<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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<tr>
<td>Centre ID:</td>
<td>OSV-0004918</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>Noelle Neville</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the</td>
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<tr>
<td>Number of vacancies on the</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 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: 14 September 2015 09:30
To: 14 September 2015 20:30

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

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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection
This inspection was the second inspection of the centre by the Authority. The previous inspection was unannounced and was undertaken on 5 February 2015.

With this application to register the provider had applied for the registration of four additional beds to be accommodated in a separate house within close proximity to the existing service.

The inspection was facilitated by the person in charge and the area manager, PPIM (Person Participating in the Management of the Centre). Inspectors reviewed both premises, reviewed records including health and safety documentation, complaints
records, staff and resident related records. Inspectors met and spoke with residents in the evening when they returned from their day services.

While inspectors were again satisfied that there was a commitment to regulatory compliance and the provision of person centred care and services to residents there was little demonstrable improvement on the previous unsatisfactory inspection findings.

There was a definitive management structure in place and evidence that this structure sought to ensure that the centre was effectively managed and that the care and services provided to residents were monitored to ensure their appropriateness, quality and safety. However, despite this commitment and willingness it was again clear from these inspection findings, as discussed throughout the body of the report that the management systems were not sufficient in of themselves to ensure that the service provided to residents was safe, appropriate to resident’s individual and collective needs, consistent and effectively monitored.

There was evidence that staffing resources were inadequate and not sufficient to meet residents individual and collective needs and that this directly impacted negatively on the quality and safety of the care and supports provided to residents. Staffing deficits were also highlighted to the Authority by family members who submitted completed questionnaires.

The inspection findings were not satisfactory. Of the full eighteen outcomes inspected the provider was judged to be complaint in four and in substantial compliance with one, in moderate non-compliance with four and in major non-compliance with the remaining nine; staffing, resources, governance and management, medication management, safeguarding and safety, health and safety, social care needs, contracts for the provision of supports and services and the submission of notifications.

The evidence to support these judgments is presented in each relevant outcome and was discussed in detail at the end of the inspection with the management team including the provider nominee. The provider articulated its commitment to respond positively and to address the identified failings.

Given the significant non-compliance evidenced on this the second inspection of the centre the provider was requested to attend a meeting with the Authority on 16 October in its head office at which the non-compliance was discussed and the provider was issued with a warning letter as part of the Authority’s escalation procedure. A further meeting with the provider was requested and held on 15 December to discuss the response received to the action plan.
**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):**

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

**Findings:**

Residents had access to structured advocacy services on a monthly basis at their day service.

Minutes seen indicated that there were regular house meetings between residents and staff. However, the duration, date for next meeting, specific actions required or taken, specific outcomes and resident satisfaction were not noted in the meeting minutes viewed by inspectors.

Staff said that residents did not participate in recent voting as some were not registered to vote and others declined to vote. However, the most recent referendum was discussed at a residents’ meeting.

Residents had access to religious services once per month at their day service. Residents had access to television, radio, telephone including personal mobiles and magazines.

Each resident participated in a day service Monday to Friday. At the weekends, residents could avail of shopping trips, drives and various outings when the required support staff were available. However, based on records seen and staff spoken with given the varying needs of residents, resident choice to participate in social activities during the week was dependent on the availability of adequate staffing resources. The area manager confirmed that these resources were not always available and impacted on the choices available to residents in the evenings during the week. This is discussed again in Outcome 17.
Inspectors were informed by staff that residents participated in selecting their meal choices and were assisted to do so through the use of visual cues. Residents were asked which meal they would like the day before but were given a choice if they changed their mind on the day. An inspector observed the residents' evening meal time routine. It was noted that residents sat at two tables while their meal was being prepared by staff. Residents were observed to be chatting about their day and interacting with staff. Residents were asked by staff if they had enough to eat and if there was anything else they would like; any requests were facilitated. The inspector noted that staff mentioned there would be a discussion with residents at the next house meeting regarding meal choices for the coming week.

Support plans seen by inspectors indicated that some residents for their safety required staff supervision at mealtimes. Based on the inspector's observations supervision was provided but not in a discreet and dignified manner; staff stood alongside the resident for the duration of the meal.

There was a policy on the management of complaints. An easy read pictorial version of this policy and an easy read pictorial complaints card was also available to residents. The complaints process was prominently displayed. There was evidence that staff welcomed complaints; that residents did complain and their complaints were listened to. The person in charge informed inspectors that residents and their families were made aware of the complaints process following admission and were supported to make complaints. The person in charge also informed inspectors that complaints are initially dealt with locally and failing resolution at local level they were escalated to the area manager.

There was a nominated person to deal with all complaints, complaints were recorded and the majority were seen to be fully and promptly investigated. However, inspectors noted that three complaints of a similar nature while resolved took over five months to resolve due to quotation and approval timelines for the necessary works. The local complaints log did not list the outcome or resident satisfaction at the end of the complaint management process; some complaints were not signed off on or dated.

