Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From:	To:
12 May 2015 10:00	12 May 2015 17:30
13 May 2015 09:00	13 May 2015 17:00

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

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

Summary of findings from this inspection

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

This was the fourth inspection of this designated centre. The two most recent inspections that took place on 19 December 2014 and 13 January 2015 were in response to unsolicited information received by the Health Information and Quality Authority ('the Authority') on 16 December 2014 relating to allegations of poor practice and practices that could constitute the abuse of residents in specific units in this designated centre. An external investigation into these allegations was commissioned by the provider and had yet to be completed at the time of this

inspection.

Since the previous inspection, improvements had been made in a range of areas. For example, a full review of residents' health and social care needs had been completed. The opportunities available to residents to pursue interests and activities that suit their needs, wishes and capacities had been developed. Residents were accessing the community more. Action had been taken to ensure staff were aware of and supported to raise concerns and manage any concerns raised. Regular communication meetings between staff and their line managers had commenced. Bathrooms and shower rooms had been upgraded in all four units.

Inspectors spoke with five families and reviewed surveys that had been completed by a number of relatives in relation to their experience of the service. The feedback from relatives in relation to the care that their loves ones received was positive. Relatives told inspectors that there was an open door policy in place, that they were involved in care decisions and choices and they were always made feel welcome. Areas identified for improvement in the survey related to issues concerning the premises.

Group A comprises four interconnecting units accommodating 31 residents. The centre forms part of a congregated setting. Efforts had been made to personalise the bedrooms and decorate each unit.

As part of the inspection; inspectors interviewed a number of staff on duty and reviewed documentation pertaining to the areas of concern. Documentation reviewed included daily notes, communication books, personal plans, risk assessments, nutritional information and documentation pertaining to restrictive practices, medication management and behaviours that challenge. Inspectors observed staff interactions with residents, which were observed as being appropriate and respectful.

However, four major non-compliances were identified over the course of this 2-day inspection.

A major non-compliance was identified at the previous inspection in relation to Outcome 5: 'social care needs' and this remains at the level of major non-compliance. The provider had not satisfactorily ensured that the designated centre met the assessed needs of all residents. While the provider had taken some steps to try and resolve this, the situation remained unresolved.

A major non-compliance was identified at the previous inspection in relation to Outcome 6: 'safe and suitable premises' as the provider had not satisfactorily ensured that the design and layout of the centre was suitable for its' stated purpose. While the provider had taken steps to upgrade the premises, it still did not meet residents' individual or collective needs in an acceptable way. This outcome remains at the level of major non-compliance.

A major non-compliance was identified at the previous inspection in relation to Outcome 8: 'safeguarding and safety' and this remains at the level of major non-compliance. Staff did not articulate an understanding or acceptance that abuse may

occur in the centre. This carries an associated risk that allegations may not be reported in the future and consequently, investigated.

A major non-compliance was identified at the previous inspection in relation to Outcome 14: 'governance and management' and this remains at the level of major non-compliance. While the provider had taken a number of steps in line with their previously submitted action plan to address the areas of concern identified in the previous inspections; the provider had failed to demonstrate that adequate safeguards had been put in place.

The Authority did not agree the action plan response to Regulations 5(3), 8(2), 17(1)(a) or 17(7) with the provider despite affording the provider two attempts to submit a satisfactory response. These Regulations are relevant to Outcomes 5: 'social care needs', 6 'safe and suitable premises' and 8 'safeguarding and safety'. The provider has subsequently submitted a costed plan that outlines proposals to address the unsuitable premises.

Other areas for improvement included advocacy arrangements, health and safety, medication management, staff training and record keeping. Inspection findings including non-compliances are discussed in the body of the report and in the action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Significant improvement had been made in relation to the opportunities for residents to pursue activities or interests which suit their needs, wishes and capabilities and to ensuring an accessible complaints procedure was in place. Further improvements were required in relation to advocacy.

There were monthly residents meetings in place to facilitate consultation with residents. Minutes were kept of these meetings and demonstrated that topics relevant to the residents were discussed with or explained to residents. Visual cues were used during such consultations.

An easy-read version of the complaints policy was visibly displayed. While the action taken following complaints was clearly articulated by staff, the documentation pertaining to the logging of complaints was not in line with the Regulations. The introduction of a new complaints log was imminent to aid in this process.

An independent advocate had been sought for residents who had no next of kin or required independent advocacy services. Each resident had a named keyworker. Staff had received training in relation to internal advocacy. There was an advocacy committee in place at service level. However, significant improvement was required to the advocacy committee and internal advocacy system to ensure that residents were adequately represented. At the time of inspection, no residents sat on the advocacy committee. The provider nominee had identified the need for such improvement and articulated how they are working to address these gaps.

Since the previous inspection, the staff team had received support in relation to reviewing the opportunities available to residents to pursue activities, interests and new opportunities. In addition, rosters had been reviewed to support such activities in the evenings and weekends. Each resident now had a detailed timetable in place, tailored to their individual needs, capabilities and wishes. Activities and interests pursued included going for walks, to the pool or gym, to the cinema or out for tea. Residents had tried new opportunities including going for concerts since the previous inspection.

Three residents did not have access to a day service and there were clear reasons why this was the case. For those residents, daily routines and weekly timetables had been developed by the staff team appropriate to each individual. Routines and activities included going for a walk, the use of memory boxes and photographs to aid memory, hand massage, reflexology and physiotherapy programmes. Records were maintained of such daily and weekly activities.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents' communication needs were being met in the centre.

In the sample of healthcare files seen by inspectors each resident had a communication profile completed as part of their health and social action assessment. This outlined how residents communicated verbally, non-verbally and whether the resident used gestures.

Communication care plans had been developed for each resident and included details of how the resident communicated, the results of any communication assessment and prompts for staff on how to interact with the resident. Staff with whom inspectors spoke were aware of these individual communication needs, and were observed communicating appropriately with residents during the inspection. For example on the second day of inspection staff were observed offering a choice of breakfast to residents.

Some residents had communication folders which included pictures of everyday items being available and shown to the residents which helped residents to have certainty around activities during the day.

