

**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 Health Service Executive
<b>Centre ID:</b>	OSV-0003730
<b>Centre county:</b>	Dublin 10
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Kevin Brady
<b>Lead inspector:</b>	Jim Kee
<b>Support inspector(s):</b>	Sheila McKeivitt; Conan O Hara
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	31
<b>Number of vacancies on the date of inspection:</b>	2

## 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:
17 November 2015 09:45	17 November 2015 18:45
18 November 2015 08:45	18 November 2015 17:30

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**

The inspection was announced and was carried over two days. This was the first inspection of this centre by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to inform a registration decision.

As part of the inspection, the inspectors met with the person in charge, staff members, residents and residents' family members. The general manager who was the provider nominee for the centre also met with the inspectors on the first day of the inspection. The inspectors observed staff interactions with residents and reviewed policies and procedures, residents' files, staff files and other records in the

centre.

Feedback obtained from residents and relatives during the inspection, and from questionnaires completed by residents and their family members were highly complementary of the staff who worked in the centre. Inspectors observed that staff on duty during the inspection were knowledgeable of the individual residents, and all interactions were respectful and kind.

The centre was operated by the HSE, and consisted of two separate units located in south Dublin. The centre was providing long term care and respite care to adults with disabilities with a range of dependency needs. The centre could accommodate a maximum of 33 residents with up to 6 respite placements.

A significant number of residents in the centre had high medical needs due to the nature of their conditions, and required continuing medical and nursing care. The residents had good access to the medical officer and long term residents had good access to a wide range of allied healthcare professionals based in the hospital including occupational therapy, physiotherapy, dietetics, speech and language therapy and also to specialist nurses with expertise in areas such as wound management, behaviours and infection control.

18 outcomes were examined as part of this inspection, with three outcomes deemed to be fully compliant with the regulations these included notification of incidents, communication and absence of the person in charge. Two outcomes were found to be substantially compliant and these included safeguarding and safety and use of resources. The inspectors found that the system in place to control access to the units at the time of the inspection was not sufficiently robust.

Questionnaires completed by residents and their family members prior to the inspection indicated that residents felt safe in the centre.

Major non-compliances were identified in the outcomes on residents' rights, dignity and consultation. Inspectors found that residents' rights to be consulted and participate in the organisation of the centre required significant improvement. The management of complaints in the centre was not fully compliant with the requirements of the regulations. Activities within the centre were very much led by routine and resources, and not the residents and their individual support needs and wishes.

The outcome on premises was also in major non-compliance with the regulations. Multi occupancy bedrooms in one of the units were not meeting the needs of the residents in terms of maintaining residents' privacy and dignity at all times, and ensuring residents had access to suitable private space.

Overall residents healthcare needs were being met to a high standard however, inspectors deemed Outcome 11 to be moderately non compliant as residents availing of respite in the centre did not have access to physiotherapy.

The outcome on family and personal relationships and links with the community was found to be moderately non-compliant as residents had very few links with the local community or supports in place to facilitate such links.

The outcome on admissions and contracts for the provision of services was moderately non-compliant as there were no signed contracts in place for some residents and there was no centre specific admissions policy in place with clear admission criteria for residents residing in the centre on a long term or respite basis .

The social care needs outcome was deemed to be moderately non-compliant as residents had limited access to assessment by an appropriate professional with qualifications and experience in assessing the social care needs of residents with disabilities. The assessment of residents' social care needs and the development of social personal plans required improvement.

The outcome on health and safety and risk management was deemed to be moderately non-compliant as the information available regarding fire drills in the centre was not sufficiently comprehensive and there were no personal evacuation plans in place for residents. The general welfare and development needs of the residents were not being met as there was no evidence that suitable day services or programmes providing access to training or activities had been sought for all of the residents.

Moderate non compliances identified in medication management related to the system of delivering medicines to the centre from the hospital pharmacy and to the documentation of prescribed indications for PRN (as required) medicines.

The outcome on governance and management was found to be moderately non-compliant overall. The annual review was not sufficiently comprehensive and the unannounced six monthly visits to the centre had not been conducted.

The outcome on workforce was moderately non-compliant because the skill mix of staff required review to ensure residents' social care needs were met. There was no system in place to facilitate the person in charge to obtain staff documentation as specified in schedule 2 of the regulations. Staff required further training specifically relating to the provision of care and support for adults with disabilities. The statement of purpose also required review to ensure it met the regulations and the outcome on records and documentation was found to be moderately non-compliant.

The action plan at the end of the report identifies all areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Residents and their family members were consulted about matters regarding their care in the centre, but there was limited involvement of residents in the organisation of the centre. The management of complaints in the centre also required improvement.

There was a complaints policy in place within the centre. The inspectors reviewed the complaints that had been documented on both units. There were a small number of complaints recorded in the units over the previous two years. The centre was not recording if the resident was satisfied with the outcome of their complaint. Staff spoken to by the inspectors acknowledged that not all verbal complaints were being recorded as complaints, and that complaints that could be resolved locally were not always documented.

The complaints process was on display in both units but it was on display in a location that was inaccessible to wheelchair users, and in small print, and in a manner that was not user friendly or easy to understand.

Information regarding the hospital campus advocacy group was on display in the centre, and one resident from each unit represented the centre at this campus wide forum organised and facilitated by the social work department. The inspector met with representatives of this advocacy group and members of the social work department during the inspection.

