### Health Information and Quality Authority Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Brothers of Charity Services Limerick</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002869</td>
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<td>Centre county:</td>
<td>Longford</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Brothers of Charity Services Limerick</td>
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<tr>
<td>Provider Nominee:</td>
<td>Norma Bagge</td>
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<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
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<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>10</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 15 October 2014 09:10
To: 15 October 2014 19:45

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

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Summary of findings from this inspection

This was the first inspection of the centre by the Authority. As part of the inspection process the inspector met with the person in charge, the head of integrated services, staff on duty and the residents; there were ten residents living in the centre on the day of inspection. The inspector observed practice and reviewed records including health and safety records, fire safety records, accident and incident records, residents’ personal plans, policies and procedures and staff related records. The inspector was satisfied that the premises was fit for its stated purpose, was well maintained and provided residents with privacy and independence in a comfortable and homely environment. The inspector saw that residents looked well and that staff supported them to have good access to social, occupational and healthcare services. However, a substantial level of regulatory non-compliance was evidenced primarily due to the governance arrangements, staffing arrangements and deficits in staff training. It was evident from speaking with management and from records reviewed that management sought to promote the delivery of safe quality care and had identified some of the risks and deficits as also identified by this inspection process; they had not however been satisfactorily resolved at the time of inspection.

Based on the risk to resident safety, dignity and continuity of care the provider was issued with an immediate action plan to alter the night time staffing arrangements
(outcome 17: Workforce) and to consolidate the existing governance structure (outcome 14: Governance and Management). The provider responded positively to the immediate action plan within the specified timeframe.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspector saw that each resident had a person centred plan and a second “my profile, my plan”. The plans seen by the inspector were personalised, clearly set out goals/objectivities/priorities, timeframes and responsible persons; the plans had been reviewed at regular intervals by the responsible key worker. The plans addressed spiritual, social, family and community involvement. The inspector saw that residents were supported to access day services, community based social services or, in line with the nature of their disability, activities within the residential service itself. There was documentary and photographic evidence that in response to the audit completed in June 2014 efforts had been made to provide residents with a range of structured activities at the weekend.

However, it was not clear how residents’ needs including their healthcare needs were comprehensively assessed. It was not clear how the assessment was supported perhaps by the appropriate assessment tool to ensure that the assessment and care was evidenced based. There were no plans in place setting out the arrangements to meet some established needs such as falls prevention and management and wound prevention and management. Given the existing staffing arrangements it was not possible to devise and implement an effective and meaningful plan of care that promoted the residents safety, wellbeing and welfare over a continuous 24 hour period. This was clear from records reviewed including accident and incident records and acknowledged by management.

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
While improvements were required overall the inspector was satisfied that the premises was fit for its stated purpose.
The premises was single storey and purpose built; the design and layout was suited to meeting the needs of the residents; the premises was well maintained and in good decorative order. On the day of inspection the premises was visibly clean, adequately lighted, heated and ventilated.

Adequate communal space was provided and an additional segregated facility for the purpose of social and recreational activities was also available to residents on site.

A bright and spacious combined kitchen and dining area was in place and while homely in presentation the design and layout provided for ease of supervision and access for residents requiring assistive equipment for mobility. The kitchen area was adequately equipped with suitable cooking facilities and equipment.

Each resident was provided with a single bedroom the size and layout of which was suitable to meeting their needs. This was enhanced in some bedrooms by the provision of ceiling hoists to assist in manual handling. The inspector saw that resident’s bedrooms were personalised and reflected their personal interests and hobbies; sufficient personal storage was available.

Residents were seen to be provided with such equipment as was required and as recommended by other healthcare services including physiotherapy and occupational therapy.

Circulation areas were spacious and were seen to comfortably accommodate residents requiring mobility aids; two main access and egress points were universally accessible.

Adequate facilities were available for the management of residents’ laundry.

The premises was located on a spacious site and residents had ready access to well maintained and pleasantly landscaped gardens.

