Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Group A - St Anne's Residential Services
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:	Simon Balfe
Lead inspector:	Julie Hennessy
Support inspector(s):	Geraldine Ryan
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 October 2016 09:30	18 October 2016 18:00
19 October 2016 09:00	19 October 2016 16:00

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the eight inspection of this designated centre by the Health Information and Quality Authority (HIQA). This inspection was carried out to monitor on-going compliance against the regulations and to follow up on significant non-compliances identified at the previous inspection. As part of this inspection, inspectors also followed up on actions from the most recent inspection in June 2016, a fire safety inspection in October 2015 and where relevant, outstanding actions from other inspections.

Description of the service:
The centre comprises four interconnecting dormer bungalows (or 'units') and is a congregated setting. The centre can accommodate 28 residents and mainly provides a service for residents with a severe to profound intellectual disability. There were no vacancies as the statement of purpose for the centre states that no further admissions will be accepted to the centre. A phased decongregation plan is being planned to move residents from this centre into community houses.

How we gathered our evidence:

Inspectors met with 27 residents who live in this centre over the course of the two days. One resident was in hospital at the time of the inspection. Inspectors met members of the staff team, the person in charge and clinical nurse managers (CNMs). The representative of the provider attended periodically during the inspection and was available when required. Inspectors observed staff practices and interactions between residents and staff and reviewed documentation such as personal plans, healthcare plans, risk assessments and training records.

Overall judgment of our findings:
There was a warm atmosphere in the centre. While most residents were non-verbal, staff supported residents to communicate their choices and wishes through their preferred means of communication. Staff were observed to interact with residents in an appropriate and supportive manner. Inspectors observed that nurse managers led by example and promoted a person-centred and respectful approach when supporting or communicating with residents.

Inspectors found that the provider taken a number of steps in an effort to bring the centre into further compliance with the regulations. Improvements were found in key areas of concern identified at the previous inspection that related to medication management, the meeting of residents' healthcare needs and governance of the centre.

However, inconsistencies were found in practices and standards between different units. In addition, a high use of agency staff during the summer months had impacted on residents' ability to access the community and staff described how some residents had been very unsettled by the unfamiliar and inconsistent staff. The provider was actively addressing this problem at the time of the inspection.

A number of outcomes remained at the level of non-compliance at this inspection:

Under Outcome 6: Safe and suitable premises, the design and layout of the centre did not meet residents' individual or collective needs in an acceptable way. With residents' increasing age and needs, the negative impact of the lack of space on individual residents was observed to be worsening in some units. The provider had been requested to submit a funded and time-bound plan to HIQA at a meeting in January 2016. While the provider was working with their main funder to progress this issue, such a plan has yet to be submitted to HIQA.

Under Outcome 7: Health, safety and risk management, oxygen cylinders were found to be stored unsafely and a plan in relation to the full completion of fire improvement works had yet to be submitted to HIQA.

Other non-compliances related to the finding that residents did not have adequate access to psychology or behaviour supports where required.

Findings are detailed in the body of this report and should be read in conjunction with the actions outlined 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Overall, the person in charge demonstrated that progress was being made to address previous failings in relation to assessments of residents' needs and residents' personal plans.

At the pervious inspection, it was found that the review of the personal plan was not multi-disciplinary. As a result, the link between a resident's assessed needs, their personal plan and their goals was not demonstrated. In addition, it was not demonstrated that the personal plan reviews assessed the effectiveness of each plan and took into account changes in circumstances and new developments.

Since the previous inspection, a multi-disciplinary assessment had been completed for each resident. Personal planning meetings were scheduled for all residents. The timeframe for completion of this action (of 1 November 2016) was behind schedule and the CNM1s confirmed that the timeframe would not be met. However, a schedule was in place to ensure that all personal plans would be reviewed by the end of November 2016. Inspectors reviewed a sample of recently completed personal plans. The review of the personal plan was multi-disciplinary.

