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

### Centre ID:
OSV-0004783

### Centre county:
Limerick

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
Brothers of Charity Services Ireland

### Provider Nominee:
Norma Bagge

### Lead inspector:
Mary Moore

### Support inspector(s):
Margaret O'Regan;

### Type of inspection
Announced

### Number of residents on the date of inspection:
8

### Number of vacancies on the date of inspection:
1
About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

▪ to monitor compliance with regulations and standards

▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge

▪ arising from a number of events including information affecting the safety or well-being of residents

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 01 September 2015 09:15  
To: 01 September 2015 20:30

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 inspection was the first inspection of the centre by the Authority.

Residential services are provided to nine residents in two houses in relatively close proximity to each other; there were eight residents living in the centre at the time of this inspection and one vacant bed.

The inspection was facilitated by the area manager and the person in charge; inspectors also met with frontline staff on duty and the provider nominee. Inspectors reviewed records including policies and procedures, health and safety and fire safety records, complaint records, staff and resident related records. Inspectors met and
spoke with the residents when they returned in the evening from their respective day care services.

Prior to the inspection residents and relatives were invited to complete on a voluntary basis questionnaires to establish their views and experience of the care and services provided. Three relative questionnaires and nine residents’ questionnaires were returned to inspectors. The feedback received was consistently positive and indicated that residents had choice and control in their daily lives but also felt safe and “minded” by staff; one resident requested a swing for the garden.

The inspection findings were positive with a good level of regulatory compliance evidenced. Inspectors were satisfied that the centre was effectively governed and operated so as to enhance quality of life outcomes for residents. There was evidence that staff supported residents to achieve their goals and objectives including their integration and participation in their local community. The feedback received from residents was positive as to their life in the centre and the choices and opportunities available to them.

Of the full 18 Outcomes inspected the provider was judged by inspectors to be in compliance with 11 and in substantial compliance with a further four. The provider was judged to be in major non-compliance with one outcome; health and safety and in moderate non-compliance with two safeguarding and medication management. While it was evident that the provider had sought to ensure that adequate fire safety measures were in place inspectors were not satisfied with these measures given the stated purpose and function of both houses. The findings to support these judgements are presented in the body of this report.
**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:**

Residents and relatives questionnaires indicated, as did residents spoken with, that residents had choice and control in their daily life both in their routines and in their choice of social engagement and activity.

Weekly house meetings were convened and inspectors were satisfied that this was a meaningful process of consultation. For example the timing of the meeting had been rescheduled following requests from residents; residents were encouraged to actively participate as staff found that residents were more engaged when aspects of the meeting were led by a resident such as reading aloud to others from an easy read policy.

Inspectors were satisfied that residents had forums for raising complaints such as the house meetings, advocacy meetings and the positive attitude of staff. Staff described good local procedures for the management of complaints. A record of complaints was maintained and staff sought to resolve complaints at local level. Relatives surveyed said they had either no complaints or complaints were satisfactorily addressed once brought to the attention of staff. There was evidence of change where residents had expressed dissatisfaction with some arrangements such as access to television. However, the redrafted complaints policy was not yet implemented in practice and there was a general lack of clarity and inconsistency amongst staff as to who was the nominated complaints person, who dealt with any appeals and who was responsible for overseeing the management and appropriate record keeping of complaints.

There was a structured programme of advocacy that included local and regional
meetings and facilitators; one resident was the designated advocate for the centre. Records were maintained of the advocacy meetings and inspectors saw that in general few issues of concern were raised but residents believed that the process gave them a voice and confidence to discuss their issues.

Residents were registered to vote and did exercise their vote.

Staff ascertained residents religious beliefs and facilitated residents to attend religious services of their choosing but individual choice to participate or not was respected.

Inspectors were satisfied that there were transparent and accountable systems in place for the management of resident’s finances. Individualised itemised records were maintained of all transactions; receipts were available for each transaction and there was evidence that on a monthly basis the person in charge reviewed the accuracy of each resident's record. No anomalies were noted in a sample of records reviewed by inspectors.

Staff spoken with were focussed on the quality of care and services provided to residents, were respectful of residents and their individual requirements when speaking of them; this respect was also noted in the records reviewed by inspectors.

Judge: Substantially Compliant

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

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

This was the centre’s first inspection by the Authority.

