<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Brothers of Charity Services Limerick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011413</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Clare</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:normabagge@limerick.brothersofcharity.ie">normabagge@limerick.brothersofcharity.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Brothers of Charity Services Limerick</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Norma Bagge</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Maurice Dowling</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Margaret O'Regan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Gemma O'Flynn</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
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 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 announced and took place over 1 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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</thead>
<tbody>
<tr>
<td>30 April 2014 09:30</td>
<td>30 April 2014 18:15</td>
</tr>
</tbody>
</table>

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

|-------------------------------|--------------------------------------------------|------------------------------------|-------------------------------|-----------------------------------|--------------------------------------|----------------------|

**Summary of findings from this inspection**

This monitoring inspection was the first inspection of this centre carried out by the Health Information and Quality Authority (the Authority), it was announced and took place on one day. As part of the inspection, inspectors met with residents, staff, the person in charge and members of the senior management team. The inspectors observed practices and reviewed documentation such as personal plans, medical records, policies, procedures and staff files.

Overall, inspectors found that residents received a good quality service in the centre. Staff supported residents to participate in the running of the house and in making decisions and choices about their lives. Residents were supported to pursue their interests, hobbies and to attend training/educational programmes. The centre was warm, comfortable, appropriately furnished and well maintained. Staff and residents knew each other well, residents were observed to be relaxed and comfortable in the company of staff.

Inspectors found major non compliances in the area of risk management and fire precautions. Other areas of non-compliance related to medication management and staff files which are discussed further in the report and included in the Action Plan at the end of this report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 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

**Judgement:**
Compliant

**Findings:**
The inspectors found residents’ well being and welfare to be maintained to a high standard with evidence of individualised assessment and personal planning. The inspectors found that residents participated in meaningful activities appropriate to their individual interests and preferences. For example, residents attended activities and social outings such as day services, a local bingo group, a local art group and went on shopping trips.

Personal plans contained resident, family and multi-disciplinary input and reflected residents’ needs, interests and capacities. The plans were divided into three themes: myself, my world and my dreams. It was evident from the plans that staff had good insight and awareness of residents' needs and circumstances. The personal plans contained important information about the residents’ life, their likes and dislikes, their interests, details of family members and other people who were important in their lives. Daily records were maintained of how residents spent their day and key workers were assigned to each resident. Also in place were weekly meetings between residents and staff to plan for the week ahead; for example what would be on the menu each day, what activities each resident would get involved in and each resident's preferred time for personal care activities.
**Outcome 07: Health and Safety and Risk Management**  
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**  
Effective Services

**Judgement:**  
Non Compliant - Major

**Findings:**  
Inspectors found that overall the centre's policies and procedures in relation to health and safety were insufficient.

There was a health and safety statement in place, however, this was out of date. Whilst there was a risk management policy in place, it did not include all the requirement of the Regulations. For example, there were no arrangements in place for residents who might self harm nor did the policy have adequate measures in place for accidental injury to residents, visitors or staff. Whilst there was some guidance on the measures in place for hazard identification, this was not implemented in the centre and required further development.

There was local guidance to staff on what to do in the event of a medical emergency but there was no formal emergency plan in place to guide staff on what to do in the event of emergencies such as loss of power, loss of water or the need to evacuate residents.

There were inadequate arrangements in place to prevent accidents as there were no risk assessments completed in the centre. For example, there was no risk assessment for slips, trips or falls, manual handling, infection control or fire. Whilst there was evidence of manual handling training for staff, there was a number of staff records that indicated that they were overdue their refresher training.

Inspectors found that there was no infection prevention policy in place. Inspectors spoke with staff and whilst they were knowledgeable on effective measures for infection prevention, they lacked clarity on effective hand washing techniques and what temperature to wash potentially contaminated laundry. Adequate hand-washing facilities were in place and antibacterial gels were available throughout the centre.