With the exception of one bedroom, there was a fully accessible shared en suite sanitary
facility located between each pair of bedrooms. The design and layout of these facilities were suited to meeting the needs of the residents and they were also adequately equipped with hand rails and grab-rails. In addition there was a further sanitary facility located in close proximity to the main dining area. The main bathroom was spacious and equipped with an assisted bath; however the person in charge confirmed that while located close to the one bedroom that did not have en suite facilities, the bath did not meet individual resident’s needs and preferences and necessitated the further use of one of the already shared en suites.

The limitation of the main bathroom was compounded by the lack of suitable storage and on the day of inspection environmental cleaning equipment and laundry equipment was seen to be stored in the bathroom. Further equipment including a hoist and exercise equipment was seen to be stored in one corridor annex that was used by residents as a “remembrance” area for deceased residents and friends.

Given the assessed needs of the residents the available sluicing facilities were inadequate. The room was seen to be extremely compact and only contained a deep ceramic sink. This particular failing is actioned as an infection control failing in Outcome 7.

Judgment:
Non Compliant - Minor

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The inspector was not satisfied that the measures in place were sufficient to protect and promote the health and safety of residents, staff and visitors.

There was an organisational health and safety statement dated August 2014 and explicit procedures for the identification and management of risks, accidents and incidents and adverse events. There was documentary evidence that a health and safety audit had been completed in October 2013 and a property survey in May 2014.

The inspector saw that some risk assessments had been completed by the person in charge including manual handling, slips, trips and falls, food safety and night time staffing arrangements. However;
• this did not extend to the identification and assessment of all risks throughout the designated centre, all work practices and all areas of work
• as discussed in the body of the report all identified control measures such as staffing and staff training were not in place.
the risks as specified in regulation 26(1)(c) were not included

The inspector found that the fire register was substantially incomplete and did not provide evidence that fire equipment was suitably tested and maintained at the required intervals. On the contrary there was documentary evidence confirmed by staff that prior to the 10 October 2014 the fire detection system had not been inspected and tested to the required standard since June 2012. There was no evidence of the inspection and testing of the emergency lighting. There were no in-house procedures for the reviewing and testing of fire equipment. Training records indicated that while fire training had been provided in May 2014 two staff had no recorded attendance at fire training and one had not attended training since 2011. There was a procedure to be followed in the event of fire, however, this was available only in the main administration office and was not prominently displayed where it could be readily accessed by all. The inspector noted that while automatic door closures were in place some fire doors were wedged open thereby negating their function in the event of fire. The building used for social and recreational purposes was not connected to the fire detection system.

There was evidence that staff undertook practical simulated fire drills with the participation of residents and took subsequent preventative actions such as the removal of obstructions from fire escape routes. There was documentary evidence that fire fighting equipment was serviced as required in 2013 and 2014. On the day of inspection the inspector saw that fire escape routes were unobstructed and all final fastenings were on easily released thumb-turn devices.

The inspector saw that staff were required to employ moving techniques in resident care (manual handling) on a regular and frequent basis. Staff had access to ceiling hoists and a mobile hoist and were also seen to utilise handling/transfer belts. Records seen confirmed that the hoists were inspected and tested in September 2014 but there were outstanding issues to be followed up on from that service. The person in charge confirmed that manual handling risk assessments were not in use and training records seen indicated that at least three staff did not have the required mandatory update in manual handling training.

The inspector saw that staff did have access to personal protective equipment and wash-hand basins were equipped with liquid soap and disposable towels. However, the person in charge confirmed that while there was a draft infection control policy, there was no infection prevention and control policy adopted and implemented in practice; sluicing facilities were inadequate and staff were not provided with the appropriate equipment to allow them to safely manage soiled linen.

There was a functioning staff-call system in place; however all call points were not within easy reach of the resident or the residents’ bed.

There was guidance in place for staff and emergency contact numbers for responding to emergency situations such as loss of power and loss of heat.

