**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-0004838</td>
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<td>Centre county:</td>
<td>Limerick</td>
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<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 Ireland</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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<tr>
<td>Support inspector(s):</td>
<td>Paul Dunbar</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>5</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>4</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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 05 March 2015 10:00  To: 05 March 2015 19:30

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 centres first inspection by the Authority. When this inspection was undertaken the designated centre compromised of two separate and distinct services; one house in which residential services only were provided and a house where respite services only were provided. Following the inspection the provider was requested to review the configuration of the designated centre in line with the guidance provided by the Authority.

On the day of inspection there were three residents in receipt of residential services and two residents availing of the respite service. All of the residents were attending their scheduled day care services. Inspectors met with the residents of the residential service but not those in the respite service as they had a scheduled social outing further to their day spent in day care.

In summary it was evident that this was a service to which regulatory requirements were new and challenging; there was some evidence of measures taken to comply with the regulations such as the appointment of a person in charge and the completion of unannounced visits to the centre to evaluate the quality and safety of the services, care and support provided to residents. The providers own review concluded that while there was evidence of good practice significant work to effect improvement was required. The findings of this inspection by the Authority would concur with that finding and the overall level of regulatory compliance evidenced was
not good. The provider was judged to be in major non-compliance with five outcomes and in moderate non-compliance with the remaining three. Risk was identified in the failure to respond in a timely manner to concerning incidents and the failure to demonstrate what learning if any had consequently occurred.

The inspector was not satisfied that the current governance structures were sufficient to address the level of non-compliance evidenced or indeed how they had possibly and inadvertently contributed to it.

The findings to support these conclusions are discussed in the body of the report; the actions required of the provider are listed in the action plan at the end of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors reviewed the procedures for the management of complaints. There was evidence of improvement made following actions issued to date by the Authority in relation to the procedure for receiving and managing complaints. However, there was still some lack of clarity that requires further review and monitoring to ensure that all complaints are effectively recorded in a co-ordinated manner, investigated, resolved and monitored.

A local complaints log book had been introduced and the person in charge said that local procedure was that any complaint received by staff that could be resolved locally was recorded in the complaints log; complaints that could not be resolved by staff were communicated to her and recorded by her in her complaints log. A pictorial format complaints form was also available to residents. In effect there were three potential complaint records.

The format of the recently introduced complaint log was not ideal in terms of demonstrating effective complaints management and satisfying regulatory requirements as it did not address what actions were taken on foot of the complaint and whether or not the complainant was satisfied. The amendments necessary to the template were discussed with the person in charge and the area manager.

The person in charge confirmed that residents readily expressed concerns of dissatisfaction to staff and there was one open complaint from a resident at the time of inspection pertaining to the garden boundary. Residents were also reported to have expressed dissatisfaction with the maintenance of the physical environment; however, there was no record of any complaint made in the centre. The person in charge
confirmed that both she and the area manager were exploring the actions necessary to resolve the open complaint; there was evidence of some improvement made to the premises such as the purchasing of new fittings and furniture.

**Judgment:**
Non Compliant - Moderate

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**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

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

**Findings:**
There was a system in place for the assessment of each residents needs; the information gathered was then used to inform a personal plan, my profile my plan. There was evidence of identified priorities in the plans and inspectors saw that some of these were achieved in reality for residents particularly those of a personal and social nature such as hobbies, skills development, and enhanced independence. Aspects of the plans were presented in a pictorial format.

The person in charge said that staff were challenged by the requirements of record keeping; however with adequate support inspectors saw that the plans had the potential to achieve full compliance.

However, much of the documentation was undated and therefore difficult to ascertain when it was completed and reviewed. Persons responsible for supporting residents to achieve priorities were not identified nor were timescales. There was no clear system for the review of the effectiveness of the plan, whether priorities had been achieved and if not why not. The participation of the resident in the plan or its review was not strongly evident.