Personal plans reviewed now reflected residents' assessed needs. Residents' goals were based on their assessed interests, needs and preferences. Personal goals considered all aspects of individual resident's lives and included supporting enhanced communication, family relationships and leisure activities. Those responsible for supporting residents' goals and timeframes to achieve those goals were specified. Goals were being tracked and monitored. There was evidence that residents had opportunities to explore new

experiences, such as trialling new therapeutic treatments, visiting the Garda training college or trialling water sports or soap-box racing.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
This outcome was inspected to determine what progress the provider had made in relation to providing a safe and suitable premises for residents since detailed failings relating to the premises were highlighted in a previous monitoring report of this centre (in 13 January 2015). The provider had been requested to submit a funded and time-bound plan to HIQA when invited to attend a meeting in the HIQA head office in January 2016. Overall, while the provider was working with their main funder to progress this issue, a fully funded and time-bound plan has yet to be submitted to HIQA.

The centre forms part of a congregated setting. There were four units (dormer bungalows) in the centre which were all of a similar size and layout. The ground floor of each unit comprised a kitchen (not accessed by residents), an open living room/dining space, one very small 'quiet room', eight bedrooms, one accessible shower room, one bathroom (with accessible bath), a staff/visitor toilet, an office and a storage room. The first floor contained the laundry facilities, a staff toilet and staff bedroom/office.

At previous inspections, it was 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. Due to the confined space in the premises, parts of the premises were in a poor state of repair with doors and walls visibly marked and damaged by wheelchairs. All units in the centre had limited storage space.

The provider had previously acknowledged in a submission to HIQA that the residential units in this centre were not appropriate to meet residents' needs. The provider had previously proposed to reduce the number of residents in each bungalow from eight to six by the end of 2016. At this inspection, there had not been any reduction in occupancy of the centre as a result of relocation of residents to a more appropriate

environment. While the provider was working with their main funder to progress this issue, a fully funded and time-bound plan has yet to be submitted to HIQA in relation to decongregation of this centre and ensuring that the service provided meets each individual resident’s assessed needs.

While some décor and upgrading works had previously taken place, particularly in the bathroom areas, it was again found on this inspection that the poor design and layout of the premises continued to have an impact on residents need for space and did not meet residents’ mobility needs or need for personal space. Seven residents in each unit shared a single communal space (the living/dining area). Inspectors observed breakfast in the four units. The living/dining room was cramped when residents were at the dining table. In one unit, increasing age and mobility needs of residents meant that residents were spending time in wheelchairs for their own safety. There was insufficient communal space to provide suitable alternative places for residents to go who did not interact positively with each other. Inspectors found that the noise levels were very high in some units, despite the fact that individual residents living in those units preferred a quiet or low arousal environment in relation to their own behaviour support needs.

The physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, approximately half of the bedrooms were limited in size. Given the level of physical needs of 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. In addition, the lack of space did not enable residents to circulate freely around their beds or staff to readily access both sides of the a bed in the event of an emergency. There was inadequate ventilation in some parts of the centre, with strong unpleasant odours lingering for extended periods of time.

As on the previous inspections, there was limited natural light in parts of the premises due to the design and layout of the units. Suitable storage areas for equipment was not available within units to accommodate the number of specially adapted wheelchairs and chairs assessed for use by residents.

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

Findings:

Overall, improvements were demonstrated in relation to the protection of residents from injury or harm, infection control and risk management. However, inconsistencies were found between different units. In addition, most but not all of the fire improvement works identified during a fire inspection in October 2015 as being required had been completed. However, oxygen cylinders were found to be stored unsafely and steps were taken by management to address this on the day of the inspection. The combined lack of a final plan in relation to fire improvement works and the unsafely stored oxygen cylinders meant that this outcome remains at the level of major non-compliance.