There was evidence of review and assessment of communication needs by speech and language therapists as required. The recommendations from these reviews included the use of object cues which involved staff using a real object or part of an object to represent an activity, place, or routine. For example, during the inspection staff used a coat to ask a resident if they wished to go outside. In response to the changing needs of one resident, a further referral had been made for communication assessment by a speech and language therapist.

Inspectors observed communication boards in use which included pictures of which staff were in the house. The boards also included a picture of the weather for the day. There was a communication forum for residents which took place in each house on a regular basis and items discussed included choice for mealtimes, activities planned and birthdays. Mealtimes were identified as good opportunities for residents and staff to meet and talk in a more relaxed environment and inspectors observed this throughout the inspection.

Television and stereo systems were provided in the main living rooms and in many of the residents' bedrooms. It was identified in one resident's communication plan that an iPad had been recommended by the speech and language therapist. The iPad had been used as a trial but it did not meet the resident's needs.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that positive relationships with family and friends were supported.

There was a policy on visiting. Relatives said to inspectors that they could visit at any time and frequently did so on an unannounced basis. A log was maintained of all visitors.

Family relationships were supported by staff in various ways as applicable to each individual resident. Residents were supported to visit their family members, to stay overnight or for weekends in their family home and to go out on day visits with family.

Relatives told inspectors that they were kept informed of residents' wellbeing and were

kept up to date of any changes. Relatives confirmed that they were invited to attend personal planning review meetings.

Other personal relationships were supported, including relationships with friends from day services or with whom residents previously resided.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspectors found that there was an admissions process in place in the service. Each resident had a written contract of care, which met the requirements of the Regulations.

The most recent admission to the centre had been approximately eight months previously in response to the changing health needs of a resident in another centre managed by the Daughters of Charity. It had been demonstrated that the process considered the needs and safety of the individual in terms of meeting individual nursing care needs.

Inspectors reviewed a sample of residents' contracts of care and found that they had been signed either by the resident or their representative. The sample contracts seen by the inspectors included: an introduction; personal effects; staffing arrangements; provision for family contact; policies; assessment/care planning; medication management; suggestions; comments/complaints and; insurance.

The contract also outlined the residential charges for accommodation of the resident. Two appendices at the back of the contract outlined a number of different charges that could be applied. The person in charge outlined the specific charge that applied to each resident currently. This charge was set out in a further appendix at the back of the contract. The centre maintained a monthly record of the charges that were asked from each resident. The information on monthly charges was available to residents and their families on request. Financial records were subject to internal auditing.

Judgment:

Compliant

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

Findings:
Improvement had been made in relation to personal plans since the previous inspection. This outcome remains at the level of major non-compliance due to the finding that the centre failed to meet the needs of all residents. Other improvements were required to the setting of personal goals and the review of personal plans.

The provider nominee was taking steps to address the finding from the previous inspection that the centre failed to meet the needs of all residents. At the previous inspection, it had been identified that a number of residents were either inappropriately placed or were ready to move to a more community-based setting. The finding in relation to the inappropriate placement remained unchanged. This continued to have a significant impact on a resident in terms of meeting their social, emotional, developmental and safety needs. While the provider nominee demonstrated that steps were being taken to progress this issue, the finding remains at the level of major non-compliance due to the impact on the resident, the length of time that this issue had been on-going (in terms of years) and that a concrete plan is not yet in place.

Inspectors found that each resident had an assessment of their health and social care needs. However, this assessment had not always been carried out as required to reflect changes in need and circumstances. Where a resident had returned from hospital, while the instructions on the treatment letter had been followed, an assessment of their health needs had not been completed and their care plan had not been updated to reflect the instructions received by the discharging hospital team. In addition, one area required development in that a comprehensive assessment to establish each resident's personal or skills development goals had not been completed. The provider was aware of this gap.

Each resident had a personal plan that had been reviewed and updated since the previous inspection. Inspectors reviewed a sample of personal plans and found that they

were individual, person-centred and overall, met the requirements of the Regulations. There was evidence of family involvement in personal planning and family were invited to attend MDT meetings and meetings pertaining to the review of personal plans.

Inspectors reviewed how residents' goals were determined, logged and tracked. Where goals were not achieved, this was documented. However, the planning, review and documentation of goals did not meet the requirements of the Regulations. Some goals were not goals, but part of the residents' health plans. It was difficult to see whether goals had been achieved in all cases due to the information provided. Sections of the forms used to capture this information was incomplete, unclear or blank. The necessary supports to achieve such goals were not outlined where applicable e.g. transport or staffing requirements. Not all readily identifiable goals had been recognised as goals. In addition, the person in charge had not commenced auditing personal plans, as necessary to identify such gaps.

Residents plans were reviewed on an annual basis, as required by the Regulations. However, the review of the personal plan was not multi-disciplinary, as required by the Regulations. Family were invited to attend all personal plan reviews.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Inspectors found that the design and layout of the centre was not suitable for its' stated purpose and did not meet residents' individual or collective needs in an acceptable way. The poor design and layout of the premises impacted on an individual resident's need for space and did not meet other individual resident's mobility or privacy needs. Inspectors found that this failing was at the level of major non-compliance.

The centre forms part of a congregated setting. There were four units (bungalows) in the centre which were all of a similar size and layout. The ground floor of each unit comprised a kitchen, an open living room/dining space, one very small 'quiet room', eight bedrooms, one shower room, one bathroom (with accessible bath), a toilet, a

staff/visitor toilet and a storage room. The first floor contained the laundry facilities, a staff toilet and staff bedroom.

In each of the four units, substantial upgrading had been completed since the previous inspection, including a new accessible shower room with toilet and wash hand basin and separate accessible bathroom with appropriate equipment.

However, due to the confined space in the premises, parts of the premises were in a poor state of repair. For example, walls and doors throughout each unit had been visibly marked and damaged by wheelchairs.

The centre did not adequately meet the individual need for space of one resident nor did it provide suitable communal space for all residents. In each unit, at least half of residents were wheelchair users and in one unit, all eight residents were wheelchair users. Inspectors observed times during the day during which a number of residents were together in the communal space (the combined living/dining room) and observed that the communal accommodation provided was very limited in terms of space for the number of residents residing in that unit. While the provider nominee had taken steps to identify additional spaces that could be freed up and converted for use in the centre, this will not increase the size of the communal area within each unit itself.

