving will be removed from the file and stored in an orderly manner which will allow ease of retrieval.

Proposed Timescale: 30/07/2015

Theme: Use of Information

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

Residents' records demonstrated that the practice for the transcription of a prescription order was not in line with An Bord Altranais agus Cnáimhseachais na hÉireann guidance, nor were audits of transcription practice taking place.

Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

The medication management documentation with regards to transcribing will be reviewed by the nominee provider, medication management co coordinator, the director of nursing and a pharmacist to bring the practice in line with An Bord Altranais agus Cnaimhseachais na hEireann. Changes made will be brought to the Drugs and Therapeutics committee for approval and sign off.

Proposed Timescale: 30/07/2015