Monthly meetings were held on the campus during which residents and their representatives could raise concerns. Meetings with management were previously held on a three to four monthly basis but there had been no such meetings held in 2015 to date at the time of the inspection. The inspector was informed that issues raised by residents including transport, activity provision at weekends and facilitating more convenient access to the community by residents via a side gate were not being adequately addressed, or feedback provided regarding progress with the issues raised. The inspectors also reviewed minutes of the advocacy group meetings and topics discussed included complaints management, and the reluctance of residents to attend the group due to concerns regarding whistle blowers.

The residents' right to participate in the organisation of the designated centre by raising issues at these advocacy meetings was not being facilitated as issues were not being adequately addressed and residents were not being kept informed of progress or reasons as to why the issues were not being addressed.

There were no formal resident meetings held within the centre that allowed residents to be consulted with and participate in the organisation of the centre. Residents were consulted by the catering staff on a regular basis regarding food choices, and were also given the opportunity to participate in satisfaction surveys regarding food and catering that were conducted on a campus wide basis.

Residents were not allowed to access the kitchens within the units to make themselves tea or to access snacks, and had to rely on staff. This practice was related to risk and is included under Outcome 7. There was no information on residents' rights on display in the centre.

The electoral officer visited the centre to facilitate residents who wished to vote. A priest visited the centre every Saturday and residents could attend mass in another unit on the campus on Sundays if they wished to do so.

Records were maintained of residents' property within their individual files. There was a system in place to ensure residents' finances were appropriately managed, including individual logs of expenditure with receipts attached. There was a policy in place on residents' personal property, finances and possessions. There was a separate laundry area available for residents to launder their own clothes. Residents who could not launder their own clothes could avail of the central laundry service.

Inspectors observed that staff treated all residents with dignity and respect at all times throughout the inspection. There were no privacy locks in place on bedroom doors or on some of the bathroom doors to ensure residents' privacy and dignity were maintained at all times.

There was an activities programme in place in the campus with a dedicated activities team that provided activities to all residents on the campus including the designated centre for adults with disabilities and the designated centre for older persons. The activity programme ran from 8.30am to 5.30pm each day from Monday to Friday. The activities team had organised a shopping trip for the second day of the inspection, but places were limited and staff explained that the trip could only be offered to certain

residents and not all residents to avoid disappointment.

The activities programme included one to one activities such as hot towel shaves, hand massages, facials and group activities such as bingo, baking, painting, card games and use of the multi sensory room. A resident satisfaction audit had been completed on the recreational activity provision on the campus, and residents from the centre had participated in this audit.

The activities team was a limited resource, and this meant that residents had very little access to activities in the evenings and at weekends. Inspectors found that for some residents meaningful activities were not available that were linked to their individual preferences. The group activities available were not always of interest to the younger residents in the centre.

Activities within the centre were very much led by routine and resources, and not the residents and their individual support needs and wishes. Inspectors observed and were informed by residents that the main activity in the evening time for the majority of the residents was watching TV.

**Judgment:**  
Non Compliant - Major

## **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):**

This was the centre's first inspection by the Authority.

### **Findings:**

Communication assessments and care plans were completed for residents. Staff were observed to be knowledgeable of residents' individual communication abilities, and were able to communicate with some residents by observing very subtle facial gestures. Input from speech and language therapists was evident for some residents, and had resulted in the development of communication guidelines for these residents. Communication boards were being used by a few residents, and one resident had access to a light writer, while another resident used speech recognition software.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Families were kept well informed of residents' wellbeing. Residents had very few links with the local community.

There was a visitors policy in place within the campus, and this policy had not been adjusted to accommodate this centre for adults with disabilities. The visiting times outlined in the patient information booklet stated that visiting times were from 8am to 8pm. This issue was discussed with staff, residents and residents' family members and inspectors were informed that visitors were welcomed into the centre and that there were no restrictions placed on residents receiving visitors in the centre.

A new visitors room had recently been completed in one unit. This was a large homely room, easily accessible by wheelchair users that was private and contained adequate seating. There was no private visiting space available for residents and their visitors to use on the other unit.

Family members spoken to during the inspection, and on questionnaires completed prior to the inspection confirmed that family members were kept well informed of residents' wellbeing, and that families were involved in making decisions about residents' care. Families were given the opportunity to review residents' care plans, and care plans were signed by residents' family members/next of kin.

The majority of residents did not access the community on a regular or frequent basis. Two residents accessed a specialised day service on set days of the week, and one resident was enrolled at a local college for further education. A number of the residents accessed the community when they were on home visits and some residents could access the community independently.

However, community access was very limited for residents with higher dependencies, and one resident had only accessed the community once over a number of years. There was no evidence that efforts had been made to establish more community based links for the residents.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was no centre specific admissions policy in place. The centre had an admission policy for older persons and young adults with physical and sensory disability which was dated May 2010.

The centre had an operational procedure in place dated February 2015 which outlined the process of admissions but did not describe the criteria for admission. The centre provided respite care for a number of residents but there was no clear admission criteria in place for residents availing of respite care.

Inspectors reviewed a number of the written agreements of the terms on which residents were residing in the centre. The documents reviewed contained detailed information on the access available to allied healthcare professional services. These contracts of care were not consistently signed by the resident or their next of kin. The contracts did not specify the fees being charged or detail any additional charges the residents were liable to pay for utilities etc.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Comprehensive assessments of residents' health care and personal care needs were being conducted in the centre, and care plans were put in place for assessed needs. Residents had access to assessment by a wide range of allied health care professionals on the campus including physiotherapists, speech and language therapists, occupational therapists, and specialist nurses in areas such as behaviour, and wound management.