A greater challenge to the process was that the plan did not reflect all of the residents needs particularly those of a psychological or behavioural dimension. Where there were clearly identified needs these were not integrated into the plan and the plan was not reviewed and updated to reflect changing needs. The rationale provided to inspectors for this was confidentiality but it was difficult to see how a plan could be truly
meaningful and safe if all needs, supports and multidisciplinary inputs were not integrated into one complete personal record for each resident. For example, up until very recently the person in charge reported that records of multidisciplinary reviews were not maintained in the file or in the centre. The provider's own governance statement on protection stated that “a system for cross-referencing confidential files in main service delivery files should be in place”. This is referenced again in Outcome 8; safeguarding and safety.

Judgment:
Non Compliant - Moderate

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:
There were measures in place relating to the health and safety of residents, staff and visitors to the centre. However, a significant failing was identified in the management of incidents; failings were also identified in fire safety precautions.

The centre had an emergency plan in place. This detailed the actions to be taken in the event of a fire, loss of power, water or heat, and other associated emergencies. Staff were knowledgeable about what to do should an emergency arise. Each resident had a personal emergency evacuation plan (PEEP) which described his specific needs should an evacuation be necessary. One resident with a sensory disability was currently awaiting the provision of assistive technology which would alert him when an alarm sounded in the centre. However, there was documentary evidence to support that the device had not yet been provided resulting in ongoing risk as there was a query as to who should fund the device.

The provider had recently carried out an audit of the health and safety provisions in the centre. This report, while only in draft form, was made available to the inspectors. One of the findings of the audit was that there was no missing persons profile available for each resident. The inspectors found that this task had been completed and each profile was placed in the person's file.

The provider's audit also found that there was no risk register in place in the centre. Inspectors found that this had also been attended to and that the person in charge had carried out risk assessments for a number of hazards in the centre. These included smoking, infection control, and uneven ground outside the house. The inspectors were satisfied there were suitable controls in place to address the identified risks.
There was a risk management policy in place in the centre. The policy outlined how risks were to be identified, assessed and managed. However, as required by the Regulations, the policy did not contain the measures and actions in place to control the following specified risks: the unexpected absence of any resident; accidental injury to residents, visitors or staff; aggression and violence; self harm. The centre did have stand-alone policies on three of the above four but there was no policy on self harm.

Inspectors were not satisfied that there were safe and adequate arrangements in place to attend to in a timely manner, and learn from adverse incidents. Incidents and accidents in the centre were recorded on a standard form and maintained in the respective residents' file. The incident/accident forms were completed by the staff member on duty and forwarded directly to an area manager. Inspectors saw that one such concerning and serious report was not reviewed by the area manager until almost three weeks post the event. At the time of this inspection, four months post the event it was not clear what learning if any had taken place from this omission and from the event itself to safeguard both residents and staff. In addition, it was not clear to inspectors that the person in charge was aware of or kept informed of the follow-up actions required after an incident/accident. For example, the person in charge informed inspectors that multi-disciplinary meeting minutes arising out of incidents/accidents were not ordinarily returned to the resident's file. This is discussed again in Outcomes 5 and 8.

Inspectors reviewed the fire safety measures in place in the centre. Fire fighting equipment was available and marked as recently serviced. The person in charge however was not aware of any certification provided by the servicing company to the centre. There were four smoke/fire alarms in the house and the person in charge advised inspectors that these were manually tested by staff on a monthly basis.

There was no emergency lighting in the centre and the emergency exits were not clearly identified. There was also no emergency evacuation plan displayed in a prominent place in the centre. One resident was a smoker and was facilitated to smoke in the utility room to the rear of one of the houses in the centre. There was no fire fighting equipment in the smoking area and it did not have a smoke alarm.

Given the centre's setting in the community the provider was unsure as to whether the fire precautions outlined above were necessary. However, at the time of inspection, the provider had not sought a report from a suitably qualified, independent engineer to certify that the centre was compliant with the requirements of the relevant fire safety legislation.

