

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003948
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd.
<b>Provider Nominee:</b>	Breda Noonan
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	12
<b>Number of vacancies on the date of inspection:</b>	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 un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 14 October 2015 09:00 To: 14 October 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was the third inspection of this designated centre. This inspection was in response to notices of proposal to refuse and cancel registration of the centre that were issued by the Health Information and Quality Authority ('the Authority') to the Daughters of Charity in response to an application by the provider to register the centre. This inspection followed up on non-compliances from the previous inspection and also considered a representation submitted by the provider in relation to the notices of proposal to refuse and cancel registration of the centre. This inspection was announced two days prior to the inspection date, in order to ensure that the new person in charge of the centre was present for the inspection.

Group E as a designated centre comprises two community houses and can accommodate 12 residents. One house is a two-storey dwelling and the second, a single-storey dwelling. Each house can accommodate six residents. Residents care needs included support in relation to behaviour that may challenge.

There was evidence of improvement since the previous inspection. For example, advocacy arrangements and the management of complaints had been reviewed and the new arrangements now met the requirements of the Regulations. In addition, the provider nominee had completed an unannounced visit and audit of the centre and other audits had also been completed. Staff told inspectors that increased staffing levels at specific times of the day and the reduced use of agency staff in the centre had led to positive outcomes for residents. These included being better able to support residents who may have behaviours that challenge and supporting residents' to enjoy individual activities.

A new person in charge had recently commenced in the centre. The person in charge was suitably qualified and experienced to meet the requirements of the role of person in charge. Since the previous inspection, the area of responsibility of the person in charge had been reduced to this centre only. Inspectors found that this new arrangement would better support the person in charge to address the non-compliances in the centre. Due to the short time-frame that the person in charge was in the role in this centre, it was not possible for inspectors to determine the effectiveness of the person in charge in addressing non-compliances.

On the day of inspection residents appeared happy. Staff demonstrated that they knew the residents and their needs well. Staff were observed to support residents to use verbal and non-verbal communication to express their choices, feelings and wishes.

However, three outcomes were found to be at the level of major non-compliance:

Under Outcome 5, it was found that the designated centre did not meet the assessed needs of all residents. There was 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. The timeframe to resolve this issue had not yet passed. While the provider nominee and Assistant CEO demonstrated that steps were being taken to address this failing, a funded time-bound plan had yet to be submitted to the Authority. This failing will remain at the level of major non-compliance until it is satisfactorily addressed.

Outcome 7 health safety and risk management was increased to the level of major non-compliance at this inspection in relation to fire safety. It was not demonstrated through fire drills that all residents could be safely evacuated in the event of a fire in timely manner. In addition, risk assessments were inadequate.

Outcome 17 workforces, was increased to the level of major non-compliance at this inspection as it was not demonstrated that the action plan submitted following the previous inspection had been satisfactorily implemented. At the previous inspection and on this inspection, it was found that not all staff had received training in relation to the protection of vulnerable adults, behaviours that challenge or fire safety as

relief and agency staff had not received training. As residents living in this centre may have significant behaviours that challenge, inspectors found that this failing was at the level of major non-compliance.

The Authority did not agree this action plan in full with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to Regulations 5(3), 9(3) and 28 (3) (a) under Outcomes 1, 5 and 7 were not accepted as they did not satisfactorily address the failings identified.

Other improvements were required in relation to healthcare planning, restraint and the premises, which 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):**

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

**Findings:**

At the previous inspection, it was not clear how the advocacy committee was representative of all residents. The person in charge outlined to inspectors that, since the previous inspection, a resident representative had been identified and support would be given to facilitate participation in the advocacy committee.

At the previous inspection, it was identified that, where a bedroom was shared, it did not meet the needs of those residents. The timeline proposed by the provider in relation to this had not yet passed at the time of the inspection and the residents continued to share a bedroom that did not meet their needs. In addition, inspectors observed that some bathroom facilities did not have the option of being locked.

At the previous inspection, it was noted that the complaints log did not record whether the complainant was satisfied with the outcome of the complaint. The complaint log made available during this inspection demonstrated that the log had been reviewed to capture the satisfaction of the complainant.

It was identified during this inspection that a 'click lock' device that could not be operated by residents was fitted on some residents' wardrobes restricting access to their personal possessions. The use of this restrictive practice is further discussed in Outcome 8: Safeguarding and Safety and Outcome 9: Notification of Incidents.

There was a disparity in relation to weekend activity levels in the two service units. In one service unit, residents enjoyed a range of activities outside the house at the

weekends that were based on the individual needs of the residents including shopping, sports, meals out, walks in the local area and visits home. In the second service unit, weekend activities were limited and activity planners were not maintained. The house manager outlined that activities outside the service unit for all residents had not been facilitated at the previous weekend as some residents could not participate.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

At the previous inspection, it was identified that not all contracts had been signed by the resident or their representative where appropriate. Inspectors noted that, based on a sample reviewed, all contracts were signed by the resident or their representative.