Residents had limited access to assessment by an appropriate professional with qualifications and experience in assessing the social care needs of residents with disabilities. The assessment of residents' social care needs and the development of social personal plans required improvement.

Staff from the activities team undertook an activities based assessment to determine residents' likes and dislikes, and details regarding family, former occupation and preferred activities. However, as discussed in Outcome 1, the provision of activities was mainly limited to those provided by the activities team and were often not linked to residents' individual interests and capacities in a meaningful way.

The majority of the staff working in the centre had no specific training or qualifications to ensure evidence based comprehensive assessment of residents social care needs, or on developing personal social care plans. The majority of residents files reviewed did not contain a personal plan reflecting residents' social care needs or supports required to maximise residents' personal development.

As discussed in Outcome 3 residents had limited access to the local community to promote social integration.

**Judgment:**

Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

This centre was located within a hospital campus and consisted of two separate buildings. The larger of the two units was accommodating 20 residents at the time of

the inspection, 16 long term residents and four respite residents.

There were two single en suite bedrooms in this unit, and the other six bedrooms accommodated from two to four residents. A number of the multi occupancy rooms had tracking hoists in place, and all multi occupancy rooms had privacy screening available and two wash hand basins. A number of the bedrooms had residents' personal photos and artwork on display and efforts had been made to make these rooms as homely and personalised as possible.

Each resident had storage available in the form of a wardrobe and a bedside locker, with lockable storage available to each resident.

The multi occupancy rooms had direct access to the internal courtyards in the centre, the two internal courtyards contained tables and chairs for residents use. These multi occupancy bedrooms were not meeting the needs of the residents in terms of maintaining residents privacy and dignity at all times, and ensuring residents had access to suitable private space.

This unit also contained a large physiotherapy room, a central day room, a multi sensory room and a large dining room. There were six assisted toilets, two assisted shower rooms and two assisted bathrooms available in the centre. A number of the toilets, bathrooms and shower rooms had been upgraded in recent years and there were plans to continue this programme of upgrade.

The smaller of the two units was accommodating 11 residents at the time of the inspection, 10 long term residents and one respite resident. The accommodation consisted of two single en suite bedrooms, and five en suite twin rooms, although at the time of the inspection one of the twin rooms was being used as a single bedroom. The twin bedrooms and the dining/day room had access doors to a garden area at the back of the centre which contained seating and was accessible for residents in wheelchairs. The centre had recently undergone refurbishment that included the installation of new fire doors, and the creation of a new spacious family/visitors rooms, and the creation of a large store room.

The centre was clean and uncluttered, with adequate lighting and felt comfortably warm during the inspection. Efforts had been made to make the centre more homely but overall the layout of the centre was very clinical in nature. Inspectors noted that a number of bedrooms, bathrooms and en suite shower rooms had no privacy locks in place as outlined in Outcome 1. There was a kitchen in each unit but these kitchens were not accessible by residents.

Equipment servicing records were available for the beds, slings and hoists to confirm servicing was conducted at appropriate time intervals.

**Judgment:**  
Non Compliant - Major

## 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):

This was the centre's first inspection by the Authority.

### Findings:

Inspectors found that health and safety systems were in place and were effective overall. However, fire management procedures were not fully robust. There were adequate risk management procedures and infection control measures in place.

The centre had an organisational Health and Safety Statement which detailed the responsibilities and duties of management and staff within the organisation. Inspectors found there were detailed health and safety procedures which addressed areas such as health and safety training, infection control, waste management, maintenance, fire, emergency planning and security.

The risk management policy guided staff on the centres risk strategy and the practice in place for the hazard identification, recording, investigation and learning from risk. There was a corporate and local risk register in place.

The centre had a risk register which recorded a number of risks in the service and the controls in place to address these. The risk register was up to date and inspectors found that the register reflected where risks had increased or been reduced. It outlined specific risks including: accidental injury to residents; slips, trips & falls; self harm; aggression and violence; manual handling and smoking.

A tool was used to score risks and determine if they were low, moderate or high, and this scoring was reflected on the register. All risks on the register had controls in place and were categorised and scored as low to medium risk. The centre had completed risk assessments for absconion. There was a risk register in place for responsive behaviour.

The two unit managers were also trained in risk management and assessments.

Procedures and equipment were in place to ensure there were effective fire safety systems in the centre. Fire extinguishers were available throughout the centre and these had been serviced in April 2015. New fire doors had recently been installed in the centre and fire escapes and exits were marked clearly and were not obstructed. The fire evacuation procedure was on display within the centre.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced by an external company. Staff also completed weekly checks of the fire equipment and escape routes however the checklists were standardised forms, contained some gaps and were not centre specific.

Regular fire drills had taken place however, only the date was recorded. The record did not show the number of staff involved in the fire drill, the scenario of the fire drill or provide a sufficient area for recording and learning from issues. The fire drill records did not indicate if a simulated evacuation of a compartment had been conducted in simulated night time conditions.

Staff interviewed were clear about their role in the event of a fire or another emergency but noted that residents were not involved in fire drills. There were no personal evacuation plans in place for residents to ensure the mobility and cognitive understanding of residents had been adequately accounted for in the evacuation procedure.

There was a system in place to ensure all accidents and incidents were reviewed. Falls audits were conducted and there was a falls incident review group in place.