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

**Theme:**  
Safe Services

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

**Findings:**  
Failings were identified in facilitating timely positive behavioural supports. Management was not clear on the regulatory requirement to integrate and review any therapeutic interventions as part of the personal planning process.

There was a policy and a clear procedure in place for the identification, reporting and investigation of any alleged, reported or suspected abuse; the person in charge was clear on the procedure and the information conveyed to inspectors concurred with the policy and procedure reviewed. The policy however was dated 2009 and while it referenced reporting responsibilities to other statutory bodies it had not been reviewed and updated to include notification requirements to the Authority.

Training records seen indicated that all staff had undertaken mandatory training both on the protection of vulnerable adults and responding to behaviours that challenged.

Records seen referenced the use of restrictive practices and the requirement of accurate record keeping for the purpose of safeguarding residents and staff. There were no behavioural support plans in place that clearly specified the nature of the restrictive practice, the rationale for its use, the duration of its use and its review. As discussed in outcome 5 the personal plans did not reflect all of the residents needs particularly those of a psychological or behavioural dimension and did not address the impact if any of behaviours and associated restrictive practices on the plan and identified priorities.

**Judgment:**  
Non Compliant - Major
### 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:**
There was evidence that staff supported residents to access services required to maintain physical health and wellbeing. The person in charge said and records seen indicated that residents had a choice or General Practitioner (GP); residents were supported as necessary to access their GP, there was evidence that prescribed treatments were facilitated such as referral to the acute hospital services, antimicrobial therapy or the administration of seasonal influenza vaccination. There was further documentary evidence that residents has access to other healthcare services such as dental review and treatment, optical review and chiropody.

However, other than the minutes of multi-disciplinary review meetings there was little or no evidence in the personal plans to support access to multi-disciplinary supports as appropriate to residents assessed needs or that the personal plan reflected the real, assessed needs of each resident. This would concur with the providers own recent reviews of the service. This is discussed again in in outcomes five and eight.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

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

**Findings:**
There were recently reviewed (February 2015) written operational policies relating to the ordering, prescribing, storage and administration of medicines to residents; however, all practice was not yet in line with policy.

The person in charge reported that residents in receipt of residential services enjoyed
good health and this was reflected in the type and number of prescribed medications in use.

Medications were securely stored and supplied to the centre by a local pharmacy; each medication seen was clearly labelled and supplied for individual resident use.

No resident was managing their medications independently, however the person in charge confirmed that this practice was not informed by a formal assessment that established each residents choice and capacity or otherwise to manage their own medications.

Each resident had a dated and signed (completed by the General Practitioner) prescription record and an administration record. However, the inspector noted that one prescription record was signed as last rewritten in October 2012.

The prescription record had an alphabetical code for each prescribed medication but this was not used by staff when recording administration. Staff recorded that the “blister pack” was administered rather than each medication and this would not concur with best practice guidance. The current medication management policy did not adequately address or provide clear guidance on this issue in that it did not specifically reference the use of medication administration aids. The policy did however define medication administration as the “giving of an individual dose of a medicinal product” rather than the administration of a “blister pack”.

The medication policy was not specific as to the timeframes for the provision of medication management training to staff; training records indicated that one staff member had no training and the remainder of staff had not received training since 2010. This was of concern to inspectors given the medication management practice for respite residents as reported by the person in charge. The person in charge told inspectors that staff did not record the administration of medications to residents receiving respite care. The rationale provided for this practice was the supply of medications in containers as opposed to a blister pack. As staff believed they were not in a position to be assured as to the content of the medication container they did not record its administration. It was of concern to inspectors that staff would proceed to administer a medication of whose identity they were unsure while somehow perceiving that not maintaining a record of administration somehow absolved them of responsibility in the event of a medication error.