**Findings:**

There was a recently reviewed and redrafted policy on communicating with residents. Staff were aware of each resident’s specific communication requirements; these and the strategies to enhance communication were set out in communication support plans. The support plan was informed as necessary by interdisciplinary team meetings. Visual cues and schedules were seen to be utilised to maximise resident consultation, choice and control over their routines. Staff told inspectors that a uniform suite of symbols was used across all services accessed by residents so as to avoid any confusion.

Residents were seen to have access to media, the local library and other technology including computers and Skype.

Residents interacted and engaged freely with inspectors in the presence of staff, clearly had their own understanding of the role of the inspectorate and told inspectors that they
were “free to say whatever they want”.

**Judgment:**
Compliant

### Outcome 03: Family and personal relationships and links with the community

**Resident and personal relationships and links with the community:**

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

**Theme:**
Individualised Supports and Care

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

This was the centre’s first inspection by the Authority.

**Findings:**

It was evident from staff and residents spoken with, and records seen by inspectors that family, social, personal and community links for residents were integral to the operation of the centre.

Residents were facilitated to have ongoing access to their family and friends and had choice and flexibility as to how these visits were arranged. Arrangements were set out in the support plan and discussed and agreed with both the resident and their family as appropriate. There was an open door visiting policy and some residents had daily telephone contact with their wider circle of family and friends. It was evident that individually and collectively residents had strong links with local and regional community facilities and organisations. Residents had access to the local “events guide” and were facilitated by staff or the “cara” system to attend events of their choosing including the cinema, the greyhound track, concerts, hotels and restaurants, adult education classes, the golf club and voluntary organisations. Staff said that the service was well supported by the local community and in return the provider held an annual open day.

Inspectors saw that staff supported residents as appropriate to develop the skills they required to integrate independently and safely into the local community such as going to the shop or visiting friends.

**Judgment:**
Compliant

### Outcome 04: Admissions and Contract for the Provision of Services

**Admissions and discharge to the residential service is timely.**

Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

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

Findings:
There were policies and procedures including a multi-disciplinary forum that governed admission to and transfer and discharge from the designated centre.

There was evidence available to inspectors that the admission and placement process took due regard of the wishes, needs, safety and wellbeing of residents, individually and collectively.

Residents were provided with an explicit contract for the provision of supports and services that detailed the services to be provided by the resident and the charge to be levied for these services. With due regard to the nature of the residents disability the contract was also available in an accessible format.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Having spoken with residents and reviewed records inspectors were satisfied that there were effective, meaningful, person centred and holistic systems in place for assessing each resident’s abilities and needs and for planning and reviewing the supports required by each resident.

It was evident that the resident participated in each aspect of this process (and their family as appropriate). Where possible residents had made their own narrative entries into the plan and/or the accessibility of the plan was supported by the use of graphics and photographs. Residents had their own “green folder” which they invited inspectors to see and which they took with them to day care to ensure that there was a consistent team based approach to their supports, priorities and goals. The plan was supported as
necessary by input from the multi-disciplinary team. Plans seen were reviewed quarterly and annually.

Identified priorities and goals were clear, reflected both short-term and long-term aspirations; it was recorded if priorities were achieved and if not why not. The practicality of achieving priorities was supported by a process of grouping like priorities and short listing in discussion and agreement with the resident. Resident satisfaction with each support or intervention was established and recorded. If an agreed priority was not achieved within a twelve month timeframe this and the barriers to it were formally progressed by staff to the appropriate head of services.

Each resident had a key worker who worked with them on their plan, staff had received appropriate training and residents were familiar with their key worker. Residents were able to articulate their own priorities to inspectors.

**Judgment:**
Compliant

### Outcome 06: Safe and suitable premises

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

**Theme:**
Effective Services

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

**Findings:**
Accommodation was provided to residents in two separate domestic style residences; both were inspected by inspectors to determine their suitability for their stated purpose and function.

Each resident was provided with their own private bedroom; these offered adequate space to meet their needs including personal storage space; bedrooms were individualised and personalised. Only one bedroom had en-suite sanitary facilities but adequate shared sanitary facilities for the number and needs of the residents accommodated were available. However, one shower in one house was not in proper working order and obviously had not been for sometime; staff reported that it “would be better” for residents to have the availability of a second shower.

Residents had access to suitable dining and communal space that was homely in presentation; meals were seen to be a sociable event.

The kitchen in one house was compact in terms of accommodating staff and residents if the latter wished to participate in household duties; both kitchens however were
adequately equipped.