Inspectors did not see any evidence that any resident who had made a complaint was adversely affected by reason of the complaint having been made. One resident informed inspectors that they knew how to make a complaint if they were not happy; they made a complaint previously and was satisfied that the complaint was dealt with by staff.

Inspectors viewed a policy on the management of residents’ personal assets which was recently introduced. Training with regard to this policy was due for all staff and full implementation of the policy was still in progress. There were systems in place for the review and audit of financial procedures. Inspectors reviewed a sample of records pertaining to residents' personal finances and found that they were practices for their safekeeping including record keeping. However, withdrawals were signed only by one member of staff with no counter signature by either another staff or residents.

While inspectors observations of staff and resident interactions were positive all records seen by inspectors and as completed by some staff did not reflect respect for residents' rights including their right to empathetic support, their right to have their privacy and
dignity respected in the records maintained. For example inspectors saw disrespectful commentary in relation to one resident’s personal hygiene; a further record intimated staff disquiet with having to “go down on hands and knees” to attend to an elimination accident by another resident.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Communication**

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

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**

There was a policy on communication with residents. Residents had access to radio, television, telephone and magazines. Some residents had access to literacy classes through their day services. Inspectors saw and the PPIM confirmed that Lamh (a manual sign system used by adults and children with an intellectual disability and communication needs) was now in use in the designated centre and the day service and an agreed new sign was introduced each week between both locations. However, staff had not received training in the use of Lamh.

Some residents did have communication needs that required support. Communication plans were in place for some residents and these set out the strategies used by residents to communicate their needs such as gestures and facial expressions. There was evidence to support speech and language, sensory and auditory referral and review. For example one resident’s communication plan was completed in April 2014 and reviewed in March 2015. It was noted by inspectors that following speech and language therapy review in April 2015 it was decided that the resident’s communication profile was a sufficient tool.

However, further records seen by inspectors indicated that staff struggled at times to understand and communicate effectively with some residents. While the communication policy noted that residents would be supported to have access to augmentative and alternative communications, residents did not appear to have been assessed in relation to their suitability for assistive technology and aids and appliances to promote their full capabilities. The person in charge informed inspectors that assistive technology was not yet available to residents. One resident’s personal plan priorities seen by inspectors stated that the resident would like their communication profile to be developed further – this was dated 08 May 2015 for review 15 August 2015.

As discussed in Outcome 8 inspectors were not satisfied that all staff had the required
skills and knowledge to understand behaviours not only that challenged but behaviours as used by residents as a means of communicating their needs.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Residents and staff spoken with and records seen by inspectors including completed questionnaires indicated that ongoing family involvement and contact was facilitated and promoted by the provider.

Staff maintained a log of family contact and these indicated that the person in charge and staff answered queries and provided information as to each resident’s well-being and welfare as appropriate.

Families as appropriate in line with each resident’s needs and wishes were facilitated to participate in care and support decisions.

There were no restrictions on visits if this was the expressed preference of the resident.

Each resident had access to off-site structured day supports/services Monday to Friday and had a visual activity planner that reflected their participation in social activities during this timeframe. Narrative records seen by inspectors indicated that staff in the centre facilitated activity within the wider community such as shopping and dining out at weekends.

**Judgment:**
Compliant

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**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was a policy on and a multi-disciplinary forum for governing the admission, transfer and discharge of residents to and from the designated centre. The centre’s admissions policy considered the wishes, needs and safety of the individual and the safety of other residents currently living in the centre.

However, each resident did not have a written agreement of the terms of their residence in the centre signed and agreed by them on their admission. The individual service agreements viewed by inspectors were only in the process of being implemented and were noted to be dated 10 September 2015. Some individual service agreements were still awaiting signature by family members who were only written to in relation to this on 10 September 2015.

The individual service agreement set out the services to be provided and the fee to be charged for the services.

Judgment:
Non Compliant - Major

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was no apparent improvement evidenced by inspectors in the standard of assessing each resident’s needs and setting out the arrangements to meet these needs in a personal plan that accurately reflected the resident, their needs, choices and preferences. Based on the 50% sample of personal plans reviewed inspectors were not satisfied that each plan accurately reflected each resident’s needs, was effectively reviewed and altered to reflect their evolving and increasing needs, and was formulated
and presented in an evidence based manner.

For example inspectors did not see a comprehensive and meaningful communication plan where there was a requirement for one and there was evidence from staff and records seen that staff struggled to communicate effectively with some residents.

There was evidence that multi-disciplinary reviews were convened in response to resident's altering needs. However, the findings and recommendations from multi-disciplinary meetings were not satisfactorily used to inform the personal plan particularly in relation to understanding and responding to behaviours that challenged; this is discussed again in Outcome eight.

The personal plans seen were initialled and dated as reviewed by staff in March 2015 with no notable required changes, however, this would not concur with residents' needs as recorded by staff in the daily narrative notes.