At the previous inspection, it was identified that the contract of care did not provide for the assessed needs of all residents. The timeline proposed in the provider's action plan in relation to this had not yet. Inspectors noted that the inappropriate placement of a resident identified at the previous inspection was still continuing.

**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:**

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

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

**Findings:**

At the previous inspection, it was found that while each resident had a personal plan, some had not been reviewed within the previous 12 months or more frequently if necessary, as required by the Regulations. The persons responsible for pursuing actions were not always sufficiently specified. The range of multi-disciplinary input into the review process was limited. Recommendations arising from reviews had not been implemented.

At this inspection, inspectors found improvement in relation to residents' personal plans. Inspectors reviewed a sample of plans and found that goals were clearly outlined, actions had been delegated to named persons, the progress in meeting those goals were being tracked on a monthly basis and supports required to meet such goals were specified. Some further improvements were identified in that required supports were not clearly tracked to ensure they would be made available (e.g. increased staffing hours to facilitate a resident to reduce their day service hours). It was demonstrated that recommendations arising from reviews were now being implemented. The review of the personal plan was not multi-disciplinary and this action was outstanding.

At the previous inspection, it was found that the designated centre was not suitable for the purposes of meeting the assessed needs of each resident. This failing was found to be at the level of major non-compliance. Five residents were 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 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 timeframe to resolve this issue had not yet passed and was the 31 January 2016. At the close of inspection, the provider nominee and Assistant CEO outlined steps that the organisation had taken and was taking in order to ensure that each resident had a suitable placement that met their needs, wishes, preferences and abilities. A funded time-bound plan had yet to be submitted to the Authority. This failing will remain at the level of major non-compliance until it is satisfactorily addressed.

**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):**

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

**Findings:**

At the previous inspection, it was noted that there was evidence of wear and tear in places and parts of the premises required further cleaning. Inspectors noted that the centre was visibly clean throughout. However, the proposed timescale for the actions outlined by the provider had passed and there was evidence of wear and tear in the a number of areas in one service unit. The following were observed in this service unit:

- extensive damage to the flooring in all areas
- scuffed and damaged skirting board in two rooms
- stained and scuffed paintwork in communal areas and bedrooms
- items of furniture were in disrepair, torn or damaged.

The person in charge and the house manager for this service unit outlined that a costed plan had been submitted in relation to replacement flooring and an item of furniture would be replaced following an occupational therapy assessment. Notwithstanding this, ongoing maintenance was inadequate overall in this service unit. The communal areas of this service unit were observed to be bare and lacked a homely feel while bedrooms were personalised with soft furnishings and personal effects.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

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

**Findings:**

There were three actions identified at the previous inspection. None of those actions had been fully implemented. An immediate risk was identified in relation to fire safety and is discussed below. In addition, it was not demonstrated that risk assessments had been developed with the input from an appropriately competent person(s) where required.

At the previous inspection it was found that personal emergency evacuation plans were available for each resident and were on display at each fire exit door. 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. Also, it was found that the risk management system was not robust and a risk assessment was not available for all identifiable hazards.

At this inspection, the failings had not been satisfactorily addressed. The risk management system again required improvement. Knowledge and understanding of risk assessment was not demonstrated. Where a resident had mobility needs, a manual handling risk assessment had not been completed. Where residents were at risk of ingesting items, risk assessments had not been completed.

An inspector reviewed a fire risk assessment for a resident who repeatedly refused to exit the building during practice fire evacuation drills in one house. There were two risk assessments available - the earlier risk assessment (dated 27.10.2014) outlined specific controls to mitigate what had been identified as a high risk. These included an assessment by a fire consultant, a health and safety meeting and the assessment of any aids within a month (such as an evacuation sheet or an approved physical move). While staff said that the health and safety meeting had been held, the other controls had not been implemented. A later risk assessment (dated 13.10.2015) rated the risk as low although the previous controls had not been fully implemented. As a result, knowledge and understanding of risk assessment was not demonstrated.

In addition, the evacuation plan had not been approved by a suitably qualified person, as was the failing on the previous inspection. Staff gave inspectors contradictory information in relation to their understanding of how to evacuate that same resident. Inspectors did note however positive practices that were being undertaken by staff in relation to supporting the same resident to develop their own awareness of fire safety.