This house also had limited space for general storage with items including environmental hygiene equipment seen to be stored in bathrooms.

Residents in both houses had access to a garden.

Adequate facilities were in place for the laundering of resident’s personal clothing.

The residents living in the centre did not have any requirement for specific equipment, aids or appliances.

**Judgment:**
Substantially Compliant

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### Outcome 07: Health and Safety and Risk Management

*The health and safety of residents, visitors and staff is promoted and protected.*

**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:**
Both a Health and Safety statement and a risk register were held in the centre.

The risk register detailed the process for identifying, assessing and managing risks and the internal procedure for escalating risks as appropriate where control measures required input from senior management.

Inspectors saw a range of completed risk assessments both centre and resident specific. These assessments indicated that the process of risk management was dynamic, risks were kept under review and controls were reduced where possible until these were the least restrictive necessary. Inspectors saw that staff sought to strike a reasonable balance between resident autonomy and independence and safety. There was evidence that staff adhered to internal procedure and escalated some risks; there was evidence of consultation between staff and management and feedback in relation to the management of the escalated risks.

Risk assessments were in place for the specific risks identified in Regulation 26(1) (c) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

As discussed in Outcome 9 there was policy and procedure for the management of accidents and incidents.

Staff had access to a practical emergency plan and there was evidence that staff reacted
cally and protected resident safety and security in response to a recent adverse event.

There was documentary evidence that vehicles used by residents and staff were maintained on a regular basis so as to ensure their safety and roadworthiness; one vehicle was purchased this year.

The person in charge told inspectors that residents did not have any manual handling requirements but staff were still trained and training records indicated that the training was within mandatory timeframes.

The provider had commissioned a fire safety audit of each house in March 2015 and these reports were made available and reviewed by inspectors. However, having reviewed relevant documentation and having taken into account the design and layout of each house, the stated purpose and function of each house and the supports required by residents, inspectors were not reassured that adequate and effective fire safety management systems were in place. There was a fire procedure and evacuation procedure, staff received fire safety training generally on an annual basis, staff convened fire drills with residents, staff tested the existing fire detection devices on a weekly basis, fire fighting equipment was in place, exits were indicated by running man signs.

However, neither house had emergency lighting; staff and residents were provided with flash-lamps. Neither house had an interlinked domestic type fire detection system with a control panel that provided coverage throughout most of the building. Fire detection was dependent on battery operated smoke detectors; there was an anomaly in both the number and location of detectors noted in both houses with only two evident in the larger two storey premises (staff reported that there was a further detector in the attic).

One bedroom in each house was removed from the main sleeping area and situated adjacent to the main kitchen/utility areas. One utility contained the electrical fuse-board, electrical equipment and the internal kerosene boiler for the heating system; there was no door between this room and the adjacent compact area that acted both as access to and as an escape route from the bedroom. There was no smoke/fire detection in this area,

Notwithstanding that both houses were of different structure there was a further anomaly in the number of fire fighting appliances available to staff in each house with only one small extinguisher and one fire blanket seen in one house with none available on the escape route or close to bedrooms.

Given the reliance on residents to respond and co-operate with the actions to be taken in the event of fire these actions were not prominently displayed in any format; diagrammatic evacuation plans were displayed.

Each resident did have a personal emergency evacuation plan and staff did convene unannounced fire drills. It was evident from both records that residents required verbal and/or physical prompts and supervision and some may not comprehend, respond to and fail to leave the building when the fire alarm when activated; there was only one staff member on duty in each house at anytime.
Both the frequency and the effectiveness of the fire drills required review to ensure that a reasonable evacuation time of less than the recommended three minutes was achievable.

**Judgment:**
Non Compliant - Major

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**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

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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 suite of policies in place including policy and procedure on the protection of residents from abuse, responding to behaviour that challenged; the use of restrictive practices and the provision of intimate care. Training records indicated that all staff had completed education and training on protection and staff spoken with confirmed their attendance. Residents were noted to be relaxed and comfortable in their environment and they told inspectors that they were “happy” and that staff were “nice” to them. It was evident from notifications submitted to the Authority that staff were vigilant and that residents were comfortable in approaching staff when they had concerns for their own safety. There was evidence that the provider responded in line with local policy and procedure in response to any alleged, suspected or reported abuse.

