

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Dun Aoibhinn Services - Cahir
<b>Centre ID:</b>	OSV-0004727
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services South East
<b>Provider Nominee:</b>	Johanna Cooney
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
24 January 2017 09:30	24 January 2017 19:00
25 January 2017 09:00	25 January 2017 14:00

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**

Background to inspection:

The centre in its current configuration had not been previously inspected. The service unit was inspected as part of previous monitoring event in March 2016. Since that time the provider reconfigured the units and assigned this as a stand alone designated centre.

The centre forms part of an organisation which has a number of designated centres in the region and others nationwide. The purpose of the inspection was to determine the registration status of the centre.

### Description of the service:

The statement of purpose as detailed indicates that the service will provide long term residential care to 4 male residents with severe to profound intellectual disability, mental health and autism. This is a high support service.

While the original application was for five persons the provider took the decision during the process to reduce this to four. This was based on the assessed needs of the residents. At time of the inspection there was one shared care arrangement between the provider and family and one resident in another facility for treatment purposes.

The inspector found that the care practises, staff ratios and services available were in compliance with the statement as outlined.

The centre is comprised of a detached spacious dormer bungalow on its own grounds a number of miles from the nearest rural town.

### How we gathered our evidence:

The inspection was announced and took place over two days. A full review of all eighteen outcomes was undertaken. As part of the inspection the inspector met with residents and staff members, service and regional managers.

Residents who could communicate with the inspector said they were happy living in the centre and enjoyed their activities and visiting their homes and staff helped them with their jobs and with their care. Residents were assisted by staff to complete questionnaires. They said they could do the activities they liked including going for a drive, and going swimming. Other residents communicated according to their own preferences and allowed the inspector to spend time with them and observe their routines.

No completed questionnaires had been received from relatives at the time of this inspection.

The inspector reviewed the findings from the previous inspection and all notifications from both centres which had been forwarded to HIQA.

The inspector observed practices and reviewed documentation including personal plans, medical records, accident and incident reports, and policies, procedures and personnel files.

### Overall judgment of our findings:

The inspector found that the provider had made improvements in a significant number of areas which promoted residents' safety and welfare.

The inspector was satisfied that the provider had put governance systems in place to ensure that the regulations were met and residents' welfare was prioritised. This resulted in positive experiences for residents, the details of which are described in the report.

Good practice was identified in areas such as:

- Residents were supported to make individual choices and routines were person centred (outcome 1)
- Positive relationships with family and friends was promoted (outcome 3)
- There was good access to health care and allied services which promoted residents wellbeing and development (outcome 5 & 11)
- Medicines management practices were safe (outcome 12)
- The premises was suitable to meet the needs of all residents (outcome 8)
- Suitable numbers and skill mix of staff were available to meet residents needs (outcome 17)

Improvements were required in the following areas:

- The systems of restraint were not effectively monitored which could place residents at risks of harm (outcome 8)
- Risk management procedures were not robust which could place residents at risk of injury (outcome 7)
- Maintenance of records of complaints and outcomes were not adequately maintained which could be detrimental to residents' rights
- Some records were not consistently maintained or detailed as required (outcome 18)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Improvements were required in the maintenance of adequate record of complaints. The complaint policy was in accordance with the regulations and issues which could be resolved locally were seen to have been completed satisfactorily either by staff or the person in charge. However, there was no record of the process or outcome of one significant matter raised by a relative. This was discussed with the relevant person and the inspector was informed that it had been duly documented and steps taken in conjunction with the social work team to resolve the matter. The inspector acknowledges that this was part of a sensitive and complex matter being managed at the time. However, the lack of adequate records of the process and outcome does not support transparency or adherence to the policy. The policy was available in pictorial and easy read format.

The inspector found that residents were supported to participate in the life of the centre to the degree that they wished and to make choices and decisions with support of relatives or representatives. Residents' meetings were held weekly for those residents who could or wished to participate in this medium. The records indicated that matters such as menus and activities were discussed with the residents.