Judgment:
Non Compliant - Major
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:
The inspector was not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents individual and collective needs, consistent and effectively monitored. The inspector was not satisfied that the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities as set out in the regulations and to ensure the effective governance, operational management and administration of the centre including the consistent monitoring of care, services and staff. In the context of regulatory requirements and legal responsibilities there was a lack of clarity on roles, responsibilities and reporting relationships between the area manager and the person in charge such as the reporting and management of accidents and incidents and medication errors. Minutes of multi-disciplinary meetings seen by inspectors indicated that the person in charge while present was not nominated as responsible for the implementation of any required actions including those relevant to the welfare and wellbeing of residents.

The person in charge was appointed to her post in July 2014. The inspector found the person in charge to be suitably qualified; she had established relevant experience within the organisation. This was the first management position held by the person in charge and the inspector was satisfied that she articulated accountability and responsibility, had a sound understanding of the requirements of her role and regulatory requirements and was committed to ongoing review and improvement.

However the post of person in charge was not full-time due to on-call and sleepover duties and the impact of these arrangements on the availability of the person in charge. At the time of this inspection there was a lack of clarity as to the extent of the on-call responsibilities. There were in effect 30 hours per fortnight of protected time for the role and duties as person in charge of the centre. Given the significant level of non compliance evidenced the inspector was not satisfied as to the effectiveness of the governance arrangements.

There was a system in place for the monitoring and review of the safety and quality of the care and services provided to residents. As required by article 23(2) the provider had made arrangements for the unannounced inspection of the centre on a six monthly
basis. The reports were made available for inspection and indicated that good practice was evidenced but deficits were also acknowledged. There was evidence of improvements made further to this process of review such as the completion of a risk register. Many of the failings identified would concur with the findings of this inspection such as record keeping, personal planning and the management of and learning from concerning incidents. The unannounced visit was recent having taken place on the 17 February 2015 and a detailed action plan and timeframes outlining what actions were to be taken to address concerns raised was not yet in place.

Minutes were maintained of regularly convened “house meetings” with residents. The minutes however read as a record of the operational management of the house and completed activities rather than a forum for consultation with residents and feedback from them on the organisation, quality and safety of services and supports provided to them.

Minutes of multi disciplinary meetings seen by inspectors indicated that they offered staff an opportunity to raise concerns and exercise their professional responsibility for the quality and safety of the care and support provided to residents.

**Judgment:**
Non Compliant - Major

**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 person in charge described the staffing arrangements in the centre. While inspectors were satisfied that one of the units within the centre was adequately staffed, inspectors were not satisfied as to the staffing arrangements in the respite unit.

The person in charge demonstrated knowledge about the mandatory training required by all staff in the centre. Training records were produced which confirmed that all staff had up-to-date training in fire, manual handling, abuse and behaviours that challenge. Staff also undertook additional training including infection control, person-centred planning and basic food hygiene. Inspectors were not however satisfied with the arrangements for the provision of medication management training; one staff member
had no recorded training and the remaining staff had not received training since 2010.

This inspection was unannounced. Staff files were maintained in a central administrative location and were not readily available in the centre at the time of inspection.

One unit in the centre accommodated three residents on a residential basis. There was one staff assigned to this house at times when the residents were present i.e. when they were not attending their respective day services. The person in charge informed inspectors that the staff would begin their shift at approximately 4.30 pm. They would transport residents from their day service to the house. The staff would then assist the residents in various activities of daily living such as cooking, cleaning or accompanying them on activities. The staff member was then present in the house from 11 pm to 7 am in a sleepover capacity. The staff would subsequently work from 7 am to 9.30 am at which point they would transport residents to their day service. There was a similar arrangement in place at weekends.

The other unit within the centre was a respite service. This house catered for a maximum number of five residents at any one time. There were currently 26 people who availed of the respite service. However, the person in charge informed inspectors that the maximum staffing complement in this unit was one staff member; this was regardless of the number or needs of the residents in respite at any one time. The person in charge informed inspectors that efforts were made to coordinate admissions of residents on the basis of similar capacities and needs. However, it was confirmed that this was not always possible. For example, the person in charge outlined a scenario whereby a person with limited mobility and a preference to remain in the centre would be placed in respite at the same time as a resident with full mobility and a desire to partake in activities outside of the centre. As such, due to staffing levels, it was not possible to meet the needs of both residents. This was an issue which was reported to be particularly prevalent at weekends. There was no evidence to support any arrangement for increased staffing supports in line with residents needs.