In the second house, an inspector reviewed fire safety records. Residents in this house required assistance to evacuate in the event of a fire. Fire safety checks were being completed as required. Servicing of fire equipment was in date and due for annual review at the end of the month. The house manager confirmed that a date for this service was arranged. The fire alarm and emergency lighting were being checked on a quarterly basis. Fire drill records however did not indicate that that all relevant evacuation scenarios had been simulated. For example, a fire drill had not been carried out to simulate night-time conditions including night-time staffing levels. Also, there was one inner room off the laundry room and a scenario relating to a fire starting in this location had not been considered. For a resident who became distressed by the sound of a fire alarm and would not evacuate during such times that the fire alarm was sounding, possible alternatives had not been considered.

For a resident who smoked, a dedicated smoking area was identified outside, which is in line with good practice. A risk assessment was in place in relation to smoking.

At the previous inspection, it was found that agency staff had not received fire safety training. At this inspection, training records indicated that not all agency or relief staff who worked in the house had received this training. In addition, it was not confirmed whether doors in the centre were fire doors, as required to contain fire and prevent the movement of fire and smoke throughout the centre.

Due to the potentially time-consuming nature of any evacuation, coupled with additional failings outlined above, the provider nominee was required to take immediate action to address the identified failings and the provider nominee was served with an 'immediate action plan' at the close of the inspection. The immediate action plan also included the previously discussed failure to clarify the evacuation plan for a resident. The provider nominee responded by pledging to first, carry out a full fire drill the following morning and address any failings identified in that practice drill and second, ensures that the evacuation plan is reviewed by the organisation's competent persons in the area of health and safety and fire safety.

At the previous inspection, it was found that 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. Since the previous inspection, hand wash dispenser and hand towel dispenser were installed in the downstairs bathroom. Inspectors observed that separate facilities had not been installed in the annex to one house.

**Judgment:**  
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**  
Safe Services

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

**Findings:**  
At the previous inspection, it was found that not all staff had received training in relation to the protection of vulnerable adults and behaviours that challenge as relief and agency staff had not received training. The provider's action plan submitted following the

previous inspection said that all staff within the centre will receive this training and that no staff will be placed in the centre without this training. At this inspection, it was not demonstrated that this action had been fully completed as training records for relief and agency staff were not available for review in the centre. As residents living in this centre may have significant behaviours that challenge, inspectors found that this failing was at the level of major non-compliance. The action for this failing is included in Outcome 17, Workforce.

At the previous inspection, it was found that where possible causes of residents' behaviour had been identified, they had not always been alleviated; all alternative measures had not been considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was not always used. At this inspection, as previously mentioned under Outcome 1, residents' personal possessions had been restricted. While there was a clear rationale for this, the practice had not been identified as a restriction and alternatives had not been explored. A resident lived in a restrictive environment without any rationale in place for such restrictions on him/her as an individual (the restrictions were in place for the safety of other residents).

Inspectors spoke with staff who demonstrated a positive approach to behaviour that may challenge. Inspectors reviewed a number of behaviour support plans for residents. Behaviour support plans were variable in quality. A number of behaviour support plans were found to be overall very comprehensive and reflected a positive approach to behaviour that challenges. Alternative strategies were outlined in the behaviour support plan, e.g. early redirection, one to one time with staff, relaxing in the bath or watching a film. Others required improvement as they did not provide adequate guidance for staff and they had not been updated to reflect ineffective strategies or changes to approved therapeutic interventions. For example, one behaviour support plan dated 29.6.2015 documented a physical restraint technique (a 'figure of four' technique) that the house manager said was no longer approved for use. Such contradictory information in relation to the use of physical restraint carries with it the risk of staff being unsure as to what techniques are and are not approved. None of the behaviour support plans reviewed provided guidance for staff in relation to the use of PRN ("as required") medication or chemical restraint that was approved for use. Where two agents were prescribed, there was insufficient guidance for staff in relation to the appropriate administration of the agents. In addition, inspectors identified occasions where the positive behaviour support plans were not implemented. For example, staff outlined to inspectors the behaviour support plan for a resident which detailed that physical pain was to be ruled out and pain relief was to be administered prior to administering the chemical restraint prescribed. However, this protocol had not been followed and chemical restraint had been administered without ruling out physical pain during a recent incident in October 2015.

Following incidents of challenging behaviour, the required documentation was completed, including incident report forms and charts that documented antecedents, behaviours and consequences (known as 'ABC' charts).

**Judgment:**  
Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

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

**Findings:**

At the previous inspection it was found that an incident that should have been notified to the Authority had not been notified as required. Since the previous inspection, all incidents had been notified as required. The provider nominee told inspectors that a review of all restrictive practices in the centre was scheduled by the end of the month and that any approved practices arising from that review would be included in the quarterly report submitted to the Authority. This action has yet to be fully completed.

**Judgment:**

Substantially Compliant

**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):**

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

**Findings:**

At the previous inspection, it was identified that 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.