There was evidence that residents’ personal priorities and goals were identified but these appeared to have been based on personal planning meetings convened in May 2014. It was not always clear to what degree the resident had influenced and informed this process and the process of review did not always establish if a priority had been met and if not why not. It was clear from one resident's personal plan seen that three of their identified priorities had been reviewed in June 2015 and the barriers to achieving one had been identified, recorded and progressed through the agreed process.

Based on the reports seen by inspectors two unannounced visits to the centre on behalf of the provider in May and June 2015 identified similar deficits in the personal planning process to these inspection findings.

As seen by inspectors in the support plans there was an overreliance on “memos” between the person in charge and staff to communicate changes in residents’ needs and supports.

Both the person in charge and the PPIM told inspectors that the lack of adequate staff resources and the overreliance on relief staff directly impacted negatively on both the maintenance and review of the personal planning process.

**Judgment:**
Non Compliant - Major

**Outcome 06: Safe and suitable premises**

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

**Theme:**
Effective Services
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
With this application for registration of the centre the provider had applied for the registration of four additional beds in a separate house located in close proximity to the existing house. Both houses were inspected to assess their suitability and level of regulatory compliance.

Inspectors were satisfied that both houses were suited to their stated purpose and function and satisfied regulatory requirements.

Both houses were of a domestic design and on visual inspection were in a good state of repair and in good decorative order.

Both houses offered adequate communal and dining space for the number of residents to be accommodated and each house had an adequately equipped kitchen.

Each resident was provided with their own bedroom and these rooms offered privacy and adequate space including personal storage space.

One of the ten available bedrooms had en-suite sanitary facilities; overall, adequate sanitary facilities were available in each house and included a newly installed universally accessible bathroom in one house. Residents had a choice of having a shower or a bath.

There were no apparent difficulties with storage.

Adequate facilities were available for the laundering of residents’ personal clothing.

Each house provided residents with access to a garden.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
There was evidence of improvements made since the last inspection.

There was a current health and safety statement, risk management policy and risk register in place. The risks as specifically identified in Regulation 26 were in place as were the measures identified for the control of these risks. There was a comprehensive range of risk assessments in place and the process of risk assessment was obviously dynamic in response to resident or centre specific changes. The risk management process provided for the escalation of risks through the organisational structures as necessary and as appropriate to each person’s level of authority.

However, based on the risk assessments seen by inspectors it was not clear that identified risks were escalated or resolved in a timely fashion. For example the risk identified during simulated evacuations (discussed below) was not escalated until just prior to this inspection and many of the risk assessments pertained to the ongoing risks associated with inadequate and inconsistent staffing resources. The main theme of the completed risk assessments reflected the varying and increasing needs of residents, the limited staff resources and the impact and risks associated with this, for example the disturbance of sleepover staff who had to get up so as to attend to and supervise residents.

Based on the recommendations of a fire survey completed in 2014 fire safety precautions had been installed since the last inspection, these included an automated fire detection system and emergency lighting. Escape routes were clearly indicated by illuminated “running-man” signage. Fire action and fire evacuation notices were both prominently displayed; fire doors had been inserted and self closing devices were provided on the doors. Certificates were available of the inspection and servicing of the fire detection system in September 2015 and fire fighting equipment in February 2015. There were in-house records of the inspection of fire safety measures on a monthly basis by the person in charge.

However, as these fire safety measures were new to staff organisational clarification for staff was required on the prescribed frequency of inspecting and testing of each measure be it daily, weekly, monthly or quarterly. The person in charge confirmed that the inspection of the fire detection system in September was the first since its installation in February.

Each resident had a personal emergency evacuation plan; these indicated that all residents required verbal prompting and three required both verbal prompting and staff assistance and guidance in the event of evacuation. Records indicated that simulated fire evacuation drills were convened. The inspector reviewed the evacuation drill reports for this year and noted that each time a night-time drill had been undertaken that residents had either failed to respond or had responded poorly and slowly with evacuation of the premises taking up to four, five and six minutes. There was only one sleepover staff on duty and these times are well outside the recommended evacuation time. This was also of concern to inspectors given the recent errors in the administration of night sedation.

The maintenance of vehicles was managed centrally by the transport manager but there was documentary evidence that the person in charge kept oversight of their servicing
and maintenance to ensure that vehicles were safe and roadworthy.

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

There was a suite of policies in place with a protective component including policies on the management of any alleged, suspected or reported abuse, the provision of intimate care, responding to behaviours that challenged staff and other residents and the use of restrictive practices. Training records indicated that all staff including relief staff had completed education on protection and safeguarding. There was documentary evidence in the form of notifications to the Authority and records seen on inspection that staff were aware of, vigilant and diligent in their safeguarding responsibilities and of the provider's procedures on reporting all alleged, suspected or reported abuse. There was a nominated designated person whose responsibility it was to investigate or co-ordinate the investigation of these matters. There was evidence that through these agreed structures the provider responded to any alleged, suspected or reported abuse in consultation and in conjunction with other statutory bodies as appropriate.