However deficits were identified in the providers safeguarding measures as an identified safeguarding measure of relationship and sexuality training for residents had not been facilitated. Based on information submitted on a notification to the Authority and confirmed on inspection with management, frontline staff had not received timely, clear guidance and instruction from senior staff in response to a safeguarding matter when frontline staff had sought such guidance. There were no apparent negative outcome from this but it was evident that all staff were not clear on the providers safeguarding policies and procedures.

Residents did present with behaviours that posed challenges to themselves and others. The inspector saw that a person centred, multidisciplinary and therapeutic approach was taken to understanding, risk assessing and managing behaviours. Staff had received training on responding to and managing behaviours that challenged and detailed
management plans that outlined the behaviour and the practical strategies for staff to employ so as to reduce or manage the behaviours. However, having spoken with staff it was clear to inspectors in the interest of positive outcomes for all residents that further input from the provider was required to ensure that;

- staff had up to date knowledge of the plan
- staff had the skills to implement the plan
- staff were clear on the requirement to report behaviours particularly where there was a safeguarding component to them
- staff were clear on where and how to record behaviours so as to measure the effectiveness of the plan.

**Judgment:**
Non Compliant - Moderate

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### Outcome 09: Notification of Incidents

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**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 for the identification, recording, investigation and learning from accidents and incidents. A sample of accident and incident records seen by inspectors was comprehensively completed by staff. Inspectors were satisfied based on the records seen on inspection that incidents where required had been notified to the Chief Inspector.

**Judgment:**
Compliant

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### Outcome 10. General Welfare and Development

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

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

**Findings:**
Inspectors were satisfied as outlined in each resident's person-centred plan that there
was a robust assessment process further to which staff sought to facilitate and promote opportunities for residents to enjoy new experiences, learn new skills, enhance their independence, personal development and social integration. Much of this has also been discussed in outcomes one and five.

Each resident on a daily basis attended off-site services structured to meet their needs and agreed priorities. Learning focussed on the practical acquisition of new skills such as safety in the community, cooking or further education including participation in accredited programmes. Residents were also facilitated to enrol in local adult education classes which both broadened their skills and their social contacts. Staff spoken with were aware of each resident’s particular skills and preferences and ensured that they participated in programmes that suited these and were therefore successful.

**Judgment:**
Compliant

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**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 the assessment process was holistic and supported equally the social and healthcare domains of the resident’s life. Residents had access to their General Practitioner (GP) of preference and there was documentary evidence that residents were supported to access medical review and treatment in line with their specific needs. In addition care was supported by referral and access to the multi-disciplinary team including physiotherapy, psychiatry, dentistry, neurology, optician, behavioural therapist and social work. There was an ethos of promoting health and early detection as evidenced in regular blood-profiling and the vaccines and health screening afforded to residents.

Healthcare support plans were in place where there was an established healthcare need such as epilepsy or diabetes; staff spoken with were familiar with the plan. General nursing care was accessed from the community if required.

End of life care was not normally provided in the centre but bereavement and counselling service was made available to residents who experienced loss in their life.

**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 a recently reviewed and redrafted medication management policy; the policy was comprehensive and addressed the salient aspects of medication management. However, practice was not fully reflective of policy and medication management practice had not been and was not routinely subjected to audit.

For example staff reported a colour coded procedure for the recording of medication administration that was not referred to in the policy.

Each resident had three possible prescription records for long term, PRN and episodic prescriptions (medication that may be required but not on a regular or scheduled basis and medication prescribed only for a specific period of time). However, inspectors noted that these were not always used as intended with PRN medications prescribed on the episodic record. One resident had two concurrent but differing prescriptions for the same analgesic one on both the PRN and episodic record.

Policy and procedure required of staff that they check the accuracy of all medications supplied to the centre; staff spoken with confirmed that this included both the quantity and content of the blister pack. However when staff recorded the administration of medication they recorded only that the blister pack was administered rather than each individual medication as indicated on the prescription record. For example where a liquid medication was prescribed and administered a blister pack was recorded as administered. Inspectors were of the view that this practice was somewhat ambiguous in terms of safety and accountability as staff who checked the accuracy on supply may not be the staff who administered the medication to the resident; some staff were reported to have concerns as to their role and responsibility in ascertaining the accuracy of supplied medications as this was reasonably not within the remit of their scope of knowledge and practice.

All medications were managed by staff and there were no policies and procedures to support staff in assessing and facilitating residents to manage their own medications in line with their wishes and capacity. Self administration of medication was an identified resident priority in the context of pursuing independent living in the community.