Since the previous inspection, while a new policy in relation to access to education, training and development had been developed, it did not address all of the relevant Regulations. While steps had been taken at organisational level in relation to carrying out a formal assessment of each resident's educational, employment and training goals, this action was not yet fully implemented.

At the previous inspection, it was identified that 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 at the time of the previous inspection being provided only 1-day a week. This recommendation had been identified in September 2014. 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. This was discussed with the (then) person in charge at a meeting in the HIQA head office following the previous inspection and reassurances had been given that the matter would be resolved. At this inspection, it was found that the situation was overall unchanged. The same resident was still attending that day service only 1-day a week. When asked by inspectors, the provider nominee said that there were questions in relation to what was the most suitable day service to be provided. Overall, it was not demonstrated that satisfactory progress had been made to find a suitable day service for all residents that met their individual capabilities, wishes and needs.

**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:**

Aspects of this outcome were assessed on this inspection as inspectors noted areas that required improvement. Healthcare plans were not always developed based on assessed needs.

Work had been completed in relation to healthcare plans. While some healthcare plans, for example in relation to healthy eating and exercise directed the care to be given to residents in order to support the best possible health, others required improvement. For example, a healthcare plan had not been completed for a resident who had been queried with a diagnosis of dementia, nor had one been completed following a dementia assessment. Where a resident had been assessed as having mobility needs, a healthcare plan had not been developed.

Overall, it was evidenced that residents had access to allied health. One exception was noted in relation to an outstanding occupational therapy (OT) assessment. For a resident who smoked, the general practitioner (GP) had made recommendations in

relation to how to support him/her to achieve the best possible health. Staff clearly articulated the challenges being faced and the efforts they had made to support a resident to reduce smoking. Options were being explored, although with mixed success to date. The importance of breaking the association between cigarettes and a positive reward system was emphasised by the GP at the multidisciplinary team meeting for the same resident. However, a referral to an OT sent on 15.05.2014 for a sensory integration assessment to support the resident to seek alternatives to cigarettes had not proceeded (1 year and 5 months later). In addition, while the healthcare assessment had identified the need for the OT assessment, a corresponding healthcare plan had not been developed that included that assessment and would have allowed for the referral to have been tracked. A number of steps to support smoking cessation were outlined in a respiratory healthcare plan, however, it was not clearly demonstrated how the effectiveness or otherwise of these interventions were being monitored and reviewed through the healthcare plan.

Inspectors noted an occasion where there was a delay in relation to the implementation of the recommendations of the multi-disciplinary team. An occupation therapy review completed on 06 July 2015 seen by inspectors recommended the replacement of a damaged wheelchair 'immediately'. The house manager confirmed that, despite a quotation being sought on the date of the review, the wheelchair had not yet been ordered on the day of inspection, over three months from the initial recommendation.

Healthcare records reviewed by inspectors indicated that clear processes may not always be in place to guide non-nursing staff in relation to the timely and appropriate reporting of epileptic seizures to medical professionals.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

At the previous inspection, it was outlined that the statement of purpose did not meet the requirements set out by Schedule 1 of the Regulations. The proposed timescale outlined in the provider's action plan had passed and the actions had not been satisfactorily implemented. The statement of purpose made available to inspectors on

the day of the inspection contained information relating to residents in another centre. The statement of purpose did not adequately outline the specific care needs and facilities provided by the centre to meet these needs. The arrangements for residents to access employment, training and development were not clearly set out. The admissions criteria for this centre were not clearly specified.

**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):**

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

**Findings:**

At the previous inspection, it was found that 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.

Since the previous inspection, the deputising arrangements in place in the event of the absence of the person in charge for 28 days or more had been clarified with a clinical nurse manager (CNM3) deputising in the event of any such absence.

Since the previous inspection, the systems for accountability had been strengthened. There was a new person in charge of the centre. The person in charge is a qualified nurse in intellectual disability nursing with experience in supporting residents who may display behaviours that challenge. The person in charge previously worked as a house manager (at CNM1 level) in a high-support house within the St. Anne's service. The person in charge had received an induction into his new role and was currently familiarising himself with each resident and their individual needs and capabilities. The person in charge had completed two days training since commencing in the role of person in charge including in relation to leadership and care planning. The person in charge told inspectors that he had only been working in the centre as person in charge for six days. Since the previous inspection, the area of responsibility of the person in charge had been reduced to one centre comprising two houses. Inspectors found that this new arrangement would better support the person in charge to address the non-

compliances in the centre. Due to the short time-frame that the person in charge was in the role in this centre, it was not possible for inspectors to determine the effectiveness of the person in charge in addressing non-compliances.