The arrangements for fire safety were insufficient. A recent fire safety audit had been completed by an external provider and the subsequent report made recommendations for improvements. The provider informed inspectors that they were in the process of implementing these recommendations. Fire fighting equipment that was in place had been serviced within the last year, however, there was inadequate provision of such equipment. There were an inadequate number of fire detection units in the centre. The procedure for the safe evacuation of residents and staff was not displayed in a prominent location nor was there one available in the centre.

Inspectors found that each resident had a personal emergency egress plan in place and
there was evidence that these were regularly reviewed. Staff were able to discuss what they would do in the event of a fire but had not received training in same. The person in charge informed inspectors that this training was scheduled to take place within the following two weeks. The provider informed inspectors that as a result of the recent fire audit, an entire new, more appropriate fire alarm system was going to be installed.

There was evidence that fire drills had been conducted but were not done so on a six monthly basis. Inspectors were not satisfied that learnings were used to improve emergency evacuations in the future.

**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

**Judgement:**
Non Compliant - Minor

**Findings:**
Overall inspectors were satisfied that measures were in place to protect residents from being harmed or suffering abuse. There was a policy in place on the prevention, detection and response to abuse. However, it was dated 2009 and needed to be reviewed. Staff, with the exception of one, had received training on adult protection. However, the frequency in which updated training was provided was inadequate. It was over 2 years since some staff had received updates.

In general there were little restrictive practices in place. For safety reasons, some restriction was placed around entry into the kitchen. Staff on duty were aware of this restriction and handled it sensitively. Family members were involved in the decision to put this restriction in place.

Residents with whom inspectors spoke confirmed that they felt safe in the centre. They stated they "loved it here". Inspectors observed respectful trusting interaction between residents and staff in a relaxed easy atmosphere. Residents’ finances were reviewed and were satisfactory.
**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

<table>
<thead>
<tr>
<th><strong>Theme:</strong></th>
<th>Health and Development</th>
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<tbody>
<tr>
<td><strong>Judgement:</strong></td>
<td>Compliant</td>
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<table>
<thead>
<tr>
<th><strong>Findings:</strong></th>
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<tbody>
<tr>
<td>Overall, inspectors were satisfied that residents were supported on an individual basis to achieve best possible health. The inspectors found that residents had appropriate access to general practitioner (GP), speech and language therapist (SALT), physiotherapist, psychiatrist, dentist, orthodontist and chiropodist. In addition other therapies such as reiki and reflexology were offered to residents.</td>
</tr>
<tr>
<td>A staff member accompanied residents when they attended their GP or any clinic appointment. On return, a record was made of the outcome including the proposed treatment plan. Inspectors were satisfied that residents' nutritional needs were met to an acceptable standard. Weights were recorded and where indicated residents were referred for dietetic and SALT support.</td>
</tr>
<tr>
<td>As discussed in outcome 5 the inspectors found that health plans were in resident files and that these plans were regularly reviewed, updated and they guided practice. For example, two residents had a SALT assessment that guided practice in terms of the consistency levels these residents' food and drinks needed to be. This was documented in the resident's health plan. Staff were knowledgeable in this regard and supported residents at mealtimes both safely and respectfully.</td>
</tr>
<tr>
<td>Residents were actively encouraged to take responsibility for their own health by partaking in planning their own weekly activities and attending their own GP surgery. Staff had given consideration as to how end of life care would be delivered. Such care needs were an unusual event for this centre. If nursing care needs to be provided there were arrangements for residents to be accommodated in a centre that provided full time nursing care. Care decisions were in consultation with the resident and his/her family.</td>
</tr>
<tr>
<td>The inspector noted an appropriate mealtime experience with residents supported to enjoy their meal in a dignified and respectful manner. There was flexibility around mealtimes, in particular around the timing of breakfast.</td>
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</tbody>
</table>
Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Minor

Findings:
Inspectors were satisfied that each resident was protected by the centre's policies and procedures for medication management. All medications were administered by a social care worker. Detailed descriptions of each medication were available to assist staff. Each resident's medication was supplied in a blister pack and these were stored in a locked press. These packs were delivered on a monthly basis by the pharmacist who was available to assist staff with medication management issues. At the time of inspection no residents were self medicating. Staff spoken with outlined with clarity their role and responsibility as regards medication management.