The capacity of the residents to communicate and genuinely participate and benefit from such a medium differed however. There was however, evidence that staff individually and in consultation with relatives sought to ensure that the views and communicated wishes of the residents were heard. This was evident from a number of records seen by the inspector where the staff, managers and the social work team acted as advocates for the resident's rights.

It was apparent to and observed by the inspector that staff understood and responded

to residents' needs and choices in their daily lives. This was observed being done with due regard to maintaining residents dignity and privacy.

There was a regional advocacy group where one resident had previously represented the views or wishes of the others on occasion.  
Staff were seen to interact with the residents warmly and in a respectful manner.

**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:**

The provider was found to be in compliance with this regulation. There was evidence of referral to and assessment by speech and language therapists and the development of personal plans in relation to this.

Pictorial images were seen to be used to help with sequencing of events and some sign language was used with the details outlined in plans. This aspect was recognised as being crucial in both communication and also in the implementation of the behaviour and mental health supports plans for the residents.

Some staff were already familiar with the use of sign language and further training was scheduled for 2017. Staff demonstrated an understanding of the residents own means of communication. There was evidence of frequent communication with relevant specialists to further assist in this process to address both behaviours and anxieties the residents may be expressing.

**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:**

The inspector saw evidence from records reviewed that familial and significant relationships were respected, maintained, supported and where necessary re-established. There was evidence of regular communication with families, who were involved in all decisions and planning with the residents. Appropriate safeguarding systems and additional supports for families were evident where required. There was ample room in the centre for visits to take place in private. Holidays and visits home were regularly facilitated and supported by staff where this was necessary.

There was evidence that families were quickly informed of any incidents or changes in health status. Residents had regular access to the local community via activities, shopping, and attendance at local events based on their preference for such activities and the suitability of the environments.

**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:**

The admission policy was detailed and outlined the formal assessment and decision making process. It was also informed by the need to ensure residents could be protected from abuse and were compatible to live together. The most recent admission in 2016 had been managed appropriately with a transition plan implemented.

There was suitable documentation available in the event of residents being admitted to acute or other services for treatment purposes.

The inspector reviewed the details of a formal discharge which was being planned. There was evidence that this was being managed with due regard to the safety and wellbeing of the resident and in conjunction with the relevant statutory agencies and services. The staff had maintained contact with the service and the provider was seen to be implementing their duty of care to the resident in the intervening period. However



some documentation in relation to the initial transfer and ongoing arrangements were not available.

The inspector reviewed the contract for the provision of services which was satisfactory. The fees were in the process of being revised based on the provision of nursing care and families were being consulted in regard to this. The agreements were signed by a representative of the residents.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that systems for assessment, planning and review were being implemented to support residents care and development with two issues which required review. Formal external day care had been discontinued in one instance due to unsuitability. It was apparent from records and observation that this decision had been beneficial and had allowed for development and significant improvement in other areas pertinent to the residents well being. The inspector noted that one bedroom was not furnished in the usual manner though the basic equipment was available. This was explained as being the resident's preference and the need to reduce levels of anxiety. However, these decisions and practices had not been the subject of reassessment or multidisciplinary review. Both of these findings were discussed with the service and regional manager who agreed to have them reviewed to ensure these arrangements remained relevant and necessary for the resident.

There was good access to allied and multidisciplinary services including speech and language, physiotherapy, occupational therapy, sensory and mental health assessments. The inspector found that the recommendations of allied specialists for specific interventions were being implemented on a day to day basis by staff. Evidenced based assessment tools were used to identify needs and updated as needs changed.

Each resident had a personal plan which outlined their individual wishes, preferences and assessed needs which were completed with the participation of the resident where possible and or relatives.

These were in the process of being updated to ensure all needs and goals had been identified. The plans covered a range of domains including, health, nutrition, safety, communication, family supports and social inclusion. They included timeframes and named persons responsible for implementation.