The person in charge did not maintain a copy of the staff rota in the centre.

The person in charge informed inspectors that she was regularly present in both units in the centre and was in a position to supervise staff in this manner. However, her ability to meet with all staff was also reported to be constrained by her current working arrangements. There were no formal staff appraisals completed with any grade of staff within the organisation.

**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

**Centre name:** A designated centre for people with disabilities operated by Brothers of Charity Services Limerick

**Centre ID:** OSV-0004838

**Date of Inspection:** 05 March 2015

**Date of response:** 28 May 2015

**Requirements**

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

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

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

**Theme:** Individualised Supports and Care

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

There was a lack of clarity that required further review and monitoring to ensure that all complaints are effectively recorded in a co-ordinated manner, investigated, resolved and monitored.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
- The current Complaints policy of the Brothers of Charity Services Limerick is being revised in order to clarify the recording, investigation, resolution and monitoring of complaints. This revised policy must be approved by the HSE.
- Once this Policy is approved by the Policy Review Group training will be provided to Managers and Staff on this policy.
- In the interim a book to log all complaints is now placed in the Designated Centre.
- Revised complaints logs will be printed after Complaints Policy is passed. A log will then be placed in the designated centre.
- Area manager will discuss with designated centre staff and PIC the importance of logging all complaints from residents and others and tracking any complaints made and informing complainant of outcome.

**Proposed Timescale:** 31/05/2015

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**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:**
Traditionally records of multi-disciplinary reviews were not maintained in the file or in the centre.

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

**Please state the actions you have taken or are planning to take:**
- The My Profile My Plan filing system has a section for Multidisciplinary meetings.
- All multidisciplinary meeting will be filed in this file for each individual as appropriate.
- The process for person centred planning supports the involvement of multidisciplinary team as part of the circle of support.

**Proposed Timescale:** 15/04/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no clear system for the review of the effectiveness of the plan, whether priorities had been achieved and if not why not. The participation of the resident in the plan or its review was not strongly evident.
**Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
- The process of person centred planning recommends the review of priorities and their achievement on a quarterly basis.
- A quarterly review will be scheduled for each resident in order to review priorities with the resident.
- Any barriers to achieving priorities will be documented on the existing barrier form and escalated where appropriate.
- The person centred planning process is being reviewed at present by the Quality forum.

**Proposed Timescale:** 15/04/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The plan did not reflect all of the residents needs particularly those of a psychological or behavioural dimension. Where there were clearly identified needs these were not integrated into the plan and the plan was not reviewed and updated to reflect changing needs

**Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
- My Profile My Plan for each resident is an overarching file which includes sections for all relevant plans including
  - The resident's person's centre plan (where the resident and their circle of support identify priorities for the resident to work on for the coming year)
  - The resident's behaviour support plan where required (where any behaviour supports required are outlined).
  - Information on any multidisciplinary supports received – including support for Psychology and Social Work.
- There is an organisational requirement for the keyworker and the PIC to review My Profile My Plan on a semi-annual basis.
- The area manager will discuss the requirement for regular review of MPMP with the PIC and staff in the centre and will ensure same is carried out. A template to aid this review has recently been developed and circulated to all PICs.
• The PIC will link with MDT regarding required access to documentation.

**Proposed Timescale:** 31/05/2015

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### 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:**

The risk management policy did not contain the measures and actions in place to control the following specified risks: the unexpected absence of any resident; accidental injury to residents, visitors or staff; aggression and violence; self harm. The centre did have stand-alone policies on three of the above four but there was no policy on self harm.