An inspector reviewed prescription and administration records and procedures for the storage of medication including those requiring refrigeration. The inspector was satisfied that in general appropriate medication management practices were in place guided by a policy. However, eye drops which were in use did not have the date of opening recorded. Another matter which needed attention was the manner of maintaining a record of drugs which were returned to the pharmacist. It was insufficiently robust. The medication management policy was being updated to reflect ongoing improvements in the service.

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

Judgement:
Non Compliant - Moderate

Findings:
The management systems in place to ensure that the service provided was safe, appropriate to residents’ needs, consistent and effectively monitored was under review.
This review was instigated by management’s assessed need to provide a more robust, supportive and accountable structure for the person in charge. At the time of inspection the person in charge was responsible for seven centres within an 18 kilometre radius of Limerick city. His input into the management of this centre consisted of three to four visits per fortnight to the house and daily contact with staff by phone (if needed). Given these arrangements there were gaps in the person in charge familiarity with the day to day operation of the centre.

Arrangements were in place for a suitably qualified person to deputise for the person in charge. This information was displayed in the house. Monthly management meetings where in place where the persons in charge of all Brother of Charity services in Limerick could meet to discuss common areas of interest and share their learning. The person in charge was supported in his role by an area manager, who in turn was supported by the head of community services. The head of community services reported to the director of services who was the person nominated by the Brothers of Charity Limerick as being responsible for ensuring Regulations and Standards were complied with.

The provider had not yet established a formal annual review of the quality and safety of care in the centre. Some audits had been completed including a medication audit and an audit of accidents and incidents. Although further improvement was required there was evidence that efforts were under-way to ensure that all staff were aware of the Regulations and the Standards. For example, regulatory matters were discussed at staff meetings.

Staff appraisals had commenced for senior management but had not been implemented for all staff. Improvement was required to ensure that effective arrangements were in place to support, develop and performance manage all staff as required by the Regulations.

The person in charge had specific expertise in the area of nursing and liaison between front line staff and management staff. The person in charge worked at improving communication between families and their relative by conducting family meetings. Through this and in other ways, family members were encouraged to visit the community house. The family meeting forum also allowed families to be involved in residents’ personal plans. The inspectors noted evidence of this from residents’ files.

**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

**Judgement:**

Non Compliant - Moderate
Findings:
Overall, inspectors were satisfied that there was appropriate staff numbers and skill mix to meet the assessed needs of residents. There was normally one staff member on duty at night time and two/three staff members on duty during the day. Staffing arrangements were flexible in order to meet the needs of residents. There was a person in charge who also covered six other houses. This has been discussed in Outcome 14.

The inspector reviewed the records relating to staffing and found that they contained most of the information outlined in Schedule 2 of the Regulations. However, some improvements were required to be fully compliant. Inspectors reviewed the training records which demonstrated that training was made available to staff. Mandatory training in the areas of managing behaviours that challenge, awareness of protection of the vulnerable adult and moving and handling had been provided. However staff had not received fire prevention training as discussed in Outcome 7.

Throughout the inspection residents appeared to be content with the staff members on duty who demonstrated a good rapport and knowledge of the residents. Inspectors observed that residents received care in a respectful, timely and safe manner. The inspectors viewed the staffing rosters which matched the personnel on shift at inspection time. The staff interviewed demonstrated good knowledge and understanding of their role and of each resident’s needs. Staff highlighted the importance of the social model of care when meeting residents’ needs and spoke of the importance of providing a professional caring home environment.

As discussed in Outcome 14 there were inadequate arrangements in place around staff appraisals. There were some shortcomings in the recruitment policy in that it did not refer to the requirements of the Regulations. There was no policy in place around lone working.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Margaret O'Regan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID: ORG-0011413
Date of Inspection: 30 April 2014
Date of response: 29 May 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:
A risk management policy was not in place which included the measures and actions in place to control risks identified.