Multidisciplinary reviews and support meetings were held as required.

From a review of three such records the inspector saw that they were comprehensive reviews of the resident's welfare, development and psychosocial needs. Relatives were involved in planning and review meetings.

Resident's wishes and preference for social activities were very well supported based on their individual assessment, capacity and wishes. A significant number of individual activities occurred each day and this required a high ratio of staff. These were carefully planned activities identified as being crucial to the residents' wellbeing. Their implementation was being monitored by the person in charge and the service manager to ensure the best outcome for the resident. Some residents went for drives, swimming, bowling or to the cinema horse riding and had regular visits home.

However, at the time of inspection only one regular means of transport was available. This did create some difficulties as residents' required individual transport in some instances. Adherence to the daily plans was vital for behaviour support purposes and where the second transport was not available this did create some difficulties despite the best efforts of the staff. This is actioned under outcome 16 Resources.

**Judgment:**

Substantially 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:**

The premises were not reviewed at the previous inspection. The centre is comprised of a dormer type bungalow on its own grounds. It is suitable to meet the needs of the residents with space for individual time yet allows for residents to be well supported and

supervised by staff.

There is a suitably equipped large kitchen/ dining living area with a separate quiet sitting room.

All residents have their own bedrooms. There is one resident's bedroom on the first floor with a large en suite with another en suite bedroom on the ground floor. There is another large bathroom which has been fitted with a ceiling hoist and an additional toilet.

With the reduction in numbers the person in charge stated that the additional space will be used to develop a sensory room for day to day use by residents who would benefit from this.

There are large gardens to the rear of the building. However, a risk identified in the garden is detailed and actioned under outcome 7 Health and Safety.

Equipment including ceiling hoists and specialist beds had been serviced and maintained as required. Transport used for residents was also serviced and had evidence of road worthiness.

The heating and ventilation was suitable and the standard of cleanliness was good. Some painting and remedial decoration was needed which was scheduled.

**Judgment:**

Compliant

**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:**

There were four actions required from the previous inspection which related to fire safety and infection control systems and all had been addressed. However, some improvements were required in systems for identification and management of risk however, and this is demonstrated by the following:

- An alternative fire evacuation plan for a resident was not suitable as the resident could not be evacuated in the manner outlined
- Identified fire exit doors had unsecured keys with no secure spare keys attached.
- Two newly appointed staff had not taken part in fire drills since commencing duty.
- The preventative actions and plans in the event of a resident going absent were not satisfactory and actions outlined should this occur did not take sufficient account of the geographical environment or timelines for alerting the emergency services.
- The front door locking mechanism required review to ensure all person safety.
- There is a unsecured steep drop at the rear of the garden, currently filled with debris

which could cause injury to residents who cannot maintain their own safety.

As required following the previous inspection there were suitable fire detection systems installed with emergency lighting and fire fighting equipment also available. Fire doors in crucial areas, namely the kitchen and utility room had been installed. The inspector was informed that the provider was awaiting the definitive guidelines from the relevant authority as to the installation of other fire doors. These systems were supported currently by the availability of sufficient staff during the day and night times.

Exits were unobstructed at the time of the inspection.

All fire safety and management equipment had been serviced annually and quarterly as required and staff carried out regular checks on alarms and other electrical equipment.

Fire drills had taken place regularly with one early morning drills simulating night time staffing levels. Any issues noted were addressed. The training matrix indicated that staff had undergone fire training, with the two most recent staff members scheduled for this.

Infection control systems were also satisfactory with guidelines for staff in specialist's procedures and protective equipment and disposal systems available and seen to be used.

The emergency plan made suitable arrangements for untoward events including suitable interim accommodation arrangements in the event that the centre had to be evacuated.

There was a signed and current health and safety statement available. A number of safety audits of the environment and work practices had been undertaken and were updated regularly.