At the previous inspection, the systems in place for the assessment, management and ongoing review of risk required improvement. At this inspection, improvements were found in relation to risk management, although there were inconsistencies between units. For example, in one unit where residents' risk of falls had increased, a risk assessment had been completed and input from the occupational therapist sought and implemented. However, in another unit, while screening for risk of falls had been completed, a risk assessment had not been carried out to outline how falls would be prevented and managed for those residents concerned. Safe manual handling practices were observed.

A hazard was identified on the day of inspection in relation to the safe storage of oxygen. Oxygen cylinders were not stored safely, as they were stored in poorly ventilated areas along with combustible materials, including copious amounts of paper. A CNM1 responded promptly and made contact with appropriate in-house personnel in relation to sourcing an alternative storage place for the cylinders. However, this action had yet to be satisfactorily addressed at the close of the inspection.

At the previous inspection, the provider had not ensured that residents were protected from the risk of healthcare associated infection as one of the units was visibly unclean and a hoist sling was dirty and in poor condition. Since the previous inspection, a 'deep clean' had taken place. In addition, arrangements had been put in place to ensure that the centre was adequately cleaned on a daily basis. However, the standard of hygiene and implementation of these arrangements varied between units with one unit remaining less visibly clean than the others. Infection control audits had been completed since the previous inspection. However, where deficits were identified in the audit, a risk assessment had not been completed to determine the adequacy of the controls in place e.g. where it was identified that there was no hand hygiene sink in the clinical area. In addition, the adequacy of the cramped clinical area (which doubled as the office) had not been assessed.

As identified during a fire inspection in October 2015 and unchanged at this inspection, many fire resistant doors required replacement due to physical damage to the doors. The provider had retained the services of an external consultant to advise as to whether to repair or replace the damaged doors. Other failings identified at that inspection had been addressed following the issuing of an immediate action plan at the previous inspection. Failings relating to the non-fitment or incomplete fitment of the requisite intumescent fire and smoke seals of fire doors had been addressed and automatic fire detection had been installed to four storage rooms.

As identified during a fire inspection in October 2015 and unchanged at this inspection,

the arrangements for reviewing fire precautions were not adequate. Inspectors reviewed a sample of fire drill records. While some contained sufficient detail to review the fire precautions in place for an evacuation of the centre, records of more recent drills did not. For example, who was present at the time of the practice fire drill was not recorded.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Overall, staff supported residents to manage any behaviours of concern. However, the lack of access to behaviour support or psychological support continued to be a deficit in the service being provided to residents.

At this inspection, staff were observed to interact with residents in a warm manner. Inspectors found that nurse managers led by example and promoted a person-centred and respectful approach when supporting or communicating with residents. For example, inspectors observed that nurse managers did not engage in conversations with their colleagues while supporting residents during meal-times and they greeted and communicated directly with residents on entering their homes.

At the previous inspection, it had not been demonstrated that all alternatives had been considered before putting in place restrictive practices nor had it been demonstrated that this was the least restrictive practice that could be used. Following that inspection, the provider gave a timeframe of 1 September 2016 to ensure that all restrictive practices in the centre would be reviewed by the organisation's restrictive practices committee. This timeframe was not met. However, a date for completion of this review, while overdue, was confirmed as taking place on 11 November 2016.

At the previous inspection, it was identified that the full range of multidisciplinary supports were not available as required to support residents with behaviours of concern.

This falling was unchanged at this inspection. Some residents were observed to interact with each other in a negative manner. While staff endeavoured to manage this by keeping residents apart, there were limited options due to the limitations of the environment and single shared communal room in each unit. There was no input from a behaviour support specialist and/or psychologist into resident's' behaviour support plans. There was no date for when residents who had been identified as requiring behaviour support or psychological assessment would receive this support.