Two vehicles were available to the centre to assist in the transportation of residents for occupational and recreational activities. There was documentary evidence that the vehicles were insured and regularly serviced.
Judgment: Non Compliant - Moderate

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

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
There were policies and procedures in place for the prevention of and responding to any alleged, reported or suspected abuse. Staff were aware of the procedure to be followed including the role of the designated person. The inspector also saw that policies on the use of restrictive practices, the management of behaviours that challenged and the provision of intimate care were available to staff. The inspectors observations indicated that residents were relaxed and comfortable in their general demeanour and in the presence of staff; the overall environment was restraint free and staff spoken with had a good understanding of managing behaviours that challenged and the appropriate use of chemical intervention if and when necessary.

However, the robustness of the protective measures in place was diminished by deficits in staff training and staffing arrangements that did not support the safe, evidence based use of bedrails. Two sets of bedrails were in use but the night time staffing arrangements did not support the safety of their use as it was not possible to supervise and monitor their use in accordance with national policy and evidence based practice.

Training records indicated that training frequency on protecting vulnerable adults for at least four staff was not in line with local policy, not up to date and therefore not sufficient to meet the needs of current residents.

Judgment: Non Compliant - Moderate

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

**Theme:**
Health and Development
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The person in charge said and there was documentary evidence to support that residents were facilitated to have good and timely access to healthcare services. Records seen indicated that residents had access to timely General Practitioner review and out-of-hours medical services. In line with their needs the inspector was satisfied that residents had good access to a broad range of specialist services (some of which were provided from within the wider organisation) including physiotherapy, occupational therapy, speech and language services, psychology and psychiatry, social work support, dementia specific services, dental services, chiropody and optical review. Records of referrals and reviews were maintained. The inspector saw that residents were provided with the assistive equipment necessary to maintain their wellbeing and independence.

The inspector saw that at each structured mealtime staff prepared, cooked and served meals. Potion sizes were seen to be sufficient, meals appeared to be appetising and appealing, reflected choice and specific requirements such as diet of a modified consistency; the latter was supported by a swallow care plan. The social dimension of meals was encouraged but the inspector also saw that independence was encouraged by the provision of adaptive cutlery or a resident’s choice to take their meals in private. There was documentary evidence that residents were consulted with in relation to the variety of meals provided. Residents were seen to be provided with a good variety of fluids and measures were in place to ensure ongoing nutritional wellbeing included monthly monitoring of body weight.

However, there was a deficiency in assessing and setting out the arrangements in place to meet assessed needs and in the organisation of care that ensured the continuity of care delivery; this non-compliance is addressed in Outcome 5.

Judgment:
Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
There was an organisational medication management policy in place dated September 2011. There were adequate arrangements for the secure storage of medication. Staff
confirmed that at the time of inspection no resident was self-managing their medications but residents were seen to have a medication management plan which indicated that they were provided with information as appropriate to the nature of their disability. Each resident had current medication and prescription records that satisfied regulatory requirements.

However, staff spoken with confirmed that some medication was required to be administered in an altered format (crushed) and there was no evident medical authorisation for this.

While a prescription was in place to support all medications administered, one medication required by more than one resident was not labelled as resident specific and was as necessary administered to a resident other than the resident for which it was prescribed and supplied.

The policy on and procedure for the disposal of unused, unwanted or out of date medications was insufficient and not supported by the maintenance of records.

While no major risks were identified on this inspection and staff said that there was a low incidence of medication errors it was of concern to the inspector that staff training records indicated that a significant number of staff had not attended generic medication management training and/or received the required annual training as specified in the local medication management policy. Some staff had received training in the administration of a specific medicine in 2013.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector reviewed the statement of purpose and found that it did largely contain all of the information required by Schedule 1. The information at times however was focussed on the wider organisation rather than specific to the centre. This will require review to ensure that the statement of purpose is an accurate description of the centre, the services provided and the manner in which care is provided.

Judgment:
Non Compliant - Minor
### Outcome 14: Governance and Management

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

### Theme:
Leadership, Governance and Management

### Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

### Findings:
There was a clearly defined management structure in place and staff were clear on the structure and reporting relationships. The person in charge reported to the head of integrated services and in the absence of the person in charge the centre was managed by a clinical nurse manager or a social care worker; the person in charge also had responsibility for another designated centre. The person in charge was suitably qualified and experienced; she was a registered nurse in intellectual disability and had also completed a BA in Health Services Management in 2010. The person in charge had established management experience but had only assumed responsibility for this service in January 2014.