The risk management policy was current and complied with the regulations including the process for learning from and review of untoward events. A centre-specific risk register was maintained which detailed relevant risks and both environmental and clinical risks and was pertinent to the ongoing and changing needs of the residents. There were measures in place to manage individual identified risks such as falls, choking episodes or self harm.

**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):**

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

**Findings:**

There was one action required from the previous inspection and the inspector was satisfied that the provider had addressed this satisfactorily with adequate review and multidisciplinary assessment of the need for and use of general restrictive practices.

However, the use of physical interventions and monitoring of finances required further oversight.

Due to the assessed needs of the residents physical interventions by staff were at times prescribed ,as last resort, for the safety of residents and others. From a review of the incident records and the physical intervention plans the inspector found that such actions had been taken contrary to the national policy and current guidelines. The risk which would indicate such action was necessary was not present.

The incident identified was not adequately reviewed by managers in a timely manner and changes made to ensure such action would not be repeated by staff. While it was addressed some weeks later at the team meeting this was not a satisfactory response.

Other incident reports did not provide sufficient clarity as to why or what process or physical intervention was used. The prescribing documents did not clearly state what type of intervention was allowed and incident reports did not provide sufficient clarity. This does not allow adequate review and monitoring by management to ensure residents safety and rights are protected in this environment. Staff did have training in an approved method of physical intervention and the management of behaviours that challenge.

The protocol for and usage of chemical intervention was carefully reviewed by the psychiatric service. However, similar to the physical interventions, the record of administration was not reviewed to ensure they were given at the time stipulated to be of most benefit to the residents and prevent escalations.

There were a number of other restrictions implemented including the use of harnesses for transporting safely and some restrictors on windows. These had been prescribed and reviewed by the multidisciplinary teams and the rights committee. On examination of the rationales and any alternatives trialled the inspector found that these were implemented in accordance with current policy and not used inappropriately. There was consultation with all relevant persons including family members evident. There was also evidence that these were reduced when not required.

There was evidence that management were implementing more consistent oversight of behaviour and psychosocial support systems for residents.

A review of incidents indicated that there had been a reduction in both the use of physical and chemical intervention. There was also evidence that the behaviour support, psychology and psychiatric interventions were robust and responsive. The inspector saw that these had been made available to good effect.

Detailed behaviour support plans were implemented and there was evidence that the implementation of and adherence to these plans was monitored by the clinicians and the person in charge. In conversation with the inspector staff demonstrated an understanding of the meaning behind the behaviours for the residents. Additional training and team meetings were held to support staff in implementing these.

Oversight of resident's finances required some minor improvements. Residents were assessed as not been able to manage their own finances and required the full support of staff to do so. Personal bank and savings accounts were being opened for residents. A review of a sample of records pertaining to residents' finances and fee payments showed that the systems were transparent with all transactions recorded and receipted. There was no evidence of any untoward spending or transactions noted. However, there was no formal system for oversight of any spending on residents behalf to which all residents could not clearly give consent and which would further safeguard residents' finances.

The inspector reviewed the policies and procedures for the prevention, detection and response to allegations of abuse and the protection of vulnerable adults. The policy was in accordance with the revised Health Service Executive (HSE) policy to ensure satisfactory screening, implementation of safeguarding plans and adequate review of incidents.

There was a dedicated social work service which fulfils the role of designated officer to oversee any allegations of this nature. There was evidence that the provider understood and adhered to the terms and requirements of any specific safeguarding orders made to protect residents. Records demonstrated that all current staff in the centre had received up to date training in the prevention of and response to abuse.

However, there were no satisfactory documented safeguarding plans available in the centre where incidents which occurred would have warranted these to protect other residents. There was evidence however from other records and interviews that preventative safeguarding actions had however been taken to ensure residents safety.

Each resident had a detailed intimate care plan in place. There were also pictorial and easy read versions of safeguarding systems for residents. Residents who could communicate informed the inspector that they felt safe in the centre.