However, while there was evidence of investigation and reported measures taken by the provider including enhanced security in services accessed by residents, it was clear on speaking with staff and reviewing records that they (staff) and family members had ongoing safeguarding concerns for some residents. Based on the information available to inspectors from staff it was difficult for inspectors to be reassured that these concerns were not justified. This was discussed in detail with the management team of the centre including the provider nominee. The provider nominee agreed with the concerns held and gave a commitment that further action would be taken by the provider to re-visit certain safeguarding matters and investigations so as to reassure the provider, staff, relatives and the Authority as to the robustness of all investigations, safeguarding measures and to identify any learning required for the protection of all residents.
There was evidence of safeguarding interventions such as increased security and one to one supervision for residents but it was of concern to inspectors given that concerning safeguarding risks had been identified, that explicit safeguarding plans and the rationale for the plan and safeguarding measures were not in place for residents and accessible to all staff.

There was documentary evidence that residents presented with behaviours that challenged staff and other residents. There was documentary evidence that residents were referred for multi-disciplinary (MDT) review from which rationales for behaviours were offered as were management interventions including therapeutic interventions. However, training records indicated that all staff had not received training on the management of behaviours that challenged; narrative records seen indicated that staff were challenged by behaviours and did not have the required knowledge, skills and attitude to manage the exhibited behaviours in an evidence based manner. There was no evidence to support the implementation of recommended interventions or the monitoring of their success or failure. For example where the MDT review had provided a clear objective rationale for the exacerbation of one resident’s behaviours staff described the resident in subjective terms of “sulky” and “grumpy” and manipulative with staff interpreting the behaviours as the resident attempting to “get away with anything”. It was recorded following one MDT review that one resident's dolls were taken away and it was unknown why as they had made “her happy”. A further record did not demonstrate the implementation by staff of recommended therapeutic interventions to avoid or alleviate the known underlying causes of behaviours and distress to the resident but staff did record the consequent continuation of the behaviours with staff subjectively describing the resident as having “a complete meltdown” and being “out of control”. Available templates for personal behavioural support plans were generally blank.

**Judgment:**
Non Compliant - Major

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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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
An accident and incident reporting policy was available at the centre.

A record of all incidents occurring in the designated centre was maintained. Notifications had been submitted to the Authority since the last inspection. However the
incident/apparent log and residents records indicated that resident falls had occurred in
the centre and there was a recorded incident of resident bruising of unknown origin;
these incidents had not been submitted to the Authority in an NF39 form. The incident
report did not reassure inspectors that injuries of unknown origin including bruising were
adequately and comprehensively investigated. There was a lack of clarity between the
records and staff spoken with as to the exact nature of the falls sustained. Based on the
notifications that had not been submitted to the Chief Inspector clarity was required as
to who was responsible for the submission of notifications in the absence of the person
in charge.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The statement of purpose and function stated that the provider provided services to
residents identified as requiring increased supports due to personal health requirements
and increasing age. The provider sought to offer them “a more relaxed” pace of life and
activity, and the supports to retain and develop skills as outlined in their personal plan.
Three residents had an allocated support in the morning to facilitate this more relaxed
pace. All residents had access to structured day services and it was through this
resource that there was evidence of how residents were facilitated to engage in social
and developmental activities such as literacy classes, sports, music and art and crafts.

However, notwithstanding the stated purpose and function of the centre it was clear
from speaking with staff and from records seen that each resident presented with
varying needs. Given the deficits identified in the support/personal plans inspectors were
not reassured that with reference to each resident’s needs and the nature of each
resident’s disability that each resident had the opportunity to develop and experience
new skills such as a desire to learn to tell the time, manage their own medications or
enhance their communication capacity.

Judgment:
Non Compliant - Moderate
Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
The person in charge confirmed that each resident had access to their choice of General Practitioner (GP) or one that was acceptable to them. Records seen by inspectors indicated that staff facilitated medical review and treatment for residents as appropriate to their needs. In addition there was a process for a formal annual medical review.

Residents also had access as required to other healthcare professionals/services including dental, optical, chiropody, behaviour therapist, psychiatry and speech and language therapy. The person in charge had put in place health care plans which set out each resident's identified healthcare needs and the supports and interventions required to ensure resident wellbeing. There was further documentary evidence that the person in charge followed up on referrals recommended by multi-disciplinary reviews and maintained a record of all referrals, appointments and efforts made to ensure timely access to services for residents.

There was documentary evidence that residents were facilitated to participate in individual health screening and national screening programmes.

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

Findings:
There was a recently reviewed medication management policy and procedure.
Arrangements were in place for the secure storage of medications.

Residents had access to a pharmacist that was acceptable to them including their pharmacist of preference.

Arrangements were in place including signed verified records for the receipt of medications and the return of medications no longer in use or no longer required.

Each resident had a medication prescription record signed and dated by their GP. The person in charge confirmed that there were no medications in use that required stricter controls and no resident was in receipt of medications in an altered format; crushed. The maximum daily dosage of medications prescribed on a PRN basis (as required) was stated.

However, no resident was actively managing their own medications though two had expressed an interest in doing so and there were no policies and procedures including assessments in use to support residents in managing their own medications.