There was evidence of a system for reviewing the quality and safety of care and services provided and there was documentary evidence of audits completed by the wider organisation, in the centre, on health and safety, property maintenance and an unannounced review of the personal planning process had been undertaken in June 2014. The person in charge had recognised the requirement for and benefit of consultation with service users and records seen indicated that formal weekly meetings were convened where routines, meal choices and social activities were discussed and agreed with residents.

It was evident from speaking with staff and from records reviewed that management sought to promote the delivery of safe quality care and had identified some of the risks and deficits as also identified by this inspection process; they had not however been satisfactorily resolved. Given the inspection findings the inspector concluded that the management system in place did not allow for the person in charge to be sufficiently engaged in the governance, operational management and administration of the service to ensure that the service provided was safe, appropriate to and adequate to meet residents needs, was consistent and effectively monitored.

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

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The staff rota indicated and the person in charge confirmed that while two staff were present in the centre overnight, night time staffing consisted solely of “sleepover staff” from 23:00hrs to 07:30hrs. Based on her observations, records reviewed including clinical records, accident and incident records and risk assessments the inspector concluded that these night time staffing arrangements were not appropriate to ensuring the safe delivery of services; did not meet the needs of the residents and did not ensure that residents received support and assistance in a timely manner. While acknowledging that the risk to resident safety and quality of care had been identified by the person in charge, was fully accepted by management and that plans were in progress to address this deficiency, given the risk identified an immediate action plan was issued to the provider prior to the conclusion of the inspection. The provider responded positively and confirmed by e-mail on the 16 October 2014 that the staffing arrangement required was in place from 22:00hrs on the day of inspection.

While staff were very familiar with each residents needs and requirements there was no evidence based, explicit and quantitative tool utilised to assess needs and ensure that staff numbers and skill-mix were appropriate and adequate to the assessed needs of the residents and other factors such as the layout of the building and the services provided including transportation to and from the service.

The scope of the staff training programme and the monitoring of attendance at staff training were not sufficient to ensure that staff had and were facilitated to maintain up to date knowledge and skills to meet the assessed needs of the residents. There were approximately 12 staff listed on the staff rota and training records for the purposes of inspection were available for 10. The records indicated and the person in charge confirmed that there were deficits for significant numbers of staff (on average 30%) in mandatory and core areas including fire safety, protecting and safeguarding vulnerable adults, the management of behaviours that challenged, manual handling and medication management. The scope of the staff training programme did not reflect the assessed needs of the residents in areas such as falls prevention and management, wound prevention and management and continence promotion.

The person in charge was not present in the centre on a daily basis and while formal
collective staff meetings had been initiated, the person in charge confirmed that there was no explicit system in place to ensure that staff were adequately and appropriately supervised.

A sample of staff files were made available to the inspector for the purposes of facilitating the inspection; their content satisfied the information requirements of Schedule 2 and supported the provider’s robust recruitment process. Core qualifications seen indicated that staff had qualifications suited to the stated purpose of the service including intellectual disability nursing and social care.

**Judgment:**
Non Compliant - Major

**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:**

Mary Moore  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
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<td>Date of Inspection:</td>
<td>15 October 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>07 November 2014</td>
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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 05: Social Care Needs

Theme: Effective Services

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

It was not clear how residents’ needs including their healthcare needs were comprehensively assessed. It was not clear how the assessment was supported perhaps by the appropriate assessment tool to ensure that the assessment and care was evidenced based.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
- Each resident visits their GP annually, at a minimum.
- Each resident has a Person Centred Plan as well as an Adaptive Behaviour Scale Assessment tool completed to identify priorities within their lives.
- Each resident has access to community health nurse, dietician, optician & dentist from the local Primary Care Team.
- Each resident has access to Multi-Disciplinary Supports (Psychology, Social Work, Behaviour Support Team, Occupational Therapy, Physiotherapy and Psychiatry as required) from within the Services.
- Multi-Disciplinary Team meetings took place for 2 residents on 02/10/14  
  Multi-Disciplinary Team meetings took place for 2 residents on 06/11/14  
  Multi-Disciplinary Team meetings scheduled for remaining residents on 06/12/14.
- System of 3 monthly scheduled Multi-Disciplinary Team Meetings agreed to commence 2015.
- The Barthel Assessment Tool has also been completed as discussed with the Inspector, to identify dependency levels for all residents. This will be reviewed annually or more frequently if there is evidence of a change in dependency. Barthel Assessment completed for all residents 23/10/14