An emergency plan was in place for the centre which provided guidance for staff to in the event of an emergencies or unforeseen event such as utility outages or fire. The plan described the process for evacuation, who to contact and identified a place of safety outside the centre should an emergency evacuation be required. The centre kept a list of residents with next of kin details in an emergency book.

Inspectors found that there were measures in place to control and prevent infection. Staff were knowledgeable in infection control. Staff had access to supplies of gloves and disposable aprons and alcohol hand gels which were available throughout the centre. The centre also had a cleaning schedule in place which showed tasks had been completed on a regular basis. Infection control audits were conducted in the centre.

A visitors book was also maintained at the entrance of the two units to show who was in the building in the event of an emergency however, it was not signed regularly and inspectors observed staff and visitors accessing the centre without signing the book.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There were policies and procedures in place for the prevention, detection and response to abuse and staff had received training in protection of vulnerable adults and were knowledgeable on recognising and reporting any potential abuse.

The use of bed rails in the centre was monitored, appropriate assessments were conducted and there were clear care plans in place with documented safety checks. The centre had implemented alternatives to bedrails where possible including the use of low low beds, placement of crash mats and the use of alarm systems.

The centre had access to a clinical nurse specialist in behaviour, and risk assessments had been completed for residents who exhibited responsive/challenging behaviours. There were detailed plans in place to guide staff in the management of these behaviours. The clinical nurse specialist had completed an audit of these behaviours in the units in 2014.

The inspectors were shown the resident responsive behaviour risk register maintained for the centre, which was part of the quality improvement plan in place for responsive behaviours. This quality improvement plan had also included an audit of the prescription and administration of as required (PRN) psychotropic medications.

There were care plans in place for the delivery of personal/intimate care. Staff were observed to treat residents kindly and with respect throughout the inspection.

Inspectors observed that over the two days of the inspection there was a significant number of staff (who were not rostered to work in either of the two units but who were part of the hospital campus staff) coming and going from the centre. There was no access control system in place on the units at the time of the inspection to restrict entry to the centre and the visitors book was not used to record non rostered staff. This posed a potential safeguarding issue.

**Judgment:**

Substantially Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

A record of all incidents occurring in the designated centre was maintained, and where required notified to the Chief Inspector within the specified time frames.

**Judgment:**

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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was no policy available to inspectors on access to education, training and development. Residents' opportunities for new experiences, social participation, and training were limited. Residents' opportunities to participate in social activities in the community were limited as discussed in Outcome 1 and 2.

Three of the residents attended an external day service, and one resident was currently attending a local college of further education. There was no evidence that suitable day services or programmes providing access to training or activities had been sought for the other residents.

A number of the residents residing in the centre on a long term basis went on home visits, but there was no programme in place to facilitate residents to go on regular trips or excursions apart from those organised by the activities staff which did not always suit the needs and interests of all of the residents.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

A significant number of residents in the centre had high medical needs due to the nature of their conditions, and required continuing medical and nursing care. The residents had good access to the medical officer and long term residents had good access to a wide range of allied healthcare professionals based in the hospital including occupational therapy, physiotherapy, dietetics, speech and language therapy and also to specialist nurses with expertise in areas such as wound management, behaviours and infection control.

Healthcare assessments and care plans were detailed and regularly updated. There was a good system of multi disciplinary review in place to ensure residents healthcare needs were met. However, inspectors did note that residents availing of respite care in the centre had limited access to allied healthcare professionals such as physiotherapists. This restricted access particularly for residents who resided in the centre on a substantive basis meant that their healthcare needs were not being fully met.

Inspectors observed lunch being served in one of the dining rooms. Residents who required assistance were assisted and supported in an appropriate manner. Staff were knowledgeable of residents individual requirements and there was a system in place to ensure dietary advice and recommendations from dieticians and speech and language therapists were implemented.

Food was delivered to the units from the main kitchen in the hospital. Residents were consulted on a regular basis by catering staff regarding their menu choices, and the menu on Fridays had been changed specifically for the younger residents in the centre and now offered meals such as pizza and chicken curry. A breakfast buffet had also been set up on one of the units to enable residents to have more choice and exercise more independence at breakfast time.

Catering satisfaction surveys had been conducted as part of a hospital wide survey in 2014, in which residents from both units had participated. Residents had access to snacks from the kitchens located on each unit when the main kitchen was closed, but access to the kitchens on the units was restricted as outlined previously.

Inspectors noted that on one of the units the dining experience could have been improved to promote a more homely dining experience for residents.

**Judgment:**

Non Compliant - Moderate

## **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):**

This was the centre's first inspection by the Authority.

### **Findings:**

There were policies and procedures in place relating to medication management. The centre's policy on medication management had not been updated at the time of the inspection and a replacement policy was in the progress of being drafted. There were no indications for use on all prescribed PRN medicines to ensure consistent administration by all staff. The system of delivering and tracking deliveries of medicines from the hospital pharmacy to the centre required review.

Medicines were supplied to the centre by the hospital pharmacy. Inspectors observed that the system of deliveries of medicines to the units from the hospital pharmacy was not sufficiently robust to ensure all medicines were stored securely in the centre at all times.

During the inspection an inspector observed one such delivery where a locked container was deposited in the office which was unlocked at the time, with no centre staff present to take receipt of the container. The office in question was located just inside the front door of the centre which was also open at the time.

The inspectors were shown the storage areas for medicines within the centre and this area was secure and had facilities available to refrigerate medicines when necessary. Controlled drugs were appropriately stored and records were kept to verify that balances of these medicines were checked by staff twice daily.