Overall inspectors were not satisfied that there was sufficient oversight of medication management practice that ensured residents were protected by the provider’s medication management procedures. Sixteen medication errors had been recorded since the last inspection in February 2015. On reviewing these records the inspector concluded that 50% of the errors were directly related to medication management practice by staff and indicated that while staff reported errors, staff were not always vigilant when administering and recording the administration of medications to residents. The most recent errors involved five failures in the medication management cycle;
• failure to dispense the prescribed medication, night sedation, in the prescribed strength.
• failure to attach the correct label with the correct instructions to the correct prescribed strength of the medication.
• failure by staff to identify the above failings.
• the administration of the incorrect dosage (double the prescribed strength) of the medication to a resident on two consecutive nights by two different staff
• in addition to the administration of the incorrect dosage staff failed to adhere to the strict prescribing protocol for the administration of the night sedation medication.

There was no evidence to support the robust review of medication errors, to guarantee learning and protect residents from further errors. Staff said that the current system was concerned solely with the collection of data and not analysis. Medication management practice was not subjected to routine audit.

Both the person in charge and the PPIM told inspectors that the demands on staff due to a lack of resources and the overreliance on relief staff were factors contributing to the medication errors.

Judgment:
Non Compliant - Major
**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):**
No actions were required from the previous inspection.

**Findings:**
The statement of purpose submitted with the application for registration contained much but not all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013. The missing information included;
- The full organisational structure including all frontline staff
- Room sizes
- The arrangements for consultation with and participation of residents in the operation of the designated centre
- The arrangements for residents to access education, training and employment

Practice in the centre in relation to the supports available to residents to facilitate them to achieve their goals and priorities did not reflect the statement of purpose.

**Judgment:**
Non Compliant - Moderate

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**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There was a definitive management structure in place and evidence that this structure sought to ensure that the centre was effectively managed and that the care and services provided to residents were monitored to ensure their appropriateness, quality and safety. For example there was evidence that complaints were listened to and acted on; there was evidence that staff took their responsibility to safeguard residents seriously and acted on any safeguarding concern brought to their attention; the person in charge identified risks to the quality and care of services and escalated the risks; a risk based business plan for additional staffing resources had been prepared and submitted by the area manager. It was evident on speaking with the person in charge and the area manager (PPIM) that they were committed to the provision of safe quality care and supports to residents. However, despite their commitment and willingness it was again clear from these inspection findings, as discussed throughout the body of this report that the management systems were not sufficient in of themselves to ensure that the service provided to residents was safe, appropriate to residents' individual and collective needs, consistent and effectively monitored.

The person in charge was suitably qualified; had established experience within the organisation and had a sound understanding of the legislation and her responsibilities. The person in charge confirmed that since the last inspection there had been some review of her working arrangements in relation to on-call responsibilities and the parameters of the duties and responsibilities of the on-call manager had been discussed and clarified with all staff. However, the person in charge said that she felt her management of the centre was largely reactive in the absence of adequate and consistent staffing resources. The PPIM was spoken with separately and she too said that the lack of adequate and consistent staffing supports had a definitive negative impact on the consistency, quality and safety of the care and services provided to residents.

The provider had since the last inspection arranged for persons on their behalf to undertake two unannounced visits to the centre in May and June 2015; the reports were made available for the purpose of inspection. The findings from both visits were not satisfactory with an improvement action issued in almost every area reviewed. Identified failings included out of date personal plans, residents not supported to achieve their identified priorities, communication difficulties between staff and residents, deterioration in the quality of the resident house meetings, staff not aware of resident’s specific support plans, incomplete care records. The issuing of the action plan from the visit in May was not timely and the person in charge said that at the time of this inspection the actions from the unannounced visit were largely not implemented.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.
Theme: Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The provider was aware of its notification requirements to the Chief Inspector and there had been no absence of the person in charge for a duration that required notification. The area manager was the nominated PPIM and confirmed to inspectors that she would be responsible for the management of the service in the absence of the person in charge.

Judgment:
Compliant

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

Theme: Use of Resources

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre was well maintained and in a good state of repair and decoration following recent investment in fire safety upgrading works.

However, as discussed in Outcome 17 below there were inadequate resources available to guarantee adequate and consistent staffing resources to ensure the effective delivery of the required care and supports to each resident in line with their assessed and evolving needs and in accordance with the statement of purpose.

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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The statement of purpose and function stated that the provider provided services to residents identified as requiring increased supports due to personal health requirements and increasing age. Based on discussions with both the person in charge and the area manager, records reviewed including risk assessments and multi-disciplinary team meeting minutes and the findings of this inspection, inspectors were satisfied as at the time of the last inspection that there were inadequate staff resources to meet the assessed needs of the residents. MDT records clearly stated that the ratio of staff to service users at 1:6 may be too low to facilitate residents' needs and made it difficult for staff to focus on all service users' needs. Further supportive evidence has been presented in the body of this report in relation to failures in health and safety, medication management and social care needs.