All units in the centre had limited storage space. Inspectors noted one sluice room was in use as storage for nine chairs. The store room had limited space and was full to the point of being barely accessible. Inspectors observed that a resident's chair, that had been recommended by the occupational therapist was stored in the courtyard as there was nowhere to store it inside the unit.

Inspectors observed that the physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, 15 of the 31 bedrooms were limited in size. Given the level of physical needs of the residents in one unit, the bedroom sizes presented challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces.

Efforts had been made to make the communal areas and bedrooms homely and personalised. There was adequate heating and ventilation in all areas of the centre. However, there was limited natural light in the units due to the design and layout of the units.

In one unit, one resident's individual needs determined that s/he required space, which was also relevant to support that resident to manage their behaviours that challenge. Inspectors found that this need for individual space was not met by the congregated setting. This was previously discussed under Outcome 5: Social Care Needs.

Residents had access to equipment which was appropriate to their needs. Residents who required transfers had access to hoists in communal areas and ceiling hoists in their own bedrooms. There was evidence of assessment of residents for new equipment which would improve their comfort. However, some equipment used by residents was unclean and in need of repair. For example, the cover of one resident's recliner chair was torn and tape was being used at the junction point between the chair legs and the chair

wheels; two other chairs were observed to be unclean, which carried a risk of infection and; finally, a number of chair handles were torn and damaged.

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

Findings:
Inspectors found that while arrangements were in place for health and safety and risk management, improvements were required in relation to the management of risk. In addition, fire safety arrangements required further review. Since the last inspection the centre was visibly clean and training on hygiene/infection control had been provided to all staff.

The risk management policy made available to inspectors did not include incident reporting as a tool to identify hazards. The policy also did not include the measures to control specified hazards including unexpected absence of a resident, accidental injury, aggression and resident self harm. Following the inspection a revised risk management policy dated March 2015 was submitted to the Authority. However, the revised policy does not meet the requirements of the Regulations.

There was a safety statement in place that was in date, although not centre-specific. Some specific risk assessments relevant to the centre were available. However, the system in place for identifying hazards and completing risk assessments required improvement. A risk assessment had not been completed for all identifiable hazards, including accessible latex gloves in an unlocked store room in one house. A number of the risk assessments, for example the risk assessment on manual handling, did not include a date or an indication as to whether it was a low, medium or high risk.

Each resident had participated in identifying specific hazards relating to their lives and individualised risk assessments had been completed where necessary. Examples included falling from bed and use of transport. Inspectors found however, that an individual risk assessment had not been completed for all identified hazards. For example, where a fire risk assessment had been recommended for one resident, there was no evidence in the resident's file that it had been completed. Where it had been identified that steps needed to be stored in a particular way during transport, a risk assessment had not been completed that included this control measure.

As was found on the last inspection a number of bedrooms provided inadequate space to ensure staff could move and handle residents safely. Finally, while staff had received manual handling training, such training was not consistently implemented in practice as inspectors observed techniques being used which were outdated and unsafe and carried a risk of injury to residents.

Inspectors reviewed the incident reporting record from January 2015 to 13 May 2015 and saw records for 66 incidents. Inspectors found that although incidents were being recorded and collated, they were not analysed at centre-level. This will be further discussed under Outcome 14: Governance and Management.

In relation to fire safety, the provider had taken a number of actions since the first inspection of this centre in May 2014. This included a review of evacuation procedures and works had taken place where necessary e.g. the installation of patio doors in bedrooms to facilitate timely evacuation. The provider nominee said that an upgrading of doors throughout the premises was planned. However, further improvement was required as it had not been demonstrated that effective fire safety management systems were in place in throughout the designated centre; a risk assessment by a competent person was not available for all four houses that considered whether adequate precautions were in place against the risk of fire in the designated centre. Such a risk assessment had been completed for the upstairs laundry in one house only.

Personal emergency evacuation plans were on display. The person in charge outlined the on-call arrangements in place to respond to an emergency but there were no guidelines available for staff in response to specific emergencies like loss of power or heating. There were no formal emergency arrangements in place for the provision of alterative accommodation for residents in the event of an evacuation.

Since the last inspection, records of servicing of fire equipment were now available. Inspectors saw evidence that suitable fire prevention equipment was provided and the equipment was adequately maintained by means of servicing of the fire alarm system, the alarm panel, fire extinguishers and emergency lighting.

Training records indicated that staff members had received the mandatory fire training. While the sample of agency staff with whom inspectors spoke during the inspection demonstrated an awareness of what to do in the event of a fire; the person in charge was unable to confirm whether agency staff had received fire training. Fire drills were undertaken regularly and there was a record kept of such fire drills.

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

In relation to infection control, since the last inspection four new bathrooms each with toilet, wash hand basin and shower had been provided. However, some of the bathrooms did not have facilities for drying hands. Four new shower rooms had also been provided and each had an assisted bath, a shower and a shower bed. Wall mounted hand cleaning products were available throughout. Inspectors saw evidence that all staff had received training from a clinical nurse specialist in infection control. This training included hand hygiene, waste management and environmental cleaning.

An audit of hygiene and control of infection had been completed in April 2015 and the results had been implemented.

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

Findings:
On 16 December 2014, the Authority received unsolicited information related to allegations of poor practice and practices that could constitute the abuse of residents in specific units in this designated centre. This resulted in two unannounced inspections on 19 December 2014 and 27 January 2015. While allegations of abuse at the centre were in the process of being investigated, the provider had failed to demonstrate that adequate safeguards had been put in place.

Since the previous inspection, the provider had taken a number of steps in line with their previously submitted action plan to address the areas of concern. This included but was not confined to: the commissioning of an investigation by an external party, which was on-going at the time of inspection; the provision of up-to-date training for all staff in relation to the protection of vulnerable adults and; support for staff in relation to care planning, personal planning and how to manage and respond to any complaints. In addition, staff had been supported in relation to how to raise any concerns that they might have. However, further action was required by the provider to ensure that adequate safeguards were in place. Specifically, staff did not articulate an understanding or acceptance that abuse may occur in the centre. This carries an associated risk that allegations may not be reported in the future and consequently, investigated. The Authority was not re-assured by the action plan response by the provider to this failing.