Staff was able to demonstrate their understanding of abusive behaviours and of the correct reporting procedures. They expressed confidence in their management to take the appropriate action in the event of such incidents.

**Judgment:**

Non Compliant - Moderate

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<b>Outcome 09: Notification of Incidents</b> <i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i>
<b>Theme:</b> Safe Services
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> A review of the accident and incident logs, resident's records and notifications forwarded to the Authority demonstrated that the person in charge was in compliance with requirement to forward the required notifications to the Authority. All incidents were found to be reviewed internally.
<b>Judgment:</b> Compliant

<b>Outcome 10. General Welfare and Development</b> <i>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.</i>
<b>Theme:</b> Health and Development
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> The arrangement for residents to attend training or day care and meaningful occupation were based on the assessed need and capacities of the residents. To this end the inspector was satisfied that the provider was in compliance with the regulation. One resident attended formal day care. The remaining resident's activities were planned individually and operated from the centre. These included walks, swimming and sensory supports assessed as beneficial and required by the clinicians.  The residents were supported to develop small but fundamental life and self care skills within the centre as part of the day programmes. They were also being supported to open and operate bank accounts with supports from staff. As observed by the inspector these daily plans were carefully adhered to and staffing which was either one to one or two to one was deployed to ensure this occurred.

<b>Judgment:</b> 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):**  
No actions were required from the previous inspection.

**Findings:**  
The inspector found that residents' healthcare needs were well supported.

It was evident from records that there was ongoing and timely access to general practitioner (GP) services with staff noting any changes in residents' health. Residents had good access to allied services including neurology, haematology and medicines review, dentistry, ophthalmology and physiotherapy. There were support plans implemented for healthcare needs and staff were familiar with them. Dieticians and speech and language assessments had been provided and the inspector observed staff following the intervention as prescribed. Suitable support plans were also implemented for issues related to self harm including head injury.

There was policy on end of life care but such care was not required at the time of this inspection.

There was documentary evidence of advice from dieticians and speech and language therapists available and staff were knowledgeable on the residents' dietary needs. The inspector observed that they received the correct consistency of food and fluids. The meal times as observed were managed in a manner pertinent to the residents' assessed needs for support and interaction and suitable crockery and cutlery was used. Staff shared meals with residents which were social occasions.

**Judgment:**  
Compliant

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

**Theme:**  
Health and Development



<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The policy on the management of medicines was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for medicines were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medicines and robust auditing systems evident. There was good communication noted with the dispensing pharmacist. Where errors were noted actions were taken to minimise risk and remedy these. The inspector was informed that only staff who had undergone medicines management training were administering medication and competency was assessed following the training.</p> <p>Medicines were reviewed regularly by both the residents GPs and the prescribing psychiatric service. No resident was assessed as having the capacity to self-administer medication.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 13: Statement of Purpose</b> <i>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.</i></p>
<p><b>Theme:</b> Leadership, Governance and Management</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The statement of purpose was forwarded as part of the application for registration and found to be in accordance with the regulations. Admissions to the centre and care practices implemented were congruent with the statement as a service for residents with moderate to severe and profound intellectual mental health diagnosis and autism. This will be revised to reflect the changes in resident numbers proposed.</p>
<p><b>Judgment:</b> Compliant</p>

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

There were 2 actions required from the previous inspection and there was evidence that the provider had satisfactorily resolved these issues.

There were clear and effective governance and reporting structures in place with evidence of improved systems to promote accountability.

A fulltime person in charge, dedicate to this centre, had been appointed in September 2016. She was suitably qualified and experienced in working with persons with a disability and as a person in charge. She meets the revised requirements of the regulations. She is supported by the deputy person in charge and service manager. She had protected time to provide direct oversight of the care provision.

The regional management team included the regional services manager, service manager, human resources, social work and psychology department. Managers were found to be aware of their regulatory responsibilities.