There was evidence that the provider had sought to address this issue in the intervening period and agreement had been reached to increase staff resources by ten hours each day at weekends and from 17:00hrs to 22:00hrs Monday to Friday. However it was confirmed for inspectors by the area manager that it was the position of the provider that increased staff supports had not been possible to achieve and maintain due to a lack of funded posts and the unavailability of staff. It was calculated by the area manager that the weekend resources were maintained but only 50% of the additional weekday resources were maintained. Inspectors were shown a business case for additional staffing submitted by the area manager in July 2015; the business case was supported by identified risks due to inadequate staffing in the areas of resident experience including limited choice and opportunities, resident safety due to inadequate supervision, staff non-compliance with resident support plans and increasing resident needs associated with advancing age. Inspectors noted that these identified risks were ongoing at the time of this inspection.

Ordinarily there was only one staff member allocated to the centre and this staff member was a sleepover staff from 23:00hrs to 07:00hrs. In addition to the staffing deficits identified up to 22:00hrs, inspectors were not satisfied that the sleepover arrangement was sufficient to meet the increasing needs of the residents. Records seen indicated that two residents were now demonstrating disturbed sleeping patterns that required intervention and supervision by staff. As discussed in Outcome 12 poor and unsafe practice was evidenced in the administration of night sedation. Simulated fire evacuation drills had established that given the needs and capacity to respond of residents it was not possible for staff to evacuate all six residents within a safe and reasonable timeframe.

In addition to the inadequate staff resources the area manager and person in charge
said that the consistency, safety and quality of supports provided to residents was negatively impacted by an overreliance of relief staff. Management believed that this was then compounded by the fact that relief staff were engaged to work as required in a large number of houses (25-26) and did not have the opportunity to familiarise themselves with the changing needs and supports of a more defined group of residents. This was a theme articulated by relatives who completed the Authority’s questionnaire. While staff were described as approachable, helpful and respectful the dependence on relief staff and the “unsettling” impact of this was clearly articulated by family members.

An unannounced inspection of the centre by a person nominated by the provider identified deficits in staff knowledge of resident support plans and communication needs. The person in charge and area manager confirmed that identified areas of concern for them were medication management, the review and implementation of support plans and facilitating effective communication with staff and the supervision of staff, care and practice.

Records completed by some staff and discussed in detail in Outcomes one and eight indicated that all staff did not have the required knowledge, skills and attitude to provide care and support to residents in an evidence based and respectful manner.

A sample of staff files were checked against the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. While the majority of the required documentation was in place, there were some gaps in staff employment history and the relevance of the referees to the staff employment history was not clear in all cases.

It was noted from training records available for inspection that all staff had not received mandatory training or did not have in date mandatory training in fire safety, manual handling and in responding to and managing behaviours that challenged.

The centre did not ordinarily utilise the services of volunteers but one resident had recently been allocated a support “cara” from the scheme operated by the wider organisation. This scheme augmented the available social supports and “caras” were recruited, vetted, trained and supervised by a designated person within the organisation.

Since the last inspection the staff rota was electronically forwarded to the centre. This was a working document and was reissued, daily if necessary to reflect any changes.

**Judgment:**
Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Overall inspectors were satisfied that 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 were in place and were retrieved as requested by inspectors.

There was documentary evidence that the provider had appropriate insurance in place.

There were policies which reflected the centre's practice. The majority of policies were reviewed and updated and at intervals not exceeding 3 years.

The residents guide satisfied regulatory requirements and was also available in a format that enhanced its accessibility and usefulness to residents.

A directory of residents was maintained and available. However, it did not include all of the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Judgment:**
Substantially 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
Health Information and Quality Authority  
Regulation Directorate  

Action Plan

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-0004918</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>14 September 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21 December 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:
Records seen by inspectors and as completed by some staff did not reflect respect for resident’s rights including their right to empathetic support, their right to have their privacy and dignity respected in the records maintained.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Staff supervision at mealtimes was not provided in a discreet and dignified manner.

1. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
1. Code of practice training has taken place for staff in the designated centre. This training was facilitated by a Senior Psychologist.
2. PIC’s office is now based in the designated centre. This allows her to regularly observe interactions between staff and residents including interactions at mealtime.
3. PIC and Area Manager conduct routine reviews of documentation. They will reflect these reviews by adding a date and initials to documents reviewed.
4. The position of PIC remains supernumery in the designated centre at this time. This is currently the only designated centre under this PIC. This action is being implemented outside of the approved staffing allocation for the organisation and will be reviewed on a regular basis and HIQA will be informed in advance of any change in this arrangement.
5. Food and Nutrition policy in place setting out best practice in relation to mealtimes.
6. The PIC will link with Senior Speech and Language Therapist (SLT) to organise refresher Eating, Drinking and Swallowing (EDS) training for staff working in the Designated Centre.
7. The organisation does not have adequate multidisciplinary supports, as set out in its Service Arrangement with the HSE to fully meet all the needs of residents. Currently we have one Speech Language Therapist to support an overall population of 358 adults with Intellectual Disability. The Brothers of Charity Services Limerick has prioritised the use of the SLTs time and expertise to support the development of EDS plans for people at high risk of choking. The development of communication systems has not been prioritised. Based on the finding of major non-compliance in this inspection under Outcome 5 which references the lack of comprehensive communication plans the SLT was requested by Provider Nominee to provide training and support to the staff in the development of communication dictionaries for residents in this designated centre.
8. A business case is being developed for submission to the HSE to fund additional SLT supports.