The organisation had policies in place in relation to the protection of vulnerable adults, the management of behaviour that challenges, restrictive practices and intimate care.

Inspectors reviewed a sample of behaviour management plans and found that they

demonstrated a positive approach to behaviours that challenge and included positive supports such as the use of distraction and relaxation techniques. However, it was not demonstrated how MDT input into the development and review of behaviour management plans was sought as required. In addition, while permanent staff had received up-to-date training in relation to the management of behaviour that challenges, agency staff (including regular rostered staff) had not.

Improvement was required to the oversight and management of restrictive practices in the centre. Not all practices were acceptable, as a tray was observed to be secured in place with knotted straps. Inspectors reviewed a number of restrictive practice documents and found that they were not acceptable. For example, where physical holds had been approved to take bloods, the approved procedure had not been clearly outlined and risk assessment data had not been completed. MDT approval was not always evidenced. Improvements had however been made to the management of bedrails; alternatives such as crash mats were in use, risk assessments had been completed and checks were completed and documented when bedrails were in use.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
The person in charge is required to notify the Chief Inspector within three working days of serious adverse incidents and this requirement had been complied with. The person in charge is also required to provide a written report every three months and include details of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. Some restrictions had not been reported as required.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Residents' opportunities for new experiences, social participation and skills development were supported. Continuity of services was maintained for residents in transition.

While residents' needs and wishes in relation to general welfare and development were considered as part of a wider health assessment, a comprehensive assessment to establish each resident's personal or skills development goals had not been completed. This was previously addressed under Outcome 5: Social Care Needs.

Residents engaged in activities that suited their individual needs and capacities. Most residents attended day services either on- or off-campus including activation and skills development programs. Activation was also run in the centre and the inspector observed specific individually tailored activities including art, tabletop activities, reading, the use of memory boxes and photo albums, music and hand massage.

Where residents had been temporarily unable to attend their day service, the day service place had been maintained until such time as residents were able to resume receiving their day service .

Inspectors found that the focus on activation and skills development programs reflected the abilities of the residents, was meaningful to the residents and was enjoyed by the residents.

Judgment:
Compliant

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):

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

Findings:
The inspectors reviewed a sample of resident healthcare files and found that the synopsis of healthcare needs identified in the resident profile provided clear direction to staff in the management of the residents' healthcare needs.

The healthcare files evidenced timely access to general practitioner (GP) services. There was also evidence that residents were supported to attend appointments and had been referred to consultant specialists in acute hospitals as required. There was also evidence of timely access to specialist care in psychiatry.

Residents had access to allied health care services. Mobility assessments and exercise plans had been prescribed as required by a physiotherapist. Where required, some residents had been reviewed by an occupational therapist in relation to seating and the provision of appropriate chairs. Inspectors saw evidence of reviews of assessment by the speech and language therapist with reports detailing recommendations and advice on food consistency. Where required, residents had been referred for further evaluation in an acute general hospital. Detailed reports were kept in the healthcare record. Current nutritional assessments, completed by a dietician, were available for a number of residents. Inspectors reviewed a nutrition care plan in relation to one resident who had percutaneous endoscopic gastrostomy (PEG) feeding tube. There were clear instructions in relation to the volume of nutrition and liquids to be provided over a 24-hour period. There were records to show that the water levels on the tube were being checked weekly. Review sheets following re-insertion of the gastrostomy tube were also available.

Staff outlined the steps that were taken where a resident had to be admitted to hospital either for a day-case procedure or a longer stay. Each resident had an acute hospital communication booklet which was available in case a resident had to be admitted to hospital which outlined things that hospital staff needed to know about the resident. There had been a number of recent admissions to an acute general hospital. There was evidence that following each admission all relevant information regarding the treatment received while in hospital was obtained by the centre. Both medical and nursing treatment letters from the hospital were available on file.

There was a policy on nutrition and hydration. There was a menu plan available on a two weekly basis. Staff outlined that if residents attended day service their lunch was provided there but otherwise staff prepared the meals for residents. Inspectors saw that the food was properly and safely prepared. The food as prepared by staff appeared wholesome and nutritious. Where residents required assistance, this was offered discreetly.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Since the last inspection, nursing staff were now able to demonstrate knowledge of the contents of the policy on medication management. There was also evidence that since the last inspection that adverse reactions to medications were being recorded and the GP was being informed of such reactions. Each prescription sheet recorded if residents had known allergies to medication. There was a list available to staff of all known medication allergies for residents.

The inspector found that the practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais. Medication prescription records did not contain the signature of the nurse who transcribed the record. Transcribed medication prescription records did not clearly outline the dose to be administered or the start date. In addition there was no audit of transcribing practice as recommended by An Bord Altranais agus Cnámhseachais (Bord Altranais).

Medication was dispensed from the pharmacy. The medication was checked by nursing staff on delivery from the pharmacist. It was kept securely in a locked cabinet. There was separate storage of as required (or PRN) medication. Some of these medications were creams that were applied as required. There was no indication on one corticosteroid cream as to when it was opened for the first time and so the effectiveness of the medication could not be guaranteed. There was specific recording of any time as required medication was administered which meant that the practice could be monitored.

Where required, residents had a specific medication care plan relating to the administration of medication via a percutaneous endoscopic gastrostomy (PEG) feeding tube. The pharmacist had provided to staff a list of the resident's medication and instructions regarding these medications.

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):
No actions were required from the previous inspection.

Findings:
There was a written statement of purpose the outlined the aims, objectives and ethos of the centre and the services provided in the centre. However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The specific care needs that the centre is intended to meet were not specific; the facilities which are to be provided to meet those care needs were not detailed; the criteria used for admission was not clear; the number, age range and gender of the residents required review; room sizes were not included, either in narrative form or a floor plan; the total staffing complement did not specifically mention the person in charge or the provider nominee; the organisational structure of the centre was not included; the arrangements for therapeutic techniques was not accurate; the arrangement for access to education, training and employment were not included; the arrangements for consultation required review; it was not clear whether the centre accepted residents of all faiths or none; the arrangements for dealing with complaints required review and finally; the fire precautions were not sufficiently detailed.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

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

Findings:
While improvements had been made to address the failings in relation to the governance and management of the designated centre since the previous inspection, the provider had not demonstrated that the systems in place in the designated centre ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

There was a newly appointed provider nominee in the service since the previous inspection. The provider nominee had engaged with the Authority and demonstrated a willingness to address identified failings. Actions had been and were being completed in line with the action plan proposed by the provider and accepted by the Authority following the previous inspection.