**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:**
- Included in our Health and Safety Statement, updated in June 2014, is a generic risk assessment setting out the standardised mitigations that are put in place to manage aggressive behaviour including self harm.
- Mitigations include the use of:
  - Staff training in non violent crisis and intervention
  - Restrictive practice guidelines and decision making forms.
  - Behaviour Support Plans
  - Person Centred Plans
  - Multidisciplinary team supports
  - Accident and Incident reporting
  - Policy on the management of aggression
- Nationally within the Brothers of Charity Services a group has been set up to develop a policy on positive behaviour support which will include self harm.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

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

One concerning and serious incident report was not reviewed by the area manager until almost three weeks post the event. At the time of this inspection, four months post the event it was not clear what learning if any had taken place from this omission and from the event itself to safeguard residents and staff.

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

**Please state the actions you have taken or are planning to take:**
- Acting Head to Community Services has met with PIC and Area Manager to discuss how incident reports are received, reviewed and followed up.
- PIC will receive a copy of all incident reports.
- In future incident reports will be sent directly to Area Manager (when on duty) who will review immediately.
- Issues or behaviours that are a cause for serious concern will be acted on immediately and MDT will be contacted as needed.
- Written notes will be kept in MPMP of actions taken and monitoring of same.
- Frontline staff will be informed of any actions or recommendations regarding the incident at the earliest opportunity.

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**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident had not been provided with the assistive technology required to alert him when the fire alarm sounded in the centre.

**Action Required:**
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

**Please state the actions you have taken or are planning to take:**
- Assistive technology has been purchased by the organisation and installed in the designated centre to give the resident warning of fires both during the day and at night.
- PIC has arranged for representative from installers to visit the house and demonstrate products to staff.

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**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was not aware of any certification provided by the servicing company to the centre to confirm the inspection and testing of fire fighting equipment.

**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:
• Certification is available to confirm the date that all fire safety equipment was inspected and tested in the designated centre. The document also states if equipment was replaced.
• A copy of this document has been sent to Area Manager for placement in fire register.

Proposed Timescale: 15/04/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Given the centre’s setting in the community the provider was unsure as to the sufficiency of the fire precautions in place. The provider had not sought a report from a suitably qualified, independent engineer to certify that the centre was compliant in terms of the requirements of the relevant fire safety legislation

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

Please state the actions you have taken or are planning to take:
• A qualified independent engineer has been engaged to inspect the premises and to provide a fire safety report to certify compliance with fire safety regulations and to recommend any work needed for compliance.

Proposed Timescale: 15/05/2015

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to maintain accurate record keeping for the purpose of safeguarding residents and staff of the use of restrictive practices

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:
• On reviewing the draft monitoring report, a number of restrictive practices were identified in the designated centre.
• All of these restrictive practices will be reviewed with reference to the organisation’s
restrictive practice procedures.

**Proposed Timescale:** 31/05/2015  
**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There were no behavioural support plans in place that clearly specified the nature of the restrictive practice, the rationale for its use, the duration of its use and its review

**Action Required:**  
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**  
- On reviewing the draft monitoring report, a number of restrictive practices were identified in the designated centre.  
- All of these restrictive practices will be reviewed with reference to the organisation’s restrictive practice procedures.

**Proposed Timescale:** 31/05/2015

**Outcome 11. Healthcare Needs**  
**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was evidence to support that the provider had adequate arrangements in place to meet physical healthcare needs but not other healthcare needs such as psychological and mental health

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

**Please state the actions you have taken or are planning to take:**  
- The organisation provides support for mental health needs through the services of the internal Psychiatry Department and Psychology Department. Residents can be referred and appointments sought as required.  
- Other health needs are met through the services of PCCC services or GP referral

**Proposed Timescale:** 09/04/2015
### Outcome 12. Medication Management

**Theme:** Health and Development

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

No resident was managing their medications independently, however the person in charge confirmed that this practice was not informed by a formal assessment that established each residents capacity or otherwise to manage their own medications.