**Proposed Timescale:** 28/02/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Specific actions, specific outcomes and resident satisfaction with the operation of the centre were not noted in the house meeting minutes viewed by inspectors.

2. **Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
1. Weekly house meetings occur and provide an opportunity to consult with residents.
2. A new template for house meetings was developed to support this consultation process and has now been implemented in the designated centre.
3. As part of PIC oversight of the designated centre the minutes of the weekly house meetings and status of actions arising are regularly reviewed.
4. The position of the PIC remains supernumery in the designated centre at this time. This is currently the only designated centre under this PIC. This action is being implemented outside of the approved staffing allocation for the organisation and will be reviewed on a regular basis and HIQA will be informed in advance of any change in this arrangement.

Proposed Timescale: 21/12/2015

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Withdrawals from resident petty cash were signed only by one member of staff with no counter signature by either another staff or residents.

3. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
1. Where meaningful the residents will be consulted in relation to withdrawals and purchases and this will be evidenced on the respective receipt. Where this is not possible, 2 staff will sign the relevant receipt.
2. Staff attended training in relation to the personal assets policy in 16/11/2015.
3. Area Manager completed a documentation review on 17/11/2015
4. Policy on the handling of Adult Service Users Personal Assets will be updated shortly to reflect this change.
5. The Service User Monies accounting technician completed an audit of the residents monies and a report with recommendations will issue by the end of December.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that three complaints of a similar nature while resolved took over five
months to resolve.

The local complaints logs did not list the outcome or resident satisfaction at the end of the complaint management process; some complaints were not signed off on or dated.

4. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
1. Revised complaints procedure has been developed.
2. Training for Persons in Charge will be conducted in Q1 2016 and the revised procedure will then be rolled out.
3. Complaints are included on the new template for house meetings.
4. Complaints are an item on all meeting agendas between the PIC and Area Manager to ensure they are addressed in a timely manner and if not resolved escalated to Complaints Officer (Head of Community Services) with immediate effect.

Proposed Timescale: 31/03/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that where indicated, residents are assessed and facilitated to access assistive technology and aids and appliances to promote their full capabilities.

5. Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
1. One resident who requires support on communication was seen by the Organisation’s Senior SLT in April 2015
2. Two residents who also require support on communication have been referred to and were seen by a private SLT in July 2015. Implementation of the recommendations of these assessments has commenced and will be progressed for each resident.
3. The organisation does not have adequate multidisciplinary supports, as set out in its Service Arrangement with the HSE to fully meet all the needs of residents. Currently we have one Speech Language Therapist to support an overall population of 358 adults with Intellectual Disability. The Brothers of Charity Services Limerick has prioritised the use of the SLTs time and expertise to support the development of EDS plans for people at high risk of choking. The development of communication systems has not been prioritised. Based on the finding of major non-compliance in this inspection under Outcome 5 which references the lack of comprehensive communication plans the SLT
was requested by Provider Nominee to provide training and support to the staff in the
development of communication dictionaries for residents in this designated centre.
4. The understanding is that residents living in the community will access
multidisciplinary supports through the Primary Care Teams. While this does happen in
certain circumstances the reality is the following:-
• Access to primary care teams is not universal in that some teams will not accept
referrals for people living in services provided by the Brothers of Charity Services
Limerick. We have raised this as a rights issue within the HSE.
• For those teams that are open to providing a service there is a waiting list.
• People with intellectual disabilities and complex presentation frequently require a level
of understanding of their disability and an intensity of support not readily available
through the primary care team model.
5. A Business Case will be developed for additional SLT supports to support people with
complex needs that are not appropriate for referral to primary care teams.

Proposed Timescale: 28/02/2016

Outcome 04: Admissions and Contract for the Provision of Services
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Failing to ensure on admission that an agreement in writing with each resident, or their
representative where the resident was not capable of giving consent, was given with
regard to the terms on which that resident shall reside in the designated centre.

6. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each
resident, or their representative where the resident is not capable of giving consent, the
terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
1. A Contract has been issued to families. 5 out of 6 contracts have been signed and
returned.
2. Efforts to get the 6th contract signed and returned are ongoing and this is being
followed up on a regular basis by the Area Manager and Social Worker.

Proposed Timescale: 31/03/2016

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:
Based on the 50% sample of personal plans reviewed inspectors were not satisfied that
each plan accurately reflected each resident's needs, was effectively reviewed and altered to reflect their evolving and increasing needs, and was formulated and presented in an evidence-based manner.