Inspectors observed that nursing staff administering medicines to residents followed appropriate medication management practices. The inspectors also reviewed a number of prescription and administration charts and noted that indications for use (circumstances under which medicines were to be used) were not documented for PRN (as required) medicines on the prescription charts to ensure consistent administration practice by nursing staff.

Audits of the administration of medication were conducted in the centre, and a clinical audit of medication errors had also been conducted by one of the clinical nurse managers in 2014. There was a medication management committee in place in the hospital that included a pharmacist and nursing staff.

### **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):**

This was the centre's first inspection by the Authority.

**Findings:**

The statement of purpose submitted to the Authority outlined the aims, objectives and ethos of the designated centre. However the statement of purpose did not contain the following information as detailed in Schedule 1 of the Regulations 2013:

-the arrangements for residents to access education, training and employment.

The following information was not sufficiently detailed:

-criteria used for admission to the designated centre

It was not clear in the statement of purpose if the designated centre for adults with disabilities provided separate facilities for day care.

The statement of purpose was not accessible to residents in the centre.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There was a clearly defined management structure in place in the centre. The person in charge of the designated centre was the director of nursing for the hospital campus

which included a designated centre for older persons. The person in charge was a registered general nurse, with over ten years experience in a management capacity and further post graduate qualifications in health services management.

The local management structure of the centre included three assistant directors of nursing, one of whom acted in a night superintendent role, and four clinical nurse managers, all of whom were listed as persons participating in the management of the centre. This management team were responsible for managing the designated centre for older persons and the designated centre for adults with disabilities. The provider nominee was the general manager of the campus. The inspectors were shown the minutes of three meetings that had been held between the person in charge and the provider nominee in 2015.

The two units that comprised the designated centre were each managed by a clinical nurse manager 2, supported by a clinical nurse manager 1, who both worked in the units on a day to day basis. Staff meetings were held at a unit level but these meetings were not held on a regular basis and one of the units had only held one of these meetings in 2015 to date.

Monthly management meetings involving the clinical nurse managers from across the campus were held to discuss a variety of topics including incidents and accidents, the emergency plan, medication management issues, metrics, auditing and staffing. Audits were conducted in a number of areas including care planning, falls, medication administration, environmental hygiene and infection prevention and control. Weekly nursing statistics including information on tracheostomies, pressure wounds, catheters and the other nursing specific details were compiled and maintained.

An annual review of the quality and safety of care and support in the designate centre had recently been completed by the general manager who was the provider nominee for the centre. However, the three page report generated following the review was not sufficiently comprehensive to provide assurances that the care and support being provided in the designated centre had been fully assessed to determine accordance with standards. The unannounced six monthly visits as specified by Regulation 23 had not been conducted in the centre.

Management in the centre had identified issues with ensuring residents' social care needs including social activities were fully met in the centre. However, the quality improvement plan for the centre did not include or reference a plan to address this identified shortcoming. There were no meetings held exclusively for the management team of the disability centre to ensure effective discussion and communication of issues that affected the designated centre for disabilities only.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There were suitable arrangements in place for the management of the centre in the absence of the person in charge. Inspectors were advised that in the absence of the centre manager, one of the persons nominated as participating in management would manage the centre. The centre manager had not been absent for 28 days or more, and therefore no notifications had been made to the Authority.

**Judgment:**

Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre was found to be sufficiently resourced apart from access to transport. The facilities and services reflected the statement of purpose. The only identified resource issue brought to the attention of inspectors related to the availability of transport for residents.

The centre had access to the hospital campus buses and also used taxis when necessary. However, access to transport was identified as an issue partly due to the systems in place to pre book transportation for residents.

**Judgment:**

Substantially 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):**

This was the centre's first inspection by the Authority.

**Findings:**

The staffing levels and skills mix of staff were appropriate to ensure residents' healthcare needs were met. However the skill mix of staff required review to ensure residents' social care needs were met. There was no system in place to facilitate the person in charge to obtain staff documentation as specified in Schedule 2 of the Regulations. Staff required further training specifically relating to the provision of care and support for adults with disabilities.

Staff rosters were made available to the inspectors detailing the staff on duty on the units that comprised the designated centre. A significant number of the residents had multiple and complex medical needs and the level of nursing care provided was appropriate to ensure their healthcare needs were met. The person in charge outlined that nursing staff involved in the management of tracheostomies received specific training and measures were in place to ensure only staff familiar with the needs of these residents were rostered to work on the unit.

Inspectors observed that staff on duty during the inspection were knowledgeable of the individual residents, and all interactions were respectful and kind. Feedback obtained from residents and relatives during the inspection, and from questionnaires completed by residents and their family members were also highly complementary of the staff who worked in the centre.

One of the inspectors spoke with the clinical nurse manager responsible for education who outlined the training programme in place for staff, and the induction programme in place for new staff. Training records were available to confirm that staff had received training in fire safety awareness, fire evacuation, manual handling, protection of vulnerable adults, infection prevention and control and CPR. Training had also been provided on wound care, management of responsive behaviours and medication management. Two members of the campus wide activities staff had received training relating to activities for persons with acquired brain injuries.

The majority of the staff working in the centre had no training or qualifications in the area of social care or on providing care and support to residents with disabilities. Staff knowledge of the Regulations was not consistent.

Staff reported feeling disempowered, and that ideas and suggestions to implement a more person centred approach to caring and supporting the residents was not always welcomed or considered. Communication systems that facilitated consideration of new ideas from the staff team with in depth knowledge of the residents were not in place.