Since the previous inspection, action had been taken to ensure that staff felt safe to raise concerns. For example, the Assistant Chief Executive Officer (A/CEO) had met with all senior managers to reiterate their responsibilities in relation to facilitating staff to raise concerns and managing any concerns raised. The provider nominee had met with all staff in relation to how concerns are managed. Additional steps to ensuring that there are no barriers to raising concerns have commenced since the previous inspection including regular 1:1 communication meetings between staff and their line managers.

However, the systems for review of quality and safety in the centre was not satisfactory. While an annual review of the quality and safety of care in the designated centre had been completed, it was not clear how the review provided for consultation with residents and their representatives nor had a copy of the review been made available to residents and/or their representatives. The provider or provider nominee had not carried out an unannounced visit to the centre at least once during the previous six months, as required by the Regulations. As a result, there was no written plan to address the concerns regarding the standard of care and support previously discussed under Outcome 8 and also, to ensure professional responsibility for the quality and safety of the services that were being delivered to residents.

Also, while information in relation to complaints and incidents was gathered, it was analysed at service level only. As a result, analysis of any trends was not completed in the designated centre to identify and address any areas for improvement.

The person in charge is a registered nurse in intellectual disability and general nursing. The role of the person in charge was full-time and she was the person in charge for this designated centre only. Staff were able to identify the person in charge. Relatives were able to identify the person in charge. Further improvement was required to ensure accountability and responsibility of the person in charge for the provision of the service. Gaps in relation to the setting of residents' goals and restrictive practice documentation were previously discussed under Outcomes 5 and 8. The person in charge did not complete audits or reviews of care plans or personal plans. Also, there were no formal arrangements in place for a deputy in the case of the absence of the person in charge.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
There had been no cases where the person in charge had been absent from the designated centre for 28 days or more since commencement of the Regulations. The provider nominee was aware of the requirement to notify the Authority of any such absence within specified timeframes.

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

Findings:
Resources had been deployed to carry out necessary work in the centre. As previously mentioned, upgrading had been completed since the previous inspection. In each of the four units, substantial upgrading had been completed, including a new accessible shower room with toilet and wash hand basin and separate accessible bathroom with appropriate equipment.

A maintenance book was maintained for any minor repairs that were required.

In addition, the facilities and services in the centre reflected the statement of purpose.

The provider nominee said that a review of resourcing was underway and would include a review of contact time and nursing hours to meet the needs of residents. This will be further discussed under Outcome 17: Workforce.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
There were appropriate staff numbers to meet the assessed needs of resident at the time of inspection. Skill mix and staff qualifications in the centre required review. Not all staff regular had up-to-date mandatory training in fire safety or the management of behaviour that challenges.

A review of residents' individual staff support needs was completed since the previous inspection. Inspectors spoke with a number of staff who said that levels were sufficient to allow them to carry out activities and allow for 1:1 time with residents, where needed. A new member of household staff was due to commence work in the centre by the end of the month. An additional staff nurse had commenced on night-duty since an inspection in December 2014. An actual and planned staff rota was maintained and indicated who was in charge at any one time. According to the roster, staffing levels were being maintained as planned. However, given the high medical needs of residents in the centre, it was not clearly demonstrated how the provider ensured that the number of nursing staff (including at CNM1 level) met the assessed needs of the residents. The provider nominee told the inspector that this was currently under review.

The provider nominee had previously identified the need to ensure that the skill level of all staff in the centre was of a sufficient level to meet the assessed needs of residents. The provider said that a funded plan was in place to ensure that all non-nursing staff have a minimum training course at FETAC Level 5, or equivalent, relevant to the role of healthcare assistant.

A training needs analysis had been completed since the previous inspection. While

permanent staff had received up to date mandatory training, agency staff (including regular rostered agency staff) had not received mandatory training in relation to fire safety or the management of behaviour that challenges. Staff had received other training in relation to their roles including food safety, infection control training and manual handling training.

There was a system in place for the induction of new staff an induction log was completed for new staff members. This included centre policies, routines, observation skills, incident reporting and fire safety. The person in charge told the inspector that new staff were supervised according to their roles.

There was a policy in place for the management of volunteers, the implementation of which was overseen by a volunteer coordinator. This involved ensuring that all volunteers had their roles and responsibilities set out in writing and that volunteers submitted references and a vetting disclosure.

Staff files were reviewed in the central offices by an inspector and the sample viewed were found to meet all of the requirements of Schedule 2 of the Regulations.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
While there was a records management policy in place, the management of healthcare records required improvement.

There were two sets of resident records; the personal plan and a separate file for medical records. While the personal plan is outlined in more detail in Outcome 5, it also contained some recent medical information, including for example reviews by speech and language therapists. This information was used to inform plans of care for identified

healthcare needs. The 'medical file' included reviews by the general practitioner and reviews by consultant specialists in acute general hospital. In some medical files, healthcare information was filed in plastic pockets. This system did not adequately ensure that relevant healthcare information was available to plan care for residents. For example, a plastic pocket in one resident's file contained contradictory instructions regarding the resident's need for oxygen. The medical file also contained a synopsis of GP and consultant specialist reviews and any time contact was made with healthcare professionals. It was not always clear if the plan of care was being updated following these telephone conversations.

Inspectors saw that the communication diary for one of the houses contained a number of original healthcare appointment records. These appointments were filed loosely in the diary and this practice could not guarantee the confidentiality or security of residents' personal information. In addition, it was not always clear if the plan of care for these identified healthcare needs was being updated following these healthcare appointments.

A directory of residents was maintained in the centre and was made available to the inspector.

A copy of the residents' guide was available to residents and it met the requirements of the Regulations.