Input from other healthcare professionals had been provided in relation to other areas of need that were relevant to behaviour support. For example, support from speech and language therapy (SALT) considered communication requirements and support from occupational therapy reviewed certain types of restrictive practices. A positive approach to reducing restrictive practices in place was demonstrated for a number of residents. Where a resident had increasing behaviours of concern, other possible causes such as pain, constipation, dehydration and the effect of medications had been reviewed by the general practitioner (G.P.) and registrar to the psychiatrist. However, when other causes were ruled out, input from psychology was not available to support residents needs in this area.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Overall, improvements were found since the previous inspection in the meeting of residents' healthcare needs.

As previously mentioned under outcome 8, the full range of multidisciplinary supports were not available as required to support residents with behaviours of concern. Where other clinicians had recommended psychology support and referrals had been made, such support was not available for residents. While the provider's timeframe for completion of this action (of 1 November 2016) has not yet passed, the negative impact on residents was again found on this inspection. As such, this action will be included until such time as it has been adequately addressed.

At the previous inspection, the meeting of residents' healthcare needs was found to be

at the level of major non-compliance. Since the previous inspection, the provider had taken a number of steps to better support residents in this area. A multidisciplinary assessment of residents' needs had been completed. A full review of each resident's care plans was commenced. Quality care audits were completed and these showed increased compliance between the first and most recent audits. A review of staffing skill mix, as it related to healthcare needs, had also been completed. Care plans for some residents had yet to be reviewed and the CNM1 confirmed that the original timeframe for completion of this action would not be met. However, dates for completion of this action were planned and all would be completed in six weeks following this inspection (by the end of November 2016).

Inspectors reviewed a sample of personal plans that had been reviewed, as they related to healthcare. Information reflected residents' assessed needs. Clinical risk assessments had been completed for identifiable healthcare needs.

Care plans overall reflected recent reviews by members of the multi-disciplinary team. Care plans identified at the previous inspection as being particularly lacking in accuracy and direction had been updated, for example, to adequately reflect instructions by the prescriber of oxygen therapy. Where residents received nutritional support via percutaneous endoscopic gastrostomy (PEG), the risk of aspiration was now addressed adequately within the resident's care plan.

However, some further improvement was required to address failings also identified on the previous inspection.
Care plans were not up to date for all residents with the highest healthcare needs. For example, some gaps in monitoring weights for residents at risk of weight loss were observed. Other gaps in monitoring requirements were noted, such as in relation to PEG balloon checks. It was unclear either from staff or from the documentation whether some of these checks were in fact completed in the day service, whether they were due to residents' refusing on occasion or whether they had actually not been completed by staff. In addition, it was not evidenced that recommendations from allied health professionals in relation to re-positioning and exercises were being implemented. Finally, other improvements required included the need to direct staff to information that they required to support residents e.g. to assessments or reports by the dietician or speech and language therapist.

End of life care plans had been commenced or were being developed for residents, with involvement of their families and G.P. where appropriate. Further improvement was required to ensure that end of life care planning fully met residents' needs and respected their dignity, autonomy, rights and wishes.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Overall, the arrangements in place as they related to the safe management of medication had been reviewed and strengthened since the previous inspection.

At the previous inspection, a major non-compliance was identified. Medicines had been substituted without seeking clarification from the prescriber and the review of a medication-related incident was not adequate to prevent recurrence.

At this inspection, inspectors reviewed a sample of administration records that indicated that medicines were being administered as prescribed.

Inspectors also reviewed the systems in place for the management of medication errors and for auditing and oversight of medication management. Where there had been a medication error (involving the omission of a medication), a review of the system had taken place. Steps had been taken to prevent recurrence of the incident and learning from the error was demonstrated.

Medication audits had also taken place since the previous inspection. Inspectors reviewed a sample of the audits and found that all actions identified had been completed. In addition, arrangements were in place to ensure oversight of any audit findings and a clinical nurse manager had followed up to ensure that identified actions had been completed.

Judgment:
Compliant

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:
Overall, the provider had taken a number of steps to strengthen the systems of governance and management arrangements in the centre.