The inspectors requested a sample of staff files to check that staff documentation specified in Schedule 2 of the Regulations was available. However, the person in charge informed inspectors that staff files for staff recruited nationally by the HSE were not available to the person in charge. The person in charge offered to make arrangements for inspectors to visit HSE human resources offices to view staff files at a later stage.

The centre did keep staff documentation for staff that were recruited locally. There were volunteers who visited the hospital, and the volunteer programme was operated and managed by the social work department. The files and documentation requested by the inspector in relation to volunteers were not available on the day of the inspection.

The clinical nurse managers in charge of each unit were responsible for supervising staff, but only new staff had formal one to one performance reviews/appraisals conducted.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

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 were maintained to ensure completeness, accuracy and ease of retrieval with the exception of the residents directory, and certain details as required by Schedule 2 as outlined under Outcome 17.

The residents guide was accessible to residents within the centre and contained all the information specified in the Regulations except details on how to access any inspection reports on the centre.

Insurance documentation was made available to confirm the centre was adequately insured against accidents or injury to residents, staff and visitors.

The centre had the majority of the written operational policies as listed in Schedule 5 of the Regulations. The policy on access to education training and development was not available. A number of policies were in the process of being updated and were only available in draft format at the time of the inspection. These policies included:

- provision of personal intimate care
- the use of restrictive procedures and physical, chemical and environmental restraint
- medication management

An up to date residents directory detailing all of the information as required by Schedule 3 of the Regulations was not available on the units in the designated centre. The residents directory was maintained in the nursing administration building which was not part of the designated centre.

**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:*

Jim Kee  
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 Health Service Executive
<b>Centre ID:</b>	OSV-0003730
<b>Date of Inspection:</b>	17 November 2015
<b>Date of response:</b>	15 January 2016

### 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:**

The residents' right to participate in the organisation of the designated centre by raising issues at advocacy meetings was not being facilitated as issues were not being adequately addressed and residents were not being kept informed of progress or reasons as to why the issues were not being addressed.

<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 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

A resident satisfaction survey will be completed. The Terms of Reference for the Advocacy group are to be reconstituted to reflect concerns raised through the advocacy group. A meeting with members of the Advocacy group and Senior management took place on the 15th of December 2015 and a follow up meeting will be held to progress matters by February 2016.

**Proposed Timescale:** 30/04/2016**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were no formal resident meetings held within the centre that allowed residents to be consulted and participate in the organisation of the centre

**2. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

Focus groups with residents and staff will commence in March 2016 and will continue on an ongoing basis. These meetings will be chaired by the ADON and will take place on a bi monthly basis to ensure that the residents have a voice in their daily lives. All residents will be invited to partake in each of these meetings. Topics that may be covered in standard agenda items will include activities, meal choices, maintenance matters regarding the estates etc

**Proposed Timescale:** 31/03/2016**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were no privacy locks in place on bedroom doors or on some of the bathroom doors to ensure residents' privacy and dignity were maintained at all times.

**3. 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:**

A review of all bedrooms and bathrooms with the CNM II and maintenance has taken place; some locks have been changed. Risk assessments will be developed for the rooms where it is deemed unsafe to put locks on the doors

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

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

The provision of opportunities for residents to participate in activities in accordance with their interests and capacities was not sufficient, and was dictated by routines and resources. There was very limited activity provision in the evenings and at weekends.

**4. 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:**

A multidisciplinary team approach involving the Disability services is being adopted to devise plans for each resident; the first meeting was held on the 14th of January 2016. A Multi disciplinary working group has been established along with Disability colleagues and the Provider and PIC. All care plans will be reviewed and plans developed based on the outcome and recommendations of those individual assessments. Staff participation will be based on the outcome of those assessments.

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

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

The centre was not recording if the resident was satisfied with the outcome of their complaint.

**5. 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:**

A revised complaints template has been developed to include the satisfaction of the complainant.

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

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

Verbal complaints were not being consistently documented as complaints, and complaints that could be resolved locally were not always documented.

**6. 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:**

A meeting has taken place with the CNM's for both units to ensure that all staff are made aware of the importance of documenting all verbal complaints and their outcomes at local level. Complaints analysis is discussed at the Quality and Patient Safety Committee in Dublin South Central.

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

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

The complaints process was not displayed in a location accessible to all residents and was presented in a manner which was not easy to understand.

**7. Action Required:**

Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

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

The current complaints process format will be reviewed.

**Proposed Timescale:** 30/04/2016

**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

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

There was no private visiting space available for residents and their visitors to use in one unit.

**8. Action Required:**

Under Regulation 11 (3) (b) you are required to: Provide a suitable private area, which is not the resident's room, to a resident in which to receive visitors, if required.

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

An application for funding through the Estates Department has been made. Decision for approval of funding is imminent. Accordingly, relevant quotations to provide a visitors room will be then applied for through minor capital. It is intended that we will be in a position to progress works as outlined in the timescale below.

**Proposed Timescale:** 31/08/2016

**Theme:** Individualised Supports and Care

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

The majority of residents did not access the community on a regular or frequent basis. There was no evidence that efforts had been made to establish more community based links for the residents.

**9. Action Required:**

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

A multidisciplinary team approach involving the Disability services is being adopted to devise plans for each resident; the first meeting was held on the 14th of January 2016. A working group has been established with Disability colleagues and the Provider and PIC. A Multi disciplinary working group has been established along with Disability colleagues and the Provider and PIC. All care plans will be reviewed and plans developed based on the outcome and recommendations of those individual assessments. Links are being made with the HSE's Training and Guidance Officer in Disability Services with a view to enhancing our links with the Community.