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

Please state the actions you have taken or are planning to take:
- National Risk Management Policy: Updated 13/05/2014
- Local operational procedures for risk management for the Brothers of Charity Services Limerick developed and adopted at Policy Review meeting: 31/05/2014
- Risk Management training for all persons in charge: 05/06/2014

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The development of Risk registers for all designated centres implemented by person in charge in consultation with staff and individuals will commence following training.

- Risk workshops facilitated in all designated centres to further develop risk registers: 06/06/2014 – 30/09/2014.
- Proactive risk management as risks are identified by staff and individuals who use the services will be ongoing. Reactive risk management will be informed by incidents, accidents & complaints and actions will be identified to mitigate against such risks in the future: Ongoing.

**Proposed Timescale:** 30/09/2014  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was no policy to guide staff on infection prevention and staff were unclear regarding effective prevention measures.

**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 policy currently under development.

**Proposed Timescale:** 30/08/2014  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was no fire safety plan in place in the centre.

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

**Please state the actions you have taken or are planning to take:**  
- Fire Plan currently under development, same due for completion 30th June 2014

**Proposed Timescale:** 30/06/2014  
**Theme:** Effective Services
<table>
<thead>
<tr>
<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>There was insufficient fire fighting equipment provided in the centre.</td>
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</table>

**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:**

- Fire Safety Inspection had been completed prior to the HIQA inspection.
- Action plan developed based on this report.
- Tendering process currently underway based on action plan.
- Funding has been approved.
- Work will commence once tendering process has been completed.
- All works due to be completed August 30th 2014.

**Proposed Timescale:** 30/08/2014

**Theme:** Effective Services

<table>
<thead>
<tr>
<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>There was inadequate provision for the detection of fire in some parts of the centre.</td>
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</table>

**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:**

- Fire Safety Inspection has been completed prior to the HIQA inspection.
- Action plan developed based on this report.
- Tendering process currently underway based on action plan.
- Funding has been approved.
- Work will commence once tendering process has been completed.
- All works due to be completed August 30th 2014.

**Proposed Timescale:** 30/08/2014

**Theme:** Effective Services

<table>
<thead>
<tr>
<th>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</th>
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<tbody>
<tr>
<td>Staff had not received mandatory fire training.</td>
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</table>

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**
- Fire Training has been provided for staff during the period May 12th to 26th 2014.

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong> 26/05/2014</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not undertaken on a consistent regular basis.

**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:**
- Fire drills to be completed quarterly each year. Day time drills X 3, night time drills X 1 annually. Next fire drill to be completed by June 30th 2014.

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong> 30/06/2014</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedure to be followed in the event of a fire was not available in the centre.

**Action Required:**
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

**Please state the actions you have taken or are planning to take:**
- Procedure to be followed in the event of fire is under development.

| **Proposed Timescale:** 30/06/2014 |
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:
One staff member had not received training in the protection of vulnerable adults and other staff had not received updates for over two years.

Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
- Staff member is due to undergo this training on either the 17th of June or the 22nd of July.
- Staff Members are due to undertake refresher training on the on either the 17th of June or the 22nd of July.

Proposed Timescale: 22/07/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The practices in place relating to the administration of eye drops and the return of unused medications to the pharmacy were insufficiently robust.

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

Please state the actions you have taken or are planning to take:
As part of an overall review of the community services medication management the instruction to date all items not included in blister packs is being included. This will apply to eye drops, inhalers, creams etc.

By agreement with the pharmacist, the expiry dates from date of opening will be included on the labels for non blistered items.

The medication procedure is being revised to increase the accountability of all medicines received and returned by the introduction of a duplicate book which will be countersigned by the pharmacy to confirm receipt of all items sent to the home as well as all items returned.
Medication management training is planned for this quarter and all of the above will be emphasised in the training.

**Proposed Timescale:** 30/06/2014

### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

The person in charge was appointed as person in charge of more than one designated centre. However; this arrangement was such that the inspector was not satisfied that he can ensure the effective governance, operational management and administration of the designated centres concerned.