Most, but not all of the policies and procedures as required by the Regulations were available. However, the policy on prevention, detection and response to abuse did not adequately address how anonymous allegations of abuse of residents would be managed. While the centre had infection control guidelines, there was no infection control policy in place. Finally, the policy in relation to access to education, training and employment had yet to be implemented.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Date of Inspection:	12 May 2015
Date of response:	08 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The internal advocacy arrangements were inadequate. It was not demonstrated how the advocacy committee was representative of residents.

Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
Staff and managers from the centre will attend the Advocacy training on 24/06/2015.All service users in the centre will attend a meeting/ information session in the centre, chaired by the person in charge and the house manager to share information on advocacy and its benefits to each service user.
A service user representative will be invited to be a member of the service advocacy committee, and will be supported by a staff to attend.

Proposed Timescale: 08/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The logging of complaints did not always demonstrate that complainants were informed promptly of the outcome of their complaints and details of the appeals process. As a result, practices were inconsistent.

Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
A further training session will be delivered to all staff in the centre by the nominee provider to support better practices in the management of complaints, including the logging of complaints, addressing the complaint, feedback to the complainant and detailing the appeals process available to complainants. The training will focus also on the satisfaction of the complainant with the outcome of the resolving of the complaint.
A new complaints logging book has been introduced into the centre, and will be included in the training session to all staff.

Proposed Timescale: 09/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment, by an appropriate health care professional, of the residents' healthcare needs had not been carried out as required to reflect changes in need and circumstances. For example, where a resident had been in hospital, an up to date assessment had not been completed and their care plan had not been updated accordingly.

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:
All service users care plans will be reviewed by the person in charge, the house manager and with the support and training input from the clinical nurse manager 3. Where a change in care needs is identified an assessment will be completed by a registered nurse and a multi disciplinary team member where required, and changes in care need that have been identified will have plans of care set out. The plan of care will have review dates as necessary depending on the service users care needs, and changes in same. The person in charge will monitor and the CNM3 will audit the effectiveness and ensure the completion of these assessments and plans of care, and reviews as recommended.

Proposed Timescale: 17/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not suitable for the purposes of meeting the assessed needs of each resident.

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

Please state the actions you have taken or are planning to take:
An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. The house will accommodate 4/5 individuals in total. Residents from group A and one other designate centre, will be prioritised to determine who will reside in the new centre. The service users who will move from Group A will be determined through a service user review group which will include participation from the service users and families. The review group has commenced on 20/03/2015. An individual service users who's needs are not being met currently in the centre is having his accommodation needs reassessed. There are meetings in progress with the HSE, the centre Person in charge and nominee provider, the service user is being represented by an independent advocate. The purpose of these meetings is to examine how the centre with the HSE can attain a more appropriate accommodation / house for this resident that will better meet his needs.

The Authority did not agree the action plan response to Regulation 5(3) with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 30/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews were not multidisciplinary.

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

Please state the actions you have taken or are planning to take:
The service has commenced the recruitment process for a psychologist to support residents in the centre. A review of the occupational therapist support required to support needs of residents is being completed by the service and this support will be contracted for service users in the centre as required.
These additional multi disciplinary team members will be included in the development of the person's personal plan, and will make recommendations where relevant. These team members will complete assessments for individual service users, and plans of care will be set around same. These assessments will have review dates and responsible staff to action same.

Proposed Timescale: 30/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment to establish each resident's personal or skills development goals had not been completed. In addition, the planning, review and documentation of goals did not meet the requirements of the Regulations.

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

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

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

Proposed Timescale: 31/08/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some equipment used by residents was unclean and in need of repair.

Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
All service users' equipment will have a cleaning schedule with log to be completed. This will be developed and monitored by the person in charge. The key worker for each individual will be the named responsible person for ensuring that the cleaning is carried out. Where equipment is in need of deep cleaning, and external contractor will be sourced to complete this work.

The person in charge will refer all equipment in need of repair to the relevant contractor, or the occupational therapist whichever is relevant to the particular piece of equipment.

While all staff in the centre have received training in infection control and hand hygiene, the newly appointed CNM3 will give further support to the person in charge and the staff team, around infection control and maintaining high standards of cleanliness to service users personal items and pieces of equipment.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, 15 of the 31 bedrooms were limited in size. Given the level of physical needs of the residents in one unit, the bedroom sizes presented challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
The HSE have been made aware in 2014 and again on the 28.01.2015 of the unsuitability of the premises
The ACEO and the Director of Logistics met on the 29.01.2015 to determine a phased cost plan in order to meet the requirements under schedule 6 and submit costings to the HSE for additional funding.
The Director of Logistics has audited and accessed the maintenance requirements in all the houses in the centre in February 2015.
An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. The house will accommodate 4/5 individuals in total. Residents from group A and one other designate centre, will be prioritised to determine who will reside in the new centre. The number of residents in Group A will decrease, the service users who will move from Group A will be determined through a service user review group which will include participation from the service users and families. The review group has commenced in March 2015.
Currently areas linked to the centre provides office space to employees, these areas will be redirected back to the centre for service user use, to enable increased options for living space for service users.
There is a large reception area to the centre which will be refurbished to create an additional shared living area for service users and their visitors, with open and safe access out onto the garden area.
The Director of Logistics and nominee provider and PIC have reviewed each area in the designate centre and identified storage space in each area, these spaces will be kitted out for storage for the area.
As a congregated setting, the organisations' plan is to reduce the number in the centre to 6 service users per house by the end of 2016.
The plan of works for the centre includes changing of all the doors and replacing them with new doors. All damaged and marked walls will be repaired and painted.

The Authority did not agree the action plan response to Regulation 17(1)(a) with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the premises were in a poor state of repair. For example, walls and doors throughout each unit had been visibly marked and damaged by wheelchairs.

Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound

construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The plan of works for the centre includes changing of all the doors and replacing them with new doors. All damaged and marked walls will be repaired and painted. The person in charge will coordinate the painting and minor maintenance works with the maintenance supervisor. The provider nominee and Director of Logistics will progress the refurbishment plan that is set out for the centre.

Proposed Timescale: 30/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not adequately meet the individual need for space of one resident nor did it provide suitable communal space for all residents. In addition, suitable storage was not provided in the centre.