At the previous inspection, the management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. At the time of the inspection, the CNM3 (clinical nurse manager) was also the person in charge of the centre. The CNM3 was suitably qualified and experienced to fill the role of the person in charge. A recruitment process was well advanced to allow for the separation of these two roles (i.e. a new person in charge was in the process of being recruited, who would be supported by the CNM3). There was now a CNM1 in each of the four units. CNM1s were meeting regularly themselves and there was evidence of shared learning. Where vacancies arose (particularly as they related to staff nurse and clinical nurse manager roles), suitable deputising arrangements were being promptly put in place.

As previously mentioned under outcome 11, steps had been taken to ensure that residents' healthcare needs were being met in a safe manner as this was identified as a key failing at previous inspections. A multidisciplinary assessment of needs had been completed for each resident and personal plans were now reflecting residents' assessed needs. A plan was in place to ensure that each residents' personal plan and care plans would be fully reviewed by the end of November 2016 (six weeks time). Audits of care plans were being carried out and demonstrated improved compliance. Other systems had been strengthened, including those in relation to infection control and medication management. However, and as previously mentioned, inconsistencies were found between different units in relation to the management of risk and the standard of cleanliness. As a result, adequate oversight of the quality and safety of care being provided in the centre was not demonstrated. The person in charge demonstrated an understanding of how to improve oversight and management of the centre. For example, weekly meetings with CNM1s in each house were being arranged with the objective of enhancing communication, ensuring consistency in practices and monitoring practices in the centre.

The provider had ensured that a review of the quality and safety of care in the centre was completed and a report was dated 4 April 2016. Areas for improvement were identified, with actions rated by priority. The provider representative told inspectors that a second review was scheduled to be completed.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff

have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Overall, while staffing levels at the time of the inspection were adequate to meet residents' needs, the workforce planning system did not ensure that this was always the case.

At the time of the previous inspection, the provider was in the process of carrying out a review of staff skill mix in the centre. Since that inspection, the review had been completed along with a human resources (HR) audit of staffing, qualifications, competencies and skill mix. At this inspection, it was found that the centre had almost the full complement of staff. The remaining gap related to a vacant staff nurse position on night-duty, which was in the process of being filled. In the interim, arrangements to provide suitable cover were in place. However, both staff and management told inspectors that the number and skill mix of staff over the the summer months was not adequate and there had been a high use of agency staff. Staff and management described impacts on residents, such as significant difficulties supporting residents to leave the campus and some residents had reportedly been very unsettled by the number of unfamiliar and inconsistent staff. The provider had taken steps to address this problem. A HR planning meeting had taken place with the provider representative and clinical nurse managers and further planning meetings were scheduled to ensure that residents needs would be met in a consistent way going forward.

At the previous inspection, training records indicated that not all mandatory training and training required to support residents needs had been completed or was up-to-date. At this inspection, training records again indicated gaps in training. For example, refresher training was scheduled for staff who required updated training in manual handling, hand hygiene, dysphagia (for residents at risk of choking) and fire safety. A number of staff required training in positive behaviour support (for example, seven staff of 13 in one unit required this training). A training programme for care staff in the use of oxygen therapy was under development.

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

Findings:
At the previous inspection, it was found that space was limited on medicines administration records to ensure that adequate documentation of the medicines administered could be made by nursing staff. At this inspection, while that failing had been addressed, there was no legend on the medication administration sheet to guide nursing staff as to how to record certain actions for example, where a resident refused a medicine or where a medicine had been withheld.

Judgment:
Substantially Compliant

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

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0003944
Date of Inspection:	18 and 19 October 2016
Date of response:	16 January 2017

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 06: Safe and suitable premises

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, approximately half of the 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

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

staff in such confined spaces. In addition, the lack of space did not enable residents to circulate freely around their beds or staff to readily access both sides of the a bed in the event of an emergency.