**Proposed Timescale:** 06/12/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no plans in place setting out the arrangements to meet some established needs such as falls prevention and management and wound prevention and management. Given the existing staffing arrangements it was not possible to devise and implement an effective and meaningful plan of care that promoted the residents safety, well being and welfare over a continuous 24 hour period.

**Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
- Waking night staff put in place on 15/10/14.
- Business case to fund the additional costs arising from the change in roster and skill mix forwarded to HSE (24/10/14) to increase the nursing support by day.
- Nursing supports in place pending response to business case above. These supports are being provided by 1 part-time rostered nurse post (existing roster) and supernumerary nurse manager post (CNM2 x 3 days; CNM1 x 2 days).
• Updated Manual and People handling policy adopted 24/11/14.
• A moving and handling care plan will be developed for each resident where moving and handling is required in order to mitigate against the risk of fall.
• Falls assessments by physiotherapist have been completed for 2 residents. Discussed at MDT (6/11/14)
• Would care management plan (Roper Logan Tierney Health Care adapted from DML Integrated Plans HSE 2010) completed 28/10/14 and reviewed weekly and more often as required.
• Additional nursing support: 20th October 2014
• Falls assessment completed for 2 residents: 03/11/14
• Fall assessment for relevant remaining residents will be completed on a prioritised phased basis by the services physiotherapist by 19/12/14

Proposed Timescale: 19/12/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a deficit of suitable storage.

The main bathroom was equipped with an assisted bath; however, the bath did not meet individual resident’s needs and preferences and necessitated the further use of one of the already shared en suites.

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

Please state the actions you have taken or are planning to take:
• Estimates for upgrading of room adjacent to laundry to be adapted to a sluicing area which will also provide for storage of environmental cleaning and laundry equipment have been sought.
• Estimates of upgrade of bathroom to include a floor level shower area have been sought.

Proposed Timescale: 30/11/2014

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:
Risk assessments did not extend to the identification and assessment of all risks throughout the designated centre, all work practices and all areas of work; all identified control measures such as staffing and staff training were not in place.
**Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
- Local Operational Risk Management Procedures adopted August 2014
- Person in Charge attended Risk Management Training: 16/09/14
- Night risk assessments commenced September 2014 and will be on-going as risks are identified.
- Remaining risk assessments will be completed for hazards identified. This will be an on-going process.

**Proposed Timescale:** 31/12/2014
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risks as specified in regulation 26(1)(c) were not included in the risk register.

**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
- Missing Person Policy adopted February 2014;
- Missing Person Form completed for all residents and retained in individuals My Profile, My Plan;
- Person in Charge will complete a risk assessment for unexplained absence for residents who may be at risk of absconding and implement measures required to ensure safety. A generic risk assessment for this type of risk is included in the Risk Management procedures and will guide this assessment.

**Proposed Timescale:** 30/11/2014
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risks as specified in regulation 26(1)(c) were not included in the risk register.

**Action Required:**
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.
Please state the actions you have taken or are planning to take:
• Risk assessments completed for residents for slips, trips and falls and mitigations identified to reduce same in October 2014;
• Person in Charge will complete risk assessments for visitors & staff for slips, trips and falls;
• Person in Charge will identify any further hazards that may lead to accidental injury, risk assess and implement measures identified to reduce same. This will be an on-going process as hazards are identified.