0.5 Social Worker has been allocated with specific responsibility for Lisbri and Elm Units and will be key to developing and enhancing links with other appropriate community services that might be appropriate for clients on the basis of their revised care plans.

**Proposed Timescale:** 01/03/2016

## 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:**

There were no clear criteria in place for admission to the centre (including for respite care)

**10. Action Required:**

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

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

A revised admission policy for both long term and respite care is to be developed; this will include an assessment by the Disability service to determine suitability for admission.

**Proposed Timescale:** 31/05/2016

Theme: Effective Services

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

The contracts did not specify the fees being charged or detail any additional charges the residents were liable to pay for utilities etc

**11. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Contracts are to be amended to include this action.

**Proposed Timescale:** 29/02/2016

## 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:**

Comprehensive assessment of residents social care needs were not being carried out.

**12. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

In conjunction with Disabilities Services, individual comprehensive social care assessments of all residents to be carried out and reviewed at least annually. These assessments will be carried out collaboratively by Nursing, Social Work and Occupational Therapy staff with recommendation being considered by the Multi disciplinary team to implement any actions arising there from.

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

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

The majority of the resident files reviewed by the inspectors did not contain a personal plan reflecting the residents' social care needs.

**13. Action Required:**

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

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

In conjunction with Disabilities Services, individual comprehensive assessments of all residents to be carried out and reviewed at least annually. These assessments will be carried out initially by nursing staff with recommendation being considered by the Multi disciplinary team to implement any actions arising there from.

**Proposed Timescale:** 30/04/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The multi occupancy bedrooms were not meeting the needs of the residents in terms of maintaining residents privacy and dignity at all times, and ensuring residents had access to suitable private space.

**14. Action Required:**

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

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

A long term plan has been developed by senior management to address structural deficits. Since the inspection, approval has been given under the Capital Plan 2016-2021 for a new build in Cherry Orchard Hospital. This will enable us to relocate current residents from Lisbri to a unit on campus. This unit comprises of mostly single rooms with en-suite bathrooms and does not require any remedial works in order to facilitate the relocation. A design team has been appointed to progress the new development.

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

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

**Theme:** Effective Services

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

The fire drill records did not show the number of staff involved in the fire drill, the scenario of the fire drill or provide a sufficient area for recording and learning from issues arising during fire drills. The fire drill records did not indicate if a simulated evacuation of a compartment had been conducted in simulated night time conditions to ensure staff were aware of the procedure to be followed in the case of a fire.

**15. 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:**

In conjunction with the HSE Fire Officer who will develop a template; fire 'scenarios', for example evacuation of bedrooms/ dining areas will take place on a monthly basis which will be timed; dated and attendance recorded.

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

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

There were no personal evacuation plans in place for residents to ensure the mobility and cognitive understanding of residents had been adequately accounted for in the evacuation procedure.

**16. 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:**

Evacuation procedure to be revised. Individual personal care plans to be reviewed and revised.

**Proposed Timescale:** 31/03/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

There was no access control system in place on the units at the time of the inspection to restrict entry to the centre and the visitors book was not used to record non rostered staff posing a potential safeguarding issue.

**17. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

The lock on the door to Elm unit has been mended; a disability access door for Lisbri is now in place. A new sign-in book for staff not rostered on these units is in use and all non-rostered staff are required to sign same when they enter/leave the buildings

**Proposed Timescale:** 01/03/2016

**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 evidence that suitable day services or programmes providing access to training or activities had been sought for all of the residents.

**18. 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:**

A policy for access to opportunities for education, training and employment will be developed by the Occupational Therapy and Social Work and nursing departments. The policy will be officially launched and all relevant will have the opportunity to attend the

launch. In addition, all such staff will be required to attend the training and note will be maintained of their attendance by Nurse Management.

0.5 Social Worker has been allocated with specific responsibility for the units and will work in conjunction with Disability services and other appropriate staff to identify other possible opportunities for clients in the Community. Such changes will obviously be based on the outcome of their revised individual care needs assessments. A meeting took place on the 15th of February with the DON; ADON; CNM II; Social Worker and HSE Training and Guidance Service to review the services already in place and to explore other training/activities in the community that could be accessed for the residents. A follow-up meeting has been arranged for the 14th of March

**Proposed Timescale:** 31/05/2016

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents availing of respite care in the centre had limited access to allied healthcare professionals such as physiotherapists. This restricted access particularly for residents who resided in the centre on a substantive basis meant that their healthcare needs were not being fully met.

**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:**

Assessments appropriate to respite clients needs are offered within the service and are met either through the local primary care service which is located beside the hospital or by AHP on site. Access for any client to any AHP is provided based on the individual assessment and priority of need either through primary care or on site services.

**Proposed Timescale:** 01/03/2016

### **Outcome 12. Medication Management**

**Theme:** Health and Development

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

The system of delivering medicines to the centre from the hospital pharmacy was not sufficiently robust to ensure all medicines were stored securely in the centre at all times.

**20. Action Required:**

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

The locked medicine container delivered to the units from the pharmacy is now being delivered to the locked treatment room on all units. This means the nurses must accept the delivery of the medication boxes in order for the porters to access the treatment rooms.

**Proposed Timescale:** 01/03/2016

**Theme:** Health and Development

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

Indications for use (circumstances under which medicines were to be administered) were not documented for PRN (as required) medicines on the prescription charts.