1. 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:
An environmental review will be carried out and led by the Director of Logistics. It will consist of the Nominee Provider, Occupational Therapist, CNM3 and PIC. Each of the service users bedrooms will be reviewed with a view to indentify space requirements taking cognisance of rooms that are currently available. This will commence on the 30/01/17. Where it is identified that a room may provide more space for an individual service user, enabling both the service user and staff to move more freely around, the service user will be met with and their family / next of kin and offered an opportunity to move. This will be completed by 24/02/17.

An updated action plan with an acceptable timeframe for decongregation was submitted to HIQA on 21 October 2016 by the ACEO with a plan to reduce the number of residents in this centre within a three year period. The decongregation would be completed by 31/12/19. There has been no change to this plan.

Proposed Timescale: 31/12/2019

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.

2. 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 Registered Provider, PIC and Technical Services Manager will carry a monthly environmental audit throughout the centre. All walls and doors throughout the centre that are damaged will be repaired and maintained.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The centre did not adequately meet individual resident's assessed mobility, behaviour support or developmental needs nor did it provide suitable communal space for all residents.

In addition, suitable storage was not provided in the centre.

3. 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:
All service users have access to a separate recreational room within the centre. The PIC and CNM3 will review utilisation of this room. The purpose will provide a quiet time and space for those who require same. The service users will receive individual and group time if requested or depending on their individual needs. Timeframe: 28/02/2017.

The Registered Provider, Director of Logistics and Technical Service Manager are currently carrying out a review of the centre with a view to identifying suitable storage for wheelchairs and other equipment. Timeframe: 28/02/2017.

An updated action plan with an acceptable timeframe for decongregation was submitted to HIQA on 21 October 2016 by the ACEO with a plan to reduce the number of residents in this centre within a three year period. There has been no change to this plan. Timeframe: 31/12/2019.

Proposed Timescale: 31/12/2019

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:
As detailed in the findings, further improvement was required in relation to risk management to address inconsistencies between different units within the centre.

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

Please state the actions you have taken or are planning to take:
Safety statement and risk assessment audit was carried out by the Quality and Risk Officer on the 28/11/2016 which identified shortfalls in individual risk assessments. The Quality and Risk Officer provided feedback and local in-service training within each unit in the centre. The PIC and CNM3 will review progress on the actions required from the audit.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to ensure that residents were protected from the risk of healthcare associated infection. For example, inconsistencies were found between the standard of hygiene and cleanliness in different units. In addition, not all deficits identified in an infection control audit had been adequately assessed.

5. 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:
Infection control systems in one unit have been replicated across the centre. A new household staff member has commenced. A risk assessment was completed which identified shortfalls in the clinical area. Following from this areas have been identified for clinical and medical equipment storage.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for containing fires were inadequate. Many fire resistant doors required replacement due to physical damage to the doors.

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

Please state the actions you have taken or are planning to take:
The Service has repaired a number of doors and locks within the centre. The works on replacing the fire doors remain outstanding; costings have been submitted to the HSE to fund this project. In the interim there is ongoing maintenance overseen by the Technical Services Manager who will address or repair any damage as necessary.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drill records did not contain sufficient detail to adequately review the fire precautions in place for an evacuation of the centre.

7. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
A full fire drill evacuation took place on 26/10/2016. All service users and staff were evacuated within the recommended timeframe. A new fire drill records form which identifies the number of service users involved / present in a fire drill as per 2016 fire policy is in place.

Proposed Timescale: 26/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Oxygen cylinders were not stored safely, as they were stored in poorly ventilated areas along with combustible materials (e.g. copious amounts of paper).

8. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
The service is currently in the process of fitting out a room for the Oxygen Cylinder to be contained in. The room will be used only for the storage of the O2 and no other combustible materials will be stored in the room. The room will be well ventilated in accordance with BOC recommendations.