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:
Currently areas linked to the centre provides office space to employees, these areas will be redirected back to the centre for service user use, a larger bedroom can be provided from this area for one service user and a quite place for service users who wish to spend time alone away from others. There is a large reception are to the centre which will be refurbished to create an additional shared living area for service users and their visitors, with open and safe access out onto the garden area.

There is one resident in the centre whose needs are not provided for due to the environment. This service user is prioritized with the service user review group and the HSE in order to provide a suitable residential placement for this resident.

The Authority did not agree the action plan response to Regulation 17(7) with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 30/12/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to the identification of hazards, the completion of risk assessments and the monitoring and review of risk. For example, some risk assessments had not been completed.

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

Please state the actions you have taken or are planning to take:
A CNM3 from another part of the Service will support staff in the house with onsite training in relation to the identification of hazards and risks and control measures. This CNM3 will also support the staff in the completion of centre specific, and service user specific, risk assessments; this will include a risk assessment around the proper storage of latex gloves.

The Person In Charge and House Manager will also receive refresher supports, from the CNM3, on the weekly walkabout hazard inspection checklist. This input will be delivered to staff in the centre on the 04/06/2015.

The centres manual handling practices will be reviewed for each service user requiring this support by the manual handling instructors. This will be arranged by the person in charge.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Manual handling techniques were being used which were outdated and unsafe and carried a risk of injury to residents.

Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The centres manual handling practices will be reviewed for each service user requiring this support by the manual handling instructors. This will be arranged by the person in charge. Where the support of the occupational therapist is needed in this review of practices it will be sought through referral.

A Cnm3 from another part of the organisation is giving support to the centre on 04/06/2015 around the completion of risk assessments, service users requiring risk assessment of their manual handling needs will have same completed with the support of the CNM3 and the manual handling instructor.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not accurately describe or reflect the procedures in place for hazard identification and risk assessment in the designated centre.

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

Please state the actions you have taken or are planning to take:
A service Health and Safety Officer will with the nominee provider and the person in charge review the Risk Management Policy in the centre, and amend it to include clear guidance and reflect the procedures in place for hazard identification and risk assessment in the centre.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not provide sufficient guidance for staff in relation to the management of behaviour that challenges. For example, the procedures in place in relation to behaviour support plans were not clear.

Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
A service Health and Safety Officer will with the nominee provider and the person in charge review the Risk Management Policy in the centre, and amend it to include clear guidance and reflect the procedures in place for the development and implementation of behaviour support plans and also measures in place to support people that present with behaviours that challenge and control measures to manage incidents of aggression and violence.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include learning from incidents.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A service Health and Safety Officer will with the nominee provider and the person in charge review the Risk Management Policy in the centre, and amend it to include clear guidance and reflect the procedures in place for the identification, recording, investigation of and learning from incidents and adverse events that involve service users.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the bathrooms did not have facilities for drying hands.

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

Please state the actions you have taken or are planning to take:
There is a supply of paper handtowels now available to all bathroom and toilet areas in the centre. There has been a household staff employed for the centre, her daily checklist of works includes ensuring that hand wash and the hand drying towels are available in all these areas. This is monitored by the person in charge. All staff in the area have completed the hand hygiene training and is scheduled for refreshers as appropriate by the person in charge.

Proposed Timescale: 29/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where a fire risk assessment had been recommended for one resident, there was no evidence in the resident's file that it had been completed

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

Please state the actions you have taken or are planning to take:
A Cnm3 from another part of the organisation is giving support to the staff in centre and the person in charge on 04/06/2015 around the completion of risk assessments, service users requiring risk assessment to support any aspect of their care needs will have same identified and completed with the support of the CNM3. The person in charge will monitor that risk assessments are in place and will complete quarterly audits on same to ensure they are up to date and include changes or new control measures where appropriate.

Proposed Timescale: 30/07/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was unable to confirm whether agency staff had received fire training.

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

Please state the actions you have taken or are planning to take:
All agency staff working in the centre will receive the service fire training and also training specific to the procedures in place in the designate centre

Proposed Timescale: 22/06/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not demonstrated that effective fire safety management systems were in place. A risk assessment by a competent professional was not available for all four houses that considered whether adequate precautions were in place against the risk of fire in the designated centre.

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

Please state the actions you have taken or are planning to take:
A risk assessment of all four houses in the designate centre will be completed by the Service Director of Logistics who is also fire engineer, this risk assessment will include a full review of remedial works required to bring the centre in line with all relevant fire safety legislation.

Proposed Timescale: 03/07/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While permanent staff had received up-to-date training in relation to the management of behaviour that challenges, agency staff (including regular rostered staff) had not.

Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
All staff are scheduled to attend training in relation to the management of behaviours that challenge. In addition to this training a nurse from another part of the service who is an instructor for the therapeutic Management of Aggression and Violence is supporting staff in the centre, to identify behaviours and develop comprehensive behaviour support plans for service users requiring same. This support is given to all staff in the centre. There are a number of staff from the centre on long term leave who will complete the training on their return to work.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While allegations of abuse at the centre were investigated, the provider had failed to demonstrate that adequate safeguards had been put in place.

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:
Following inspection all staff in the centre and the person in charge attended a meeting with the nominee provider, where the nominee provider outlined the seriousness of staff not understanding or accepting that abuse of service users in the centre may occur. The process for reporting a concern was highlighted to all staff. The person in charge will bring the issue of the welfare of service users to all staff meetings in the centre, reiterating at every meeting the vulnerable adults that are residing in the centre and the obligation on staff to be open to recognising and reporting any concerns of abuse. It has been highlighted to all staff and the person in charge in the centre that failure to be accept that abuse may occur, and therefore not observe for concerns of abuse will result in disciplinary action of those involved. Since the inspection there has been a CNM3appointed to the service, with responsibility to the centre. The CNM3 will attend all unit meetings, where at all meetings the importance of being open to recognising that all service users in the centre are vulnerable to abuse from staff and others and therefore all staff must be constantly aware of this. The CNM3 will monitor staff and the person in charge awareness of this.

The Authority did not agree this action plan response with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 14/05/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some restrictions had not been reported as required.