**Action Required:**
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

In accordance with the Community Medication Management Procedure:

- Each person who is supported by our services will be offered the opportunity to have a self-medication assessment. Where an individual is interested in self-medicating an assessment of capacity will be conducted and training programme will be implemented where possible. The capacity assessment and training programme are currently being developed and will be made available to all staff by the end of 2015.
- The Self-Medication Assessment will identify the levels of support required by the person regarding all aspects of administration of their medication up to and including self-administration.

**Proposed Timescale:** 31/12/2015

**Theme:** Health and Development

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

Staff administered medication of whose identity they were unsure while somehow perceiving that not maintaining a record of administration somehow absolved them of responsibility in the event of a medication error.

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

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

- The PIC and Area Manager will arrange to meet families of people who use respite services and will inform them again of the organisational policy on storing and administering medication.
- The procedure is outlined on page 9 of the Residents Information Booklet for Brothers of Charity Community Services Limerick Respite Centre as follows:
Medication is blister packed
Individual has a current Kardex which outlines the medication and the administration times of medication
This Kardex needs to be completed by the individual’s GP and updated when medication changes.

- Medication will be checked in day services on the morning that the person is due to go to respite. If the medication is incorrect families will be contacted by link workers with the view to correcting any medication irregularities.

- Individuals will not be admitted to Respite Centre if the above procedure is not adhered to.”

Proposed Timescale: 31/05/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not ensuring that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents individual and collective needs, consistent and effectively monitored.

Not ensuring that the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities as set out in the regulations and to ensure the effective governance, operational management and administration of the centre including the consistent monitoring of care, services and staff.

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

Please state the actions you have taken or are planning to take:
- There is a clearly defined management structure in place in respect of this designated Centre.
- The roles and responsibilities of the PIC are currently been reviewed and agreed.
- The PIC roster is being reviewed by the Community Management Team including PIC representatives as agreed at a meeting with the PICs on 27th May 2015.
- The roles and responsibilities of other management grades will also be reviewed and agreed.
- Direction has been given to the PICs re the escalation of issues by the PIC through the management structure.
- “On Call logs” maintained by PICs for a number of months are being reviewed by the Head of Community in conjunction with the Provider Nominee in order to review trends
and address recurring issues.
• On call arrangement will be reviewed following this analysis. Areas of system weakness/risks will also be addressed.
• Further training for the PICs and the wider management and multi disciplinary teams to be organised focused on the role of the PIC.
• Increased supervision for the PIC.
• Review of Relief Staffing to take place as a priority to ensure there is sufficient staffing in place to cover rosters.

**Proposed Timescale:** 30/09/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
House meeting minutes read as a record of the operational management of the house and completed activities rather than a forum for consultation with residents and feedback from them on the organisation, quality and safety of services and supports provided to them.

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

**Please state the actions you have taken or are planning to take:**
• PIC and Area Manager will discuss with staff the purpose of house meetings.
• PIC will develop an agenda with residents and staff that will focus on consultation, feedback and support for residents

**Proposed Timescale:** 30/04/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not satisfied as to the staffing arrangements in the respite unit. There was no evidence to support any arrangement for increased staffing supports in line with residents needs.

**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:**
• PIC has been advised that she can engage extra support staffing when required for
support of people using respite services.

**Proposed Timescale:** 09/04/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
One staff member had no recorded training on medication management and the remaining staff had not received training since 2010

**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:**
- Acting Head of Community Services has engaged with professional to provide training and refresher training for all non nursing staff who administer medication.
- The Community Medication Procedure has been reviewed and will include a definitive timeframe in which staff will receive refresher training.

**Proposed Timescale:** 31/05/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no formal staff appraisals completed with any grade of staff within the organisation.

**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:**
- A national policy on Staff Support and Supervision has been developed by Brothers of Charity Ireland. This policy will be implemented in the designated centre when passed
- A draft of this policy has been circulated
- Managers will continue to visit designated centres to meet staff and to provide support and supervision for all staff working in the centre.
- Monthly staff meetings will take place and will be documented.
- Checklist that is completed by Person in Charge is used to support staff in performance of duties. This process will be extended during 2015.

**Proposed Timescale:** 30/06/2015