Each house had a house manager, who was identified as a person participating in the management of the centre. At the previous inspection, it was found that while one house manager knew residents living in that house well, another house manager had only recently commenced in the centre. At this inspection, it was found that this house manager was now familiar with each individual resident's abilities, needs and preferences. The house manager demonstrated that she understood how to support residents who may present with behaviours that may challenge in a positive way.

The provider's representation outlined other improvements to the governance and management of the centre and these proposals were also assessed as part of this inspection. The provider outlined that there were two new CNM3's allocated to the centre. Inspectors found that this was the allocation to the service and the provider nominee was asked to submit details in relation to the specific supports allocated to the centre, both in terms of time and the nature of such supports.

The provider's representation also outlined a new auditing system that included care planning, infection control, medication management, residents' finances and provider audits. The provider nominee and A/CEO clarified that this new auditing system was not yet in place and outlined that it related to a new quality improvement system that included auditing and would be underpinned by training for all managers.

The provider nominee had completed a review of the centre and had identified a number of issues also identified on this inspection.

The annual review required improvement to ensure that it effectively reviewed the quality and safety of care in the centre.

**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):**

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

**Findings:**

At the previous inspection, it was found that 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. Since the previous inspection, there had not been any absences of the person in charge for a period of 28 days or more. The provider nominee was aware of the responsibility to notify the Authority of any such absences in the future and the arrangements that would be put in place during those periods.

**Judgment:**  
Compliant

**Outcome 17: Workforce**

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

**Theme:**  
Responsive Workforce

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

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

**Findings:**

Due to the use of agency and relief staff, continuity of care was previously identified as an issue in the centre. The provider nominee outlined progress being made in this area, including an on-going recruitment process. In the interim, staff outlined positive steps that had been taken in that house, including the addition of an extra staff member in the morning. Staff described how this had made a significant difference to supporting residents who may have behaviour that challenges. In the second house, staff described how new staff had already commenced and that had made a positive difference to ensuring continuity of care to residents.

At the previous inspection, it was identified that not all staff had received mandatory training in the protection of vulnerable adults, management of behaviour that challenges or fire safety. Since the previous inspection, the provider outlined in a representation to the Authority that training had been provided to all staff in relation to healthcare planning, risk assessment, safeguarding, advocacy, fire safety, hand hygiene and the management of behaviour that challenges. The timeframe for completion of this action from the previous inspection had passed. As previously mentioned, not all agency and relief staff working in the centre had received mandatory training, specifically in relation to the protection of vulnerable adults, the management of behaviour that challenges or fire safety.

The provider outlined in a representation to the Authority that staff had enrolled in a FETAC Level 5 healthcare assistance programme. Staff demonstrated that they knew residents well, their likes and dislikes, what each individual resident enjoyed doing and ways in which they support residents to manage their own behaviours. A number of gaps identified in this report (including in relation to healthcare planning, risk assessment, fire safety and the recognition of what constitutes a restriction), indicated that a system of on-going support was required to the staff team to facilitate them to deliver quality safe care to residents, as staff clearly demonstrated that they endeavoured to do. This was relayed to the provider nominee following the inspection.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

At the previous inspection, it was noted that not all policies under Schedule 5 were in place. The timeframe proposed in the provider's action plan had not yet passed. The policy in relation to the access to training, education and development noted to be in place. The amended risk management policy was implemented. However, the safeguarding policy did not adequately address the management of anonymous concerns. The policy in relation to the access to training, education and development did not include the arrangements in place for a robust assessment of residents' educational, training and employment goals. The measures to support residents to access opportunities for education training and employment or to ensure that continuity of education, training and employment are maintained when residents transfer between services were not outlined.

At the previous inspection, it was identified that improvement was required to records in respect of each resident to ensure accuracy and ease of retrieval. Inspectors noted that

improvements had been made and records were organised and easily retrievable.

At the previous inspection, it was observed that the practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais. Based on a sample of medication records reviewed, inspectors noted that the practice of transcription was in line with the relevant guidance and adequate controls were in place to mitigate risk.

**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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
<b>Centre ID:</b>	OSV-0003948
<b>Date of Inspection:</b>	14 October 2015
<b>Date of response:</b>	13 November 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:**

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

Some bathroom facilities did not have the option of being locked.

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

**1. 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:**

All bathrooms in the centre will have a lock fitted to afford service users the right to privacy and dignity whilst in the bathroom. These locks will be fitted by the 16/11/2015.

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report in relation to the shared bedroom. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**Theme:** Individualised Supports and Care

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

A 'click lock' device that could not be operated by residents was fitted on some residents' wardrobes restricting access to their personal possessions.

**2. 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:**

The click lock device will be removed from the wardrobes and a standard lock fitted allowing service user access to the key and thus to their wardrobes

**Proposed Timescale:** 23/11/2015

**Theme:** Individualised Supports and Care

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

In one service unit, weekend activities were limited and activity planners were not maintained.