There were facilities for the safekeeping of medications. Medications that were supplied were used solely for the resident for whom they were supplied.
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 statement of purpose required further review and amendment as while it contained much of the required information it did not fully satisfy the requirements of Schedule 1. Further information was required in relation to;
• the specific care and support needs that the provider intended to meet
• the procedures for (if any) emergency admissions
• a complete organisational structure

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors were satisfied that the centre was effectively governed.

There was a clearly defined management structure and staff were clear on their respective roles, responsibilities and reporting relationships. There was evidence that staff worked in a collaborative and supportive manner with each other and with other services such as the day care service so as to ensure the quality and safety of the care and services provided.
The person in charge was recruited to her role in March 2015 but had established experience within the service and with the residents. The person in charge was suitably qualified and there was evidence that she maintained her skills and knowledge through ongoing participation in the staff training programme. The person in charge had attended briefing sessions in preparation for inspection and regulation. The person in charge worked full time, this was her substantive role and she was present/available in the centre five days per week including weekends. It was clear on speaking with the person in charge throughout the inspection process that she had a sound understanding of her role, responsibilities and resident’s individual and collective requirements.

There were effective systems for the review of the quality and safety of the care and services provided to residents. In addition to their daily contact staff in each house compiled and submitted formal monthly reports to the person in charge. The person in charge maintained a log of each visit and the purpose of each visit that she made to each house. Regular staff meetings between all grades of staff were convened. Both the unannounced visits and the annual review as required by regulation 23 (1) (d) and 23 (2) were undertaken. Reports and action plans issued form each visit and were available for the purpose of inspection; the review incorporated consultation with residents and their families. Inspectors were satisfied that the reviews were substantive and meaningful, both good practice and where improvement was necessary were identified; the process incorporated the measurement of the implementation of actions identified by the previous review. Inspectors were satisfied that this was a transparent process as the providers findings largely concurred with these inspection findings.

**Judgment:**
Compliant

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**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There had been no period of absence of the person in charge that required notification to the Authority. The provider had submitted the required notification in relation to a change in the person in charge. There were suitable arrangements in place for the management and oversight of the service in the absence of the person in charge; these arrangements were outlined for staff on the weekly staff rota.

**Judgment:**
Compliant
Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
There was no evidence to indicate that the centre was not adequately resourced; staff told inspectors that it was adequately resourced. Where a resident had not achieved a desired goal or objective, there was no evidence to indicate that this was as a consequence of insufficient resources.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
The inspector reviewed a sample of staff files and found that they were well presented and contained all of the information required by Schedule 2.

The person in charge confirmed that the rota was planned and circulated in advance to each house; the rota identified staff on duty but also the availability of the person in charge and the manager on call.

Based on these inspection findings inspectors were satisfied that the staffing arrangements met the needs of the residents. Residents attended daily structured day services Monday to Friday, resident choice and flexibility in their routines was augmented by the “cara” programme of volunteer staff. The area manager described the recruitment, vetting, training and supervision arrangements for volunteers and confirmed that their role and responsibilities were explicitly set out.
Staff files indicated that staff were recruited with the right skills and qualifications for their role in the centre. Training records indicated that all staff including recently recruited staff had attended mandatory training in fire safety, manual handling, safeguarding and the management of behaviours that challenged. Further completed staff training reflected the services provided to residents and included medication management, food safety, record keeping and person centred planning.

The person in charge and area manager were actively involved in the centre on a daily basis and confirmed that staff, care and practice were supervised on an ongoing basis. There were structured staff meetings, grievance and disciplinary policies and procedures. However, as established on all inspections to date staff confirmed that there was no formal process for supervising and developing staff within the organisation.

Inspectors’ observations of staff interactions with residents were positive; the feedback received from residents was positive.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Inspectors were satisfied that the records as listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were in place and were maintained by staff in an a manner that ensured completeness, accuracy and ease of retrieval.

Judgment:
Compliant
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Brothers of Charity Services Limerick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004783</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>01 September 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>30 September 2015</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a general lack of clarity and inconsistency amongst staff as to who was the nominated complaints person, who dealt with any appeals and who was responsible for overseeing the management and appropriate record keeping of complaints.

1. Action Required:

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
- The complaints policy has been reviewed it will include guidance for the PIC to consult and or seek advice and input from the Area Manager if necessary to manage complaints locally.
- With the new complaints policy there will be a plain english version available to families.
- There is an easy read version available to residents.
- There is a proposed schedule to roll out training for staff and residents on the policy and pathway from complaints, in the coming weeks.