Proposed Timescale: 31/01/2017

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:
As detailed in the findings, a review of restrictive practices, while scheduled, was overdue. This review was required to ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered

before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

Please state the actions you have taken or are planning to take:
Two of the current units have had restrictive practice meetings with MDT input. The remaining two units will have their restrictive practice meetings scheduled for 31/01/2017

Proposed Timescale: 31/01/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings under outcome 8 and this outcome, the full range of multidisciplinary supports was not available as required to support residents with behaviours of concern.

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

Please state the actions you have taken or are planning to take:
Any service user with behaviours of concern will have their behavioural support plans reviewed by members of the MDT. This will ensure that all relevant information is up to date and compliant with their individual needs. The PIC and CNM3 will discuss and give guidance to all staff in the centre on identifying and dealing with behaviours that challenge. Interviews for a Psychologist took place in early December. There was a successful candidate. They are currently being processed by HR and will commence on 20th February 2017. Any service user who may require urgent psychology input will be reviewed by a psychologist from another part of the service prior to the commencement of the psychologist in February.
The PIC will review all incidents on a weekly basis. The CNM3 will link with the PIC to review the incidents and identify any concerns. All incidents will be brought formally to the monthly Governance meetings to be discussed and reviewed.

Proposed Timescale: 20/02/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to ensure that residents' healthcare needs were fully met. In particular, care plans were not up to date for all residents with the highest healthcare needs. Also, there were gaps in monitoring requirements. Other improvements were required to ensure that care plans clearly directed the care to be given to each individual resident. A number of care plans required review and clinical nurse managers confirmed that the timeframe for this action would not be met.

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

Please state the actions you have taken or are planning to take:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

AN audit was completed on all care plans by the Quality and Risk Officer and areas for improvement identified. Each service users care plan will be audited /reviewed by the PIC and CNM1 involved in the delivery of healthcare needs to ensure that actions required are completed. The PIC will link in with the GP to ensure that all relevant care is being given and any documentation required is being completed and audited on a regular basis. The PIC will ensure that the CNM1 in each area are updating plans and ensuring that they are reflective of all recommendations from healthcare professionals. Any recommendations by specific healthcare professionals will have a correlating plan of care implemented.

Proposed Timescale: 31/01/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further improvement was required to ensure that end of life care planning fully met residents' needs and respected their dignity, autonomy, rights and wishes.

12. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
Individualised end of life plans of care are being revised and developed for all service users taking into account their dignity, autonomy, rights and wishes.

Proposed Timescale: 28/02/2017

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 that the management systems in place were safe, consistent and effectively monitored, as evidenced by inconsistencies in standards between different units within the centre.

13. 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:
There is currently a new PIC and two new CNM1's in place from 19/12/2016. The PIC has oversight of the four units. They have clinical support from the CNM3 and Nominee Provider and Director of Nursing. The PIC will link with the members of the MDT and update all plans of care as required. There are Governance meetings with all PIC's the Nominee Provider and CNM3's on a monthly basis.

Proposed Timescale: 19/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, the number and skill mix of staff over the summer months was not adequate and had resulted in negative impacts on residents.

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

Please state the actions you have taken or are planning to take:
There is currently a new PIC and two new CNM1's in place from 19/12/2016. The PIC has oversight of the four units. They have clinical support from the CNM3 and Nominee Provider and Director of Nursing. A review of the skill mix and staffing was completed by the Director of Human Resources and the Nominee Provider. Interviews for vacancies within the centre were held in November. Individuals are currently going

through the HR process. Once the positions have been filled a further review of the staffing numbers and skill mix will be carried out.

Proposed Timescale: 28/02/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no legend on the medication administration sheet to guide nursing staff as to how to record certain actions e.g. where a resident refused a medicine or where a medicine was withheld.

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

Please state the actions you have taken or are planning to take:
The Medication and Drugs Committee carried out a review of the administration sheet. There is an agreed set of codes on the sheet, which guides nurses to document if a medication is refused or withheld.

Proposed Timescale: 28/11/2016