There was a clear and documented reporting structure with issues of concern and relevance forwarded to the services manager and the regional manager as necessary. Regular meetings were also held with the Person in Charge.

The provider nominee had commissioned two unannounced visits to the centre in 2016. The inspector reviewed the latest report dated October 2016 and found that it was comprehensive and focused with a detailed action plan issued which was in the process of completion.

The regional manager stated that significant data had been collated and questionnaires forwarded to relatives which would inform the annual report for 2016. The inspector did review the report for 2015 on the centre in its previous configuration and found this was detailed and comprehensive and inclusive of the views of relatives and residents. The person in charge also undertook unannounced visits on occasions to monitor resident's welfare.

The staff acknowledged that the changes to the governance structures as being

supportive and helpful.

Systems for learning and review required some improvements however. A number of audits were undertaken on accidents and incidents challenging behaviours medicines errors and restrictive practices. These provided valuable overarching data but were not sufficiently analysed to identify trends or inform changes.

The inspector was satisfied however that these systems were part of an ongoing developmental process and would provide satisfactory oversight of the delivery of care.

**Judgment:**

Compliant

**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:**

The provider had complied with the requirement to notify HIQA of any proposed absence or change to the person in charge. A suitably qualified person had been nominated prior to the inspection to undertake this function and the documentation was in the process of being forwarded.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that some additional resources were necessary to ensure that residents' individualised daily schedules could be implemented consistently. This was the availability of a second suitable vehicle for the centre. In other respects the service was funded and resourced to provide the staffing, expertise, facilities and services necessary to meet the needs of the residents.

There was a significant ratio of staff available to ensure appropriate care delivery to the residents.

**Judgment:**

Substantially Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Both actions required from the previous inspection had been addressed. There was a satisfactory staff roster and the professional registration numbers for relevant staff were available.

The skill mix of staff was found to be suitable with oversight care by a qualified nurse provided. Residents were assessed as not requiring fulltime nursing care and the inspector was satisfied that there was sufficient clinical support and oversight evident. The skill mix of staff also included qualified social care and FETAC trained staff.

There were a minimum of four staff on duty from circa 7: am until 10: pm with five staff when the shared care arrangement was in effect. There was waking and sleep over staff at night.

Staff were deployed in a manner so as to ensure that residents' preferred routines, personal care needs, behaviour support, supervision needs and activities could be supported.

From a review of the training records all mandatory training in manual handling, first aid, safeguarding and fire safety was up to date or where gaps were identified these were already scheduled within a very short time frame for new staff. Training in sign language was scheduled for 2017. Given the complexity of the residents' needs the

inspector found that some additional training / awareness in specific mental health conditions would be beneficial to the staff group. This was discussed and agreed at the feedback meeting.

Formal supervision for staff was seen to have commenced with 6 to 8 weekly meetings for all staff with the person in charge. The content however required review as it was primarily a supportive medium.

Team meetings were now held monthly and the records indicated that these were driven by residents care needs and making changes to practices and routines to support these needs.

A number of agency staff were used although there was evidence that this had decreased. The inspector saw from rosters that efforts were made to ensure there were consistent people used to provide continuity for the residents. A detailed induction programme was outlined which included supernumery time and staff confirmed this to the inspector.

An examination of a sample of personnel files showed good practice in recruitment procedures for staff with the required documentation sourced and verified by the person in charge prior to taking up appointments. No volunteers were used at this time. All staff spoken with demonstrated a very good knowledge of the residents and competency in their roles.

**Judgment:**

Substantially Compliant

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

While all documentation required for the purposes of registration were provided some changes were necessary. This included the correct documentary evidence of compliance

with the planning authority and a revised statement of purpose and application to address the proposed changes to the number of residents. The provider was aware of these and agreed to address them.

Records in relation to staff were found to be complete.

The detail and dates of a residents transfer to another facility was not outlined in the Directory of residents but this was addressed by the person in charge during the inspection.