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

**Please state the actions you have taken or are planning to take:**
- Management restructuring plan has been developed
- Interviews to fill additional person in charge posts will be completed by June 6th 2014
- Dependant on the satisfactory completion of Garda Clearance process it is expected that all posts will be completed by 30th September 2014 at the latest.

**Proposed Timescale:** 30/09/2014

**Theme:** Leadership, Governance and Management

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

A system of annual review of the quality and safety of care and support in the centre was not in place.

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

**Please state the actions you have taken or are planning to take:**
- An initial review of the designated centre was completed on March 7th. This review involved interviewing staff, residents and the person in charge. Feedback was provided to the Person in charge and an action plan developed. The review tool used was
developed based on the HIQA standards.
• An updated review tool is currently being developed based on 7 of the 18 outcomes against which designated centres are inspected.
The outcomes included are:
Outcome 5: Social Care Needs
Outcome 7: Health and Safety and Risk Management
Outcome 8: Safeguarding and Safety
Outcome 11: Healthcare Needs
Outcome 12: Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
A review of the quality and safety of care and support in the designated centre will be carried out using this review tool in the fourth quarter of 2014 and annually thereafter.
• A 6 monthly outcome focused review will be conducted by the registered provider or designate as per Regulation 23(2). The first 6 monthly review will be completed between June and September 2014 and will focus on Outcome 5: Social Care Needs.

**Proposed Timescale:** 30/11/2014

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective arrangements were not in place to support, develop and performance manage all members of the workforce in exercise their personal and professional responsibility.

**Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
• A new management structure was introduced by the Director of Services on 9th December 2013 to better support more effective service delivery. This transferred to all community residences under the management of the Head of Community Services.
• Arising from this restructuring the Head of Community Services is currently in the process of recruiting Area Managers and Community residential team leaders who will play key roles in this new management structure which will ensure an effective performance management system that will support and develop staff to ensure the delivery of a quality service in line with the organisations standards which are informed by HIQA regulations and standards.
• The initial focus of performance management will be on the 7 key outcomes defined by the HIQA inspector. The focus will extend to all outcomes in 2015 once the structure is embedded.
• Clear standards and expectations around each outcome are being clarified for staff and managers so that they understand what is expected of them.
• Each level of management will have a responsibility to ensure that staff reporting to
them have the skills and competencies to achieve the standards, that supports are provided to staff to enable them to deliver on what is required of them, that feedback is given to them on their performance and corrective action is taken if and when it is required.

- This process will be structured in such a way that there will be documented evidence of management’s ongoing engagement with staff e.g. minutes of meeting, feedback on house visits etc.
- This represents a change in the culture of how services are currently managed but will be instrumental in improving management and staff capabilities and consequently service user experience.
- This structure will be introduced in the short term and will be embedded by September 2014.

**Proposed Timescale:** 30/09/2014

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Some staff files were incomplete in that they did not contain all the documentation required per Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

**Please state the actions you have taken or are planning to take:**
- A complete audit of HR files was conducted in 2013 to determine gaps in relation to compliance.
- From promulgation of the Schedule 2 all new entrant staff are required to provide the documentation required in Schedule prior to commencing work
- Existing staff were written to in Dec 2013 outlining what information they individually were required to submit for schedule 2.
- Currently, 424 of 519 staff (from April 2014 census) have responded, of this 268 are 100% compliant with Schedule 2 requirements. Staff who responded but are non-compliant typically filled in the Garda Vetting form incorrectly or omitted some information i.e. passport photo.
- The remaining staff are being dealt with through the disciplinary process. HR promulgated notices to this effect on the 2nd of May 2014 giving staff until the 26th of May to make returns.
- HR will be furnishing managers with a list of staff and the information required during w/c 3rd of June, with a view towards initially informal counselling taking place in the following weeks up to the 27th of June. Formal disciplinary action will commence in the w/c the 30th of June for staff who have thus far failed to make returns.
Proposed Timescale: 30/06/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A system of appraisals was not in place for all staff.

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:
• The system of staff appraisal is a function of performance management. Please see actions outlined in respect of Performance Management.

Proposed Timescale: 30/09/2014