**3. Action Required:**

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

There is a newly appointed Person in Charge in the Centre since 21/09/2015. The Person in Charge is focussing on activities and recording and auditing of same within the designated centre. The Person In Charge has discussed with the house manager and staff team the importance of meaningful activities for all residents in the centre and will address same further at the next scheduled team meeting.

**Proposed Timescale:** 30/11/2015

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

**4. 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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**Theme:** Effective Services

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

The review of the personal plan was not multi-disciplinary.

**5. 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 recruitment process is in progress for occupational therapist and social workers, both are at the garda vetting stages of recruitment. The recruitment process for psychology is ongoing. In the interim Psychology support from another part of the organisation will be deployed to support service user needs in this centre. This input will involve input in personal plans and behaviour support plans. Occupational Therapist commencing 16/11/2015

**Proposed Timescale:** 18/12/2015

**Theme:** Effective Services

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

Some further improvements were identified in that required supports were not clearly tracked to ensure they would be made available (e.g. increased staffing hours to facilitate a resident to reduce their day service hours).

**6. 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:**

One resident in the centre is supported by staff from the centre to have alternate day activation programme two evenings a week. The Clinical Nurse Manager 3 and the Person in Charge will review with the service user, her wishes around attending day service for full days. A review of the roster will be examined to support this service user's wishes.

The goals of all service users in the centre will be reviewed by the Person in Charge and the key worker. The supports required by each service users will be outlined for each goal, and where additional supports are required the nominee provider will ensure that these are put in place. Each goal will be tracked and its progress noted on the monthly periodic review template. Where goals are not progressing the person in Charge and the key worker will review the goal with the support of the appropriate multidisciplinary team members to ensure that the goal is achieved in a timely manner.

**Proposed Timescale:** 30/11/2015

**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 was inadequate maintenance overall in one premises.

**7. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The Person in Charge will meet with the maintenance supervisor around essential

maintenance repairs needed in the centre. All essential maintenance will be completed. The Person in Charge will ensure that the house manager and keyworkers support service users to make the centre more personalised and homely by purchasing pictures, picture frames etc.

**Proposed Timescale: 18/12/2015**

**Theme: Effective Services**

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

The communal areas of a service unit were observed to lack a homely feel.

**8. 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 Person in Charge will ensure that the house manager and keyworkers support service users to make the centre more personalised and homely by purchasing pictures, picture frames etc.

The service users will be involved in the outing for the shopping and purchasing of items for their home.

**Proposed Timescale: 18/12/2015**

**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 again required improvement:

It was not demonstrated that risk assessments had been developed with the input from an appropriately competent person(s) where required.

Knowledge and understanding of risk assessment was not demonstrated. For example, a risk that had been correctly identified as high risk had been subsequently reduced to a low risk, despite the required controls not being implemented. Where a resident had mobility needs, a manual handling risk assessment had not been completed. Where residents were at risk of ingesting items, risk assessments had not been completed.

**9. Action Required:**

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

for responding to emergencies.

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

The Director of Logistics/Fire Engineer has reviewed the centre with specific emphasis on fire and safe evacuation of service users. The Director of Logistics is working with the Person in Charge and the Maintenance Manager on implementing recommendations made.

The Person in Charge will link with the manual handling instructor to develop a manual handling risk assessment for an individual with mobility support needs.

The staff team in the centre will receive further training on identifying risks and completing risk assessments on the 4/11/2015 from the Quality and Risk Officer.

**Proposed Timescale: 30/11/2015**

**Theme:** Effective Services

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

The evacuation plan for a resident was not clear. Staff gave contradictory information in relation to their understanding of how to evacuate that same resident.

Fire drill records did not indicate that that all relevant evacuation scenarios had been simulated. For example, a fire drill had not been carried out to simulate night-time conditions including night-time staffing levels. Also, there was an inner room off the laundry room and a scenario relating to a fire starting in this location had not been considered.

**10. Action Required:**

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

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

Post inspection a fire drill simulating night time conditions and night time staffing was carried out.

The Director of Logistics has reviewed both service units in the centre with regard to fire and fire safety. Recommendations have been made with regard to the two inner rooms and fire safety.

The plan involves forming a protected corridor (lobby) access to the bedroom thus providing safe egress via two fire separated exit routes. The corridor (lobby) will be formed by installing 30 min Fire Resisting Door set and associated wall & ceiling construction on the utility corridor and removing all fire load from same. This will be completed by 04/12/2015.

In the interim and with immediate effect we will cease using the laundry facility at night until the action is complete.

The personal emergency evacuation plans for service users in the centre are being reviewed by the Person in Charge, staff team and Director of Logistics/Fire Engineer. These will be completed on the 23/11/2015.