**21. Action Required:**

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

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

Medical Superintendent has addressed the matter and PRN are now being recorded as being prescribed for certain purposes.

**Proposed Timescale:** 01/03/2016

**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 was not accessible to residents in the centre.

**22. Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

The Statement of Purpose is available for all residents/representatives

**Proposed Timescale:** 01/03/2016

**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 contain the following information as detailed in Schedule 1 of Regulations:

-the arrangements for residents to access education, training and employment.

The following information was not sufficiently detailed:

-criteria used for admission to the designated centre

It was not clear in the statement of purpose if the designated centre for adults with disabilities provided separate facilities for day care.

**23. 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 revised containing the information required.

**Proposed Timescale:** 31/03/2016

#### **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 annual review was not sufficiently comprehensive to provide assurances that the care and support being provided in the designated centre had been fully assessed to determine accordance with standards.

**24. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

A comprehensive annual review based on the standards will be conducted.

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

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

The unannounced six monthly visits as specified by Regulation 23 had not been conducted in the centre.

**25. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

An unannounced visit will be conducted based on the standards.

**Proposed Timescale:** 30/06/2016

**Theme:** Leadership, Governance and Management

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

Management in the centre had identified issues with ensuring residents social care needs including social activities were fully met in the centre. However the quality improvement plan for the centre did not include or reference a plan to address this identified shortcoming. There were no meetings held exclusively for the management team of the disability centre to ensure effective discussion and communication of issues that affected the designated centre for disabilities only.

**26. 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:**

A Governance Group for the operation and oversight of services in both units has been formed with reps from Disability Service and the Provider and PIC. The General Managers for both Primary and Older Persons Services (The Provider), PIC, Disability Manager, Disability Case Manager, ADON for Libri and Elm will comprise the Governance Group. Any quality issue arising through the operations of the service will be raised at the appropriate Quality and Patient Safety Governance Groups. A meeting is held monthly between the CNMII's and ADON re any issue arising in each of their units respectively. This meeting between CNM's and ADON has been in place for some time.

**Proposed Timescale:** 01/03/2016

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

Access to transport required review to ensure residents' access to the community and opportunities to participate in activities and trips were not limited due to transportation issues.

**27. 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:**

Transport services will continue to be provided through the hospital by the use of appropriate ambulance transport or privately contracted services based on individual assessment of need.

**Proposed Timescale:** 01/03/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

There was no system in place to facilitate the person in charge to obtain staff documentation for all staff as specified in Schedule 2 of the Regulations.

**28. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

The HSE and HIQA have an agreement that HIQA inspectors can personally view staff files in the HSE offices in Merchants Quay once the HIQA inspector makes an appointment to do so. It is the responsibility of NRS in the HSE to provide the necessary assurances regarding the recruitment of staff.

**Proposed Timescale:** 01/03/2016

**Theme:** Responsive Workforce

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

The majority of the staff working in the centre had no training or qualifications in the area of social care or on providing care and support to residents with disabilities.

**29. 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:**

Relevant training will be sourced and provided with specific focus on social care and in line with standards and regulations.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

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

The majority of the staff working in the centre had no training in the area of social care or on providing care and support to residents with disabilities.

**30. 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:**

Relevant training will be sourced and provided with specific focus on social care and in line with standards and regulations.

**Proposed Timescale:** 31/07/2016

**Theme:** Responsive Workforce

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

Staff knowledge of the Regulations was not consistent.

**31. Action Required:**

Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

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

A copy of the appropriate legislation is available on both units; the CNM's have discussed the same with all staff.

An actual copy of the Legislation is to be given to all members of staff working on both units.

**Proposed Timescale:** 29/02/2016

**Theme:** Responsive Workforce

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

There was no formal system of staff appraisal in place to ensure appropriate supervision.

**32. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Formal staff appraisals are not carried out at this time as there are corporate discussions ongoing between the HSE and Unions. Individual appraisals are carried out with staff that are under performing and an action plan developed. An educational needs analysis is carried out annually for staff and an education programme developed based on the response. The nurse management structure comprises of an ADON over both units. In addition there is a CNMI and a CNMII in each of the units responsible for the delivery of services and staff supervision. Finally, there is a Night Superintendent also available every night.

**Proposed Timescale:** 01/03/2016

**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 policy on access to education training and development was not available.

**33. 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:**

Policies to be updated/implemented

**Proposed Timescale:** 31/07/2016

**Theme:** Use of Information

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

A number of policies were in the process of being updated and were only available in draft format at the time of the inspection. These policies included:

- provision of personal intimate care
- the use of restrictive procedures and physical, chemical and environmental restraint
- medication management

**34. 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:**

Policies to be signed off and implemented.

**Proposed Timescale:** 31/03/2016

**Theme:** Use of Information

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

An up to date residents directory detailing all of the information as required by Schedule 3 of the Regulations was not available on the units in the designated centre.

**35. Action Required:**

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

Resident directories to be made available on both units.

**Proposed Timescale:** 31/03/2016

**Theme:** Use of Information

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

The residents guide did not provide details as to how to access any inspection reports on the centre.

**36. Action Required:**

Under Regulation 20 (2) (d) you are required to: Ensure that the guide prepared in respect of the designated centre includes how to access any inspection reports on the centre.

**Please state the actions you have taken or are planning to take:**  
Information guide to be revised accordingly.

**Proposed Timescale: 30/04/2016**