**Judgment:**

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:***

Noelene Dowling  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
<b>Centre ID:</b>	OSV-0004727
<b>Date of Inspection:</b>	24 and 25 January 2017
<b>Date of response:</b>	17 February 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 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:**

There was no record of the outcome or the process used to investigate and address a significant matter raised on behalf of a resident.

**1. Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a

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

complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Documentation has been amended to include the information. The Person in Charge will ensure that all future information will be logged accordingly.

**Proposed Timescale:** 25/01/2017

**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 number of personal plans and reviews of plans did not address some aspects of residents' care needs.

**2. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

Integrated Personal Plans for all residents will be completed by the Person in Charge in conjunction with the Multi-Disciplinary Team by 31/03/17

**Proposed Timescale:** 31/03/2017

**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:**

Systems for assessment and management of risk were not robust ;

These included but were not limited to:

- The preventative systems and response plans in the event of a resident going absent
- Environmental risks in the garden and security in the premises.

**3. 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:**

Support plans to be updated to include a response time to a person going missing. This will be completed by the Person in Charge 12/02/17.

Alternative locking to be front door to be installed by 27/02/17

The Person in Charge will have arranged for a Boundary fence to be erected around the premises by 28/04/17

**Proposed Timescale:** 28/04/2017

**Theme:** Effective Services

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

The provider needed to ensure that :

- an alternative fire evacuation plan for a resident was suitable for use.
- identified fire exit doors could be exited swiftly when necessary.

**4. 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:**

1. PEEP for this resident to be reviewed and amended by The Person in Charge by 17/02/17.
2. The Person in Charge will arrange for the installation of break glass units by 27/02/17.

**Proposed Timescale:** 27/02/2017

**Theme:** Effective Services

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

Newly appointed staff had not taken part in fire drills to ensure they were familiar with the process and could assist residents safely.

**5. Action Required:**

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

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

A plan has been devised by the Person in Charge for all new staff to partake in a fire drill by 28/04/17.

**Proposed Timescale:** 28/04/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Physical interventions were on occasion implemented in a manner which did not concur with national policy.

Such interventions were not adequately reviewed.

**6. Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A log of all occasions when MAPA has been used has been devised. This log to be reviewed by the staff team monthly at team meeting. At Psychology reviews this record to be reviewed by Psychologist and the Person In Charge.

MAPA instructors to meet with the staff team at the next staff meeting on 22/02/17 to revise the appropriate use of MAPA.

Behavioural Support Plans will be reviewed to ensure clarity on the use of, timing and type of physical intervention when supporting the individual in this service

**Proposed Timescale:** 30/03/2017

**Theme:** Safe Services

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

There was no formal system of oversight of any spending on behalf of residents to safeguard their finances.

Safeguarding plans were not in place where indicated.

**7. 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:**

A monthly review by the Person in Charge of residents spending and finances will occur. Records of same will be maintained.

Safeguarding plans to be reviewed by the Designated Person and further details added.

**Proposed Timescale:** 28/02/2017

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

Consistent access to additional transport is necessary to ensure residents crucial activities and appointments can be met.

**8. Action Required:**

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

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

A second bus is now available to the service for the coming months for key activities. In the interim the organisation will seek a second permanent additional vehicle for this service area.

**Proposed Timescale:** 15/05/2017

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

The content of the staff supervision required review to focus on the resident care need and staff development in this area.

**9. Action Required:**

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

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

Resident's care needs are addressed monthly by all members of the staff team. Staff development pertaining their work environment and residents care needs also will be focused on at staff support meeting with the Person in Charge

Proposed Timescale: 22/02/17 and on going

**Proposed Timescale:** 22/02/2017

**Theme:** Responsive Workforce

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

Addition training for staff in emerging issues pertinent to the residents needs is required.

**10. 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:**

Training for all staff with the Consultant Psychiatrist is scheduled for 30/03/17

**Proposed Timescale:** 30/03/2017