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

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risks as specified in regulation 26(1)(c) were not included in the risk register

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

Please state the actions you have taken or are planning to take:
• Policy on Management of Aggression & Violence 2009 is in place. This policy is currently being updated by a National Team of the Brothers of Charity Services promoting positive approaches to challenging behaviour.
• Behaviour Management Plan in place where applicable, due for review March 2015 if earlier if necessary.
• All staff due for updating will be trained in the MAPA model of non crisis intervention on 17/11/14, 28/11/14 and a date to be confirmed in December. Review of risk assessment completed for resident who can display aggressive behaviour on 6/11/14.

**Proposed Timescale:** 22/12/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risks as specified in regulation 26(1)(c) were not included in the risk register.

**Action Required:**
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
Risk assessments completed for relevant individuals in designated centre who engage in self harm.
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a functioning staff-call system in place; however all call points were not within easy reach of the resident or the residents’ bed.

**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:**
- Waking night staff in place in centre to attend to needs of residents at night – in place with immediate effect;
- Night time observations of residents recorded – in place with immediate effect;
- Review of call system commenced with Occupational Therapist to ensure that all call points are accessible to resident. Some call points will require to be relocated.
- Educate residents on use of call bells.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Manual handling risk assessments were not in use and training records seen indicated that at least three staff did not have the required mandatory update in manual handling training.

**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:**
- Training scheduled for 3 out of date staff on 03/12/14 and 09/12/14;
- Person in Charge will complete all Manual Handling Risk assessments for relevant residents and implement measures identified to reduce risk. Risk assessments completed by 23/11/14

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no infection prevention and control policy in place to guide practice; sluicing facilities were inadequate and staff were not provided with the appropriate equipment
to allow them to safely manage soiled linen.

**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:**
- Alginate bags provided to manage soiled linen;
- Room adjacent to laundry will be adapted to a sluicing area which will also provide for storage of environmental cleaning equipment and laundry. Cost of upgrade work has been sought;
- Draft local policy has been developed and will be adopted by 30th November 2014.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire register was substantially incomplete and did not provide evidence that fire equipment was suitably tested and maintained at the required intervals. The fire detection system had not been inspected and tested to the required standard since June 2012. There was no evidence of the inspection and testing of the emergency lighting. There were no in-house procedures for the reviewing and testing of fire equipment. Some fire doors were wedged open thereby negating their function in the event of fire. The building used for social and recreational purposes was not connected to the fire detection system.

**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 drills completed bi-monthly in centre;
- Fire detection system checked 10/10/14 and procedure now in place for quarterly checks by registered company;
- Emergency lighting inspected on 06/11/14 and procedure in place for on-going quarterly checks by registered company;
- Person in Charge has set up in-house system of daily check of fire detection system.
- The building used for social and recreational purposes will be closed until a full review of the fire system takes place.

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
Training records indicated that while fire training had been provided in May 2014 two staff had no recorded attendance at fire training and one had not attended training since 2011.

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 scheduled for staff 18/11/14.

Proposed Timescale: 18/11/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure to be followed in the event of fire was available only in the main administration office and was not prominently displayed where it could be readily accessed by all.

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:
Procedure to be followed in the event of a fire is displayed in prominent places throughout the centre – 17/10/14.

Proposed Timescale: 17/10/2014

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two sets of bedrails were in use but the night time staffing arrangements did not support the safety of their use as it was not possible to supervise and monitor their use in accordance with national policy and evidence based practice.

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:
• Waking night staff put in place 15/10/14;
• Discussion on use of bedrails took place with Occupational Therapist 06/11/14. Full review to include discussion with residents and waking night staff to assess the use or removal of bedrails.

**Proposed Timescale:** 14/11/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records indicated that training frequency on protecting vulnerable adults was not in line with local policy, not up to date and therefore not sufficient to meet the needs of current residents.

**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:**
Training on the Protection and Welfare of Vulnerable Adults provided to relevant staff on 21/10/14, 22/10/14 & 24/10/14.

**Proposed Timescale:** 24/10/2014

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**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 policy on and procedure for the disposal of unused, unwanted or out of date medications was insufficient and no records of their return/disposal were maintained.