**Proposed Timescale:** 30/12/2015

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One shower in one house was not in proper working order and obviously had not been for sometime

**2. Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
- The shower had seized due to lack of use. It was serviced and is now in working order. This will be checked monthly to ensure it is working order.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was limited space for general storage in one house with items including environmental hygiene equipment seen to be stored in bathrooms.

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

**Please state the actions you have taken or are planning to take:**
• Three prices have been obtained for the purchase of a garden shed. The shed will be bought and put in place to help manage storage.

**Proposed Timescale:** 30/11/2015

### 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:

Having taken into account the design and layout of each house and the supports required by residents, inspectors were not reassured as outlined in the body of the report that adequate and effective fire safety management systems were in place.

**4. 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:**
- Extra fire extinguishers and smoke alarms were put in situ.
- Fire evacuations will be carried out monthly.
- The fire report for the designated centre has been repeated and recommendations are pending.
- Management is exploring alternative fire assessment company to carry out inspections based on the Inspectors feedback and HIQA requirements.
- Both houses will be fitted with emergency lighting, mains smoke alarms and fire panels.

**Proposed Timescale:** 30/12/2015

### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

Further input from the provider was required to ensure that where there was a behavioural management plan
- staff had up to date knowledge of the plan
- staff had the skills to implement the plan
- staff were clear on the requirement to report behaviours particularly where there was a safeguarding component to them
- staff were clear on where and how to record behaviours so as to measure the effectiveness of the plan.

**5. Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is
challenging and to support residents to manage their behaviour.

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

• Behaviour Support Training has been arranged for Staff on Tuesday the 27th October. This training will be provided to all staff of the designated centre and others involved in the support of individuals with behaviour support plans, by the CNS in behavioural support that drew up the plans.

• Discussion with the CNS in behaviour support has taken place and a decision has been made that she will continue the practice of involving staff in the development and review of plans and will provide training and support to staff as required.

• A meeting took place between the area manager and DP and it was decide that a memo will be sent to all staff to inform them that staff should report all events as outlined in the safeguarding policy on a CP1 before they go off duty.

• A meeting has been arranged between the Head of Community Services the Director of Services and Designated Person to develop a protocol for the DP reporting back to the PIC after receiving CP1 form.

**Proposed Timescale:** 30/11/2015

**Theme:** Safe Services

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

An identified safeguarding measure of relationship and sexuality training for residents had not been facilitated

All senior staff did not provide clear and timely safeguarding guidance to staff when this was sought by them

6. **Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

• The Designated Person within the organisation has arranged training for staff that will then be in a position to roll out the relationships and sexuality training. However if situations arise where there is a requirement for immediate training, these needs will be facilitated through the services of Social Work and Psychology departments.

• A meeting took place between the area manager and DP and it was decide that a memo will be sent to all staff to inform them that staff should report all events as outlined in the safeguarding policy on a CP1 before they go off duty.

**Proposed Timescale:** 30/03/2016

**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:**
Medication management practice was not fully reflective of policy and medication management practice had not been and was not routinely subjected to audit.

7. **Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
- As a result of HIQA inspections within the organisation it has become apparent that inconsistencies occur between policy and practice. As a result the policy is under review. Recommendations of this review will be brought to the next policy review meeting in November. This will include the introduction of an audit process.

**Proposed Timescale:** 30/11/2015

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All medications were managed by staff and there were no policies and procedures to support staff in assessing and facilitating residents to manage their own medications in line with their wishes and capacity.

8. **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:**
- A team have been identified within the services to design a tool which will facilitate residents to manage their own medications in line with their wishes and capacity.

**Proposed Timescale:** 30/12/2015

**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 statement of purpose did not fully satisfy the requirements of Schedule 1.

9. **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:
• The Statement of purpose and function has been reviewed and amended and returned to the authority.

Proposed Timescale: 30/09/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal process for supervising and developing staff.

10. 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:
• Support and Supervision is being reviewed at Senior Management Team level in the context of:
  • Culture of the organisation
  • Understanding structures within the Services that are effective. The learning from understanding these structure can be shared across the organisation.
  • Recognising underlying management issues in the area of supervision and identifying the training that is required to support managers in addressing these underlying issues as part of the management role.
• From this review a process of formal supervision will be introduced across the organisation.

Proposed Timescale: 31/01/2016