**Proposed Timescale:** 04/12/2015

**Theme:** Effective Services

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

For a resident who became distressed by the sound of a fire alarm and would not evacuate during such times that the fire alarm was sounding, possible alternatives had not been considered.

**11. 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:**

The Director of Logistics/Fire Engineer has contacted LIR Fire Consultancy for advice and recommendations regarding the fire alarm and its sounding. Recommendations made re an alternative sounding system will be implemented.

**Proposed Timescale:** 11/12/2015

**Theme:** Effective Services

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

At the previous inspection, it was found that agency staff had not received fire safety training. At this inspection, training records indicated that not all agency or relief staff who worked in the house had received this training.

**12. Action Required:**

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

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

All agency staff received fire safety training post inspection. Agency staff training records were forwarded to the inspectors post inspection on the 16/10/2015. All agency staff training records since inspection are now available in the centre.

**Proposed Timescale: 16/10/2015**

**Theme: Effective Services**

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

It was not confirmed whether all doors in the centre were fire doors, as required to contain fire and prevent the movement of fire and smoke throughout the centre

**13. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

"The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue".

**Proposed Timescale:**

## **Outcome 08: Safeguarding and Safety**

**Theme: Safe Services**

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

Therapeutic interventions were not reviewed as changes arose. One behaviour support plan dated 29.6.2015 documented a physical restraint technique (a 'figure of four' technique) that the house manager said was no longer approved for use.

There were occasions when the positive behaviour support plans were not implemented. Protocols in relation to the use of chemical restraint were not always followed.

**14. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

All restrictive practices within the centre are in the process of being reviewed, any restrictive practice that is ceased will be reviewed by a full team including multidisciplinary and be discontinued from use.

The Person in Charge and the Clinical Nurse Manager 3 will meet with the house managers and staff teams in the centre regarding the prescribed rationale in place for the use of any chemical restraint. The house manager, keyworker and Person in Charge will include a protocol in each service users care plan around the use of chemical restraint, all protocols will be reviewed by the prescriber to ensure they are in

line with the prescriber's indications for use.

**Proposed Timescale:** 30/11/2015

**Theme:** Safe Services

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

Behaviour support plans were inconsistent in their quality; while some provided clear guidance for staff, others did not.

**15. Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

The input of a psychologist from another part of the organisation is being deployed to the centre to support staff in the review of service user's behaviour support plans ensuring that all plans support staff to respond to a service users behaviour in an appropriate and consistent manner.

**Proposed Timescale:** 22/12/2015

## **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:**

The provider nominee told inspectors that a review of all restrictive practices in the centre was scheduled by the end of the month and that any approved practices arising from that review would be included in the quarterly report submitted to the Authority. This action has yet to be completed.

**16. Action Required:**

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

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

The review of restrictive practices has commenced by the Person in Charge and staff team. A full multidisciplinary team review of restrictive practices is scheduled for the centre for 19/11/2015. The Person in Charge has submitted the quarterly report to the Authority on the 30/10/2015 including all current restrictive practices in place in the centre.

Proposed Timescale: 19/11/2015

### 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:**

Not all residents were availing of a suitable day service.

The policy in relation to access to education, training and development had been developed, however, it did not address all of the relevant Regulations.

A formal assessment of each resident's education, employment and training goals were not on file for residents.

#### **17. 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 day service requirements of one service user were addressed at a meeting between day services and the centre staff on 15/10/2015. The staff team, Nominee Provider, day service team and HSE are meeting regarding this service users day placement on the 05/11/2015 and recommendations will be made and a plan put in place with responsible people for completing same.

The Nominee Provider has referred the revised policy in relation to access to education, training and development to the Quality and Risk Officer for review as a finding of the inspection is that it is still not meeting the requirements under the regulations.

A formal assessment tool for assessing each resident's education, training and employment goals is being piloted at present. The Person in Charge and manager in day service with key workers will pilot this assessment tool for individuals from the centre.

Proposed Timescale: 30/11/2015

### Outcome 11. Healthcare Needs

Theme: Health and Development

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

Healthcare plans were not always developed based on assessed needs.

Clear processes may not always be in place to guide non-nursing staff in relation to the

timely and appropriate reporting of epileptic seizures to medical professionals.

**18. Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

The Person in Charge will audit care plans in the centre and make recommendations and outline actions and responsible people for completing same. The Clinical Nurse Manager 3 will deliver training to all staff in the centre on care planning to include healthcare assessments and development of plans of care around the identified assessed needs.

All recommendations made by multidisciplinary teams will form part of all care plans. The Person in Charge and the Clinical Nurse Manager 3 will audit and ensure ongoing review of all care plans.