**Action Required:**
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**
• A Medication Returns Form has been put in place in the centre – November 14 - which will be signed by staff and co-signed by pharmacist at delivery of monthly medication order. Records will be maintained in centre.
- Pharmacist will provide training to staff on 27/11/14 and 04/12/14

**Proposed Timescale:** 04/12/2014  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some medication was required to be administered in an altered format (crushed) and there was no evident medical authorisation for this.

While a prescription was in place to support all medications administered, one medication required by more than one resident was not labelled as resident specific and was as necessary administered to a resident other than the resident for which it was prescribed and supplied.

**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:**
- Prescription amended by GP to include administration of medication in an altered format – 05/11/14;  
- Person in Charge has discussed with pharmacist that specific medication required by more than one resident will be labelled resident specific and will not be transferable to other residents – 06/11/14

**Proposed Timescale:** 06/11/2014

**Outcome 13: Statement of Purpose**  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The information contained in the statement of purpose was at times focussed on the wider organisation rather than specific to the centre.

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

**Please state the actions you have taken or are planning to take:**
Review Statement of Purpose and amend to be more centre specific rather than organisation specific.
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 management system in place did not allow for the person in charge to be sufficiently engaged in the governance, operational management and administration of the service to ensure that the service provided was safe, appropriate to and adequate to meet residents needs, consistent and effectively monitored.

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

Please state the actions you have taken or are planning to take:
1. Person in Charge will be based in Designated Centre for three days each week as and from week commencing 20th October 2014.
2. This placement of the PIC will continue until such time as the recommendations of HIQA inspector are in place.
3. This position will be backfilled in other centres by a CNM1 on a supernumerary basis for this period of time.
4. Immediate action of a rostered CNM1 to this centre will take place on the 18th and 19th October.
5. Full review of skill mix of staff and roster in Designated Centre with a view to increasing nursing supports using the Barthel Index of Activities of Daily Living. This review will be completed by 24th October 2014.
6. Business case to fund the additional costs arising from the change in roster and skill mix will be forwarded to HSE by Friday 24th October 2014.

Proposed Timescale: 24/10/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The night time staffing arrangements were not appropriate to ensuring the safe delivery of services, did not meet the assessed needs of the residents and did not ensure that residents received support and assistance in a timely manner.

There was no evidence based, explicit and quantitative tool utilised to assess residents’ needs and ensure that staff numbers and skill-mix were appropriate and adequate to the needs of the residents and other factors such as the layout of the building and the
services provided including transportation to and from the service.

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

**Please state the actions you have taken or are planning to take:**
1. One sleep over post replaced by a waking night staff from the 15th October 2014.
2. Night staffing in future will comprise of one waking staff and one sleepover staff.
3. Residents will be supported to understand the new staffing arrangements at night and will be educated on how to alert staff if they require their support.
4. This process has already commenced with residents and will be discussed as part of a residents meeting this weekend.

**Proposed Timescale:** 15/10/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The scope of the staff training programme and the monitoring of attendance at staff training were not sufficient to ensure that staff had and were facilitated to maintain up to date knowledge and skills to meet the assessed needs of the residents.

**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 required by staff scheduled.
- Meeting scheduled 14/11/14 between Training Department and Senior Managers to review system of how Person in Charge monitors training records of staff to include Protection and Welfare of Vulnerable Adults, Manual and Client Handling, Fire Training. This review will include the dissemination of quarterly staff training reports to Person in Charge from Training Department. Interim reports can be requested as required. Person in Charge can also access individual staff training records as required.
- Dementia training will be provided to all staff working in centre by Clinical Neuro Psychologist (member of Multi-Disciplinary Team) in January 2015.
- Continence advisor providing training to staff on 20/11/14.

**Proposed Timescale:** 31/01/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no explicit system in place to ensure that staff were adequately and
appropriately supervised.

**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:**
- Monthly staff meetings with agenda and minuted will be chaired by Person in Charge or designate and commence in centre in November 2014. Minutes of meetings will be available in the centre.
- Weekly meetings each Monday morning commencing 10/11/14 for all rostered staff and chaired by the most senior person on duty.

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