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

Please state the actions you have taken or are planning to take:
All restrictions will be reported at the end of each quarter by the person in charge. The person in charge will be a member of the restrictive practices committee for the centre and will with the committee make changes to the restrictive practices register for the centre as appropriate. The staff and person in charge in the centre will refresh themselves on the restrictive practices policy at the next staff meeting in the centre in June.

Proposed Timescale: 30/07/2015

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 practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais.
- Transcribed medication prescription records did not clearly outline the dose to be administered or the start date.
- It could not be demonstrated that all medicines were administered as prescribed. For example, there was no indication on one corticosteroid cream as to when it was opened for the first time nor was there specific recording of any time as required medication was administered.

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

Please state the actions you have taken or are planning to take:
The medication management documentation with regards to transcribing will be reviewed by the person in charge, medication management co coordinator, the director of nursing and a pharmacist to bring the practice in line with An Bord Altranais agus Cnaimhseachais na hEireann.

The document will be brought to the service Drugs and Therapeutics committee, where changes will be agreed , signed off and it will be included in the service policy on medication management.

Further training will be delivered to staff in the centre with emphasis on the administration and prescribing of medication. All medications prescribed will have a time for administration recorded on the medication prescription record.

The medication management co coordinator and the Director of Nursing and the CNM3 appointed to the area will monitor and audit the medication practices in the centre.

Proposed Timescale: 30/08/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be reviewed to include all information required. It will be reviewed by the person in charge and nominee provider.

Proposed Timescale: 16/06/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to ensure accountability and responsibility of the person in charge for the provision of the service.

Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The nominee provider is supporting the person in charge with a performance improvement plan, addressing different aspects of the role that need improvement. There are identified areas for improvement with actions to support the person in charge to achieve improvement in the areas identified. Amongst areas for improvement are, monitoring of staff, auditing of practices, communication with staff, taking responsibility for overseeing practices, highlighting and being involved in the addressing of issues that arise. There are set review dates for each area identified.

Proposed Timescale: 30/08/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to the management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. As discussed under outcome 5, the service was not appropriate to all residents' needs. As discussed under outcome 8, it had not been

demonstrated that the service provided was safe. Also, improvement was required in relation to reviewing quality and safety in the centre.

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

Please state the actions you have taken or are planning to take:
Since the inspection date, a clinical nurse manager 3 has been appointed into post. This manager as part of her management role will provide direct support to the centre staff and the person in charge. There will be a daily communication between the person in charge and the clinical nurse manager 3, but also there will be formalised communication meetings, with a focus on monitoring practices in the centre, ensuring they are of a high standard. The Clinical nurse manager 3 will support the person in charge and complete audits of practices in the area in the areas of care planning, person centred planning, risk assessments, hygiene standards, documentation and report writing, medication practices.

The provider nominee will have formalised monthly meetings with the person in charge and the clinical nurse manager 3, as well as unscheduled meetings and unannounced visits to the centre.

In the case of the absence of the person in charge for greater than 28 days the Clinical nurse manager 3 will be the person in charge of the centre for that time.

Proposed Timescale: 29/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the annual review of the quality and safety of care and support in the designated centre provided for consultation with residents and their representatives.

Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
A copy of the annual review will made available to all families and service user representatives by the person in charge. The nominee provider will include consultations with the service users, their families and representatives in review of the quality and safety of care in the centre in future reviews, these consultations will be in a meeting format at service users meetings and a meeting with families and representatives at the centre.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the annual review was not made available to residents, their family or representative.

Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
The annual review will be available and shared with families and representatives of the service users by the person in charge. The person in charge will outline the review findings to the service users at the service user meeting in June. The nominee provider will schedule a meeting with families and representatives of the service users in the centre to include as an item on the agenda the annual review and its findings and actions to be completed from same. The nominee provider will complete the provider audit detailing findings of unannounced visit to the centre, 6 monthly and annually.

Proposed Timescale: 30/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Given the high medical needs of residents in the centre, it was not clearly demonstrated how the provider ensured that the number of nursing staff (including at CNM1 level) met the assessed needs of the residents.

Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
The Service Human Resources Director, Nominee Provider, Person in Charge and Clinical Nurse Manager 3 are reviewing staffing in the centre. Service users' support needs will be the basis of this review to ensure that appropriate skill mix and safe practices are in place, this process commenced on 20/06/2015. The review will include reviewing the existing roster and ensuring that staff hours are rostered in the most

effective manner possible to meet the service user needs.

The service is committed to ensuring that appropriate skill mix is in place to ensure the assessed needs of residents are met.

Proposed Timescale: 30/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all regular staff had up-to-date mandatory training.

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

Please state the actions you have taken or are planning to take:
The person in charge will review all staff training records with the training coordinator. All staff in the area will be scheduled to attend mandatory training and refresher dates will be scheduled for staff in the centre. The person in charge in the centre will monitor staff training on an ongoing basis, ensuring that all staff training is up to date. Where training is out of date the nominee provider will ensure external trainers are contracted in to deliver training where necessary.

Proposed Timescale: 30/08/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
- The policy on prevention, detection and response to abuse did not adequately address how to respond to anonymous allegations of abuse of residents.
- The centre did not have an infection control policy in place.
- The policy in relation to access to education, training and employment had yet to be implemented.

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:

There will be a service policy, specific to infection control, developed for the centre.

The policy in relation to access to education and training is now in place since the inspection in the centre. All staff will receive training around same, and in conjunction with day service staff an appropriate plan will be developed for each service user.

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

Proposed Timescale: 09/08/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of healthcare records required review to ensure that records were accurate, up-to-date, secure and easily retrievable.

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

Please state the actions you have taken or are planning to take:
All records pertaining to a service user's care and health care needs will be stored in one file, in the c entre where the resident resides. Where a clinician has recommended a plan of care for example the speech and language therapist, this plan and recommendations will be in the relevant section of the service users care plan where the staff in the centre will have also complete an assessment and plan of care in the care plan top reflect same.

All information, appointment cards etc will be stored in the service users care plan and will be secure there and easily accessible. No appointment cards or correspondence will be placed outside of the care plan at any time. All appointments for service users will have their dates noted in the centre diary.

Proposed Timescale: 05/06/2015