The Person in Charge will complete where appropriate a protocol for all staff in the centre to ensure timely and appropriate reporting of epileptic seizure to medical professionals.

**Proposed Timescale:** 04/12/2015

**Theme:** Health and Development

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

A referral for sensory integration to the occupational therapist sent on 15.05.2014 had not taken place.

There were delays in relation to the implementation of the recommendations of the multi-disciplinary team.

**19. Action Required:**

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

The Person in Charge has contacted the Occupational Therapist to progress the referral made for sensory integration on the 15/05/2014, the sensory integration assessment process commenced on 03/11/2015.

All multidisciplinary recommendations for each service user will be reviewed by the house manager and key worker. The house manager will update the Person in Charge on progress in relation to the implementation of these recommendations. Where recommendations have not been implemented, the Person In Charge and Clinical Nurse Manager 3 will identify responsible people for ensuring these recommendations are

actioned.

**Proposed Timescale:** 04/12/2015

**Theme:** Health and Development

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

It was not clearly demonstrated how the effectiveness or otherwise of healthcare interventions were being monitored and reviewed through the healthcare plan.

**20. Action Required:**

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

The Person in Charge and Clinical Nurse Manager 3 will audit service user healthcare plans, findings will be shared with house manager and staff team. Where action is required there will be named responsible staff to complete same.

The Clinical Nurse Manager 3 will deliver training to all staff in the centre on care planning to include healthcare assessments and development of plans of care around the identified assessed needs.

**Proposed Timescale:** 11/12/2015

### **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.

**21. 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 revised statement of purpose was submitted to the Authority post this inspection on 22/10/2015.

**Proposed Timescale: 20/10/2015**

### **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:**

Further clarity was required in relation to the management systems in place:

The provider nominee was asked to submit details in relation to the specific CNM3 supports allocated to the centre, both in terms of time and the nature of such supports.

A new quality improvement system that included auditing and would be underpinned by training for all managers was to be implemented.

The annual review required improvement to ensure that it effectively reviewed the quality and safety of care in the centre.

#### **22. Action Required:**

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

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

The Provider Nominee has submitted details in relation to the specific Clinical Nurse Manager 3 supports allocated to the centre on 02/11/2015.

A quality improvement system and training will be facilitated by the National Quality and Improvement Division of the HSE. The Nominee Provider is corresponding with this department week commencing 02/11/2015 to confirm dates and training for management in the centre. There will be a number of training dates scheduled. The first date is 05/11/2015 and there will be further dates.

The annual review has been revised by the Quality and Risk Officer, the Assistant Chief Executive Officer, the Director of Nursing and the Nominee Provider.

**Proposed Timescale: 31/12/2015**

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

A number of gaps identified in this report (including in relation to healthcare planning, risk assessment, fire safety and the recognition of what constitutes a restriction), indicated that a system of on-going support was required to the staff team to facilitate them to deliver quality safe care to residents.

**23. Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

The Clinical Nurse Manager 3 linked to the centre will deliver training to all staff in the centre on healthcare planning and identification of what constitutes a restriction. Training will be complete by the 27/11/2015. The person in charge with the staff team will review the restrictive practices for the centre at the monthly staff meetings to ensure that all restrictions are identified and documented and multi disciplinary team approved. The Clinical Nurse Manager 3 will provide ongoing support to the Person in Charge and the staff team in the monitoring and recording of restrictive practices and be involved in the committee reviewing the use of restrictions in place, with focus on ensuring that they are in all cases the least restrictive measures possible.

All staff in the centre will receive training around hazard identification and completion of risk assessments on the 04/11/2015.

All staff in the centre will receive support around fire evacuation drills simulating night time scenarios.

**Proposed Timescale:** 27/11/2015

**Theme:** Responsive Workforce

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

Not all agency and relief staff working in the centre had received mandatory training, specifically in relation to the protection of vulnerable adults, the management of behaviour that challenges or fire safety.

**24. Action Required:**

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

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

The Person In Charge will link with the training co-ordinator to ensure that all agency staff working in the centre will be scheduled to receive mandatory training.

Training in the protection of vulnerable adults will be completed on 13/11/2015.

Training in challenging behaviour will be completed for all staff on 18/11/2015.

**Proposed Timescale:** 18/11/2015

## Outcome 18: Records and documentation

Theme: Use of Information

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

The policies in relation to safeguarding and access to training, education and development required review in line with the relevant legislation.

**25. Action Required:**

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

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

Protected Disclosures Interim Policy and Procedure DOCS 071 has been developed and circulated to the centre. This was submitted to the Authority after the inspection.

The Access to Training Education and Development Policy has been referred by the Nominee Provider to the Quality and Risk Officer following this inspection for revision.

**Proposed Timescale:** 31/12/2015