Findings and recommendations from multi-disciplinary meetings were not satisfactorily used to inform the personal plan.

The process of review did not always establish if a priority had been met and if not why not.

7. **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:
1. New PCPs are being developed with residents in consultation with the resident's circle of support e.g. family, day services staff. Information gathering has commenced for all residents and all planning meetings will be completed by February 2016.
2. Multidisciplinary team members will be consulted as part of this process.

Proposed Timescale: 28/02/2016

**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:
Failing to ensure that identified risks were escalated or resolved in a timely fashion. For example, the risk identified during simulated evacuations was not escalated until just prior to the inspection and many of the risk assessments pertained to the ongoing risks associated with inadequate and inconsistent staffing resources.

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

Please state the actions you have taken or are planning to take:
1. Risk management procedure is in place.
2. Risk register of the Designated Centre to be reviewed by the newly appointed PIC and Area Manager as a priority.
3. Risk management procedures to be implemented with regard to the escalation and monitoring of all risks identified.
4. Challenges in recruitment of specific posts will immediately be escalated to HR
Proposed Timescale: 31/12/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clarification for staff was required on the prescribed frequency of inspecting and testing of each fire safety measure be it daily, weekly, monthly or quarterly. The person in charge confirmed that the inspection of the fire detection system in September was the first since its installation in February.

9. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
1. Since the HIQA Inspection a Fire Safety Engineer has carried out a full review of fire safety measures in this designated centre and the report has been issued.
2. A full fire registered is being developed including the certification of the fire alarm to L1 standard, certification of the emergency lighting, certification of the electrical installation, certification of the fire doorsets and certification of the fire stopping sealant used to seal joints between the door and the walls.
3. Recommendations from the Fire Safety Engineer in respect of testing fire equipment will be included in the fire register and implemented in full.

Proposed Timescale: 31/01/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records seen reported that each time a night-time drill had been undertaken that residents had either failed to respond or had responded poorly and slowly with evacuation of the premises taking up to four, five and six minutes. There was only one sleepover staff on duty and these times are well outside the recommended evacuation time.

10. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
1. The Fire Safety Engineer has set out recommendations in his report in relation to the compartmentalisation of the Designated Centre that when implemented will allow residents and staff the opportunity to move from one part of the building where a fire may occur, into another area which is protected from the fire, for a period of 60 minutes.
2. Remedial work to address the recommendations from the fire safety review has been
completed by the contractor who installed the fire safety equipment including the fire alarm, emergency lighting and fire doors.

3. Additional remedial work to further address the recommendations from the fire safety review in relation to compartmentalisation have been documented and this work is being priced. Once this remedial work is completed fire safety training in the context of the use of compartmentalisation will be scheduled with the fire safety engineer.

4. An OT assessment has been completed in relation to fire evacuation on 14/11/2015 for each resident individually and a report in relation to this has been issued. Recommendations from this report around evacuation will be practiced as part of future fire drills in the intervening period.

5. A Business Case for waking night staff has been submitted to the HSE on 1st October 2015 following the registration inspection. Following the issuing of a warning letter by HIQA a request for clarification on the status of the Business Case has been sought from the HSE. This clarification was issued on 2nd November in respect to the funding of this business case.

The decision of the Chair of the Brothers of Charity Services Limerick and the National Chief Executive, on the basis of this letter of confirmation from the HSE, is not to sanction the introduction of waking night staff in Waxwing 1 designated centre.

The Authority did not agree elements of this action response with the provider and has taken the decision not to publish that element of the response.

**Proposed Timescale:** 31/01/2016

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**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:**

Training records indicated that all staff had not received training on the management of behaviours that challenged; narrative records seen indicated that staff were challenged by behaviours and did not have the required knowledge, skills and attitude to manage the exhibited behaviours in an evidence based manner.

**11. 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:**

1. Code of practice training has taken place for staff in the designated centre. This training was facilitated by a Senior Psychologist.
2. PIC’s office is now based in the designated centre. This allows her to regularly observe interactions between staff and residents.
3. PIC and Area Manager conduct routine reviews of documentation. They will reflect these reviews by adding a date and initials to documents reviewed.
4. All staff who work in the designated centre have now attended MAPA training.
5. The Person in Charge links with the training department monthly to get information on staff training due and schedules for staff to attend training as required.

| Proposed Timescale: 21/12/2015 |
| Theme: Safe Services |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence to support the implementation of recommended interventions or the monitoring of their success or failure.
Available templates for personal behavioural support plans were generally blank.

12. **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:
1. A multidisciplinary review meeting took place in respect of each resident on 10th and 11th November 2015 to address the concerns raised by the HIQA inspection.
2. Minutes of these meetings are currently being finalised by the AM and PIC. These minutes will be circulated to the members of the multidisciplinary team and will be filed in the residents My Profile My Plan file.
3. Recommendations of MDT meeting will be followed up with by the PIC where appropriate.
4. Staff in the designated centre worked with the Senior Psychologist and SLT to develop positive behaviour support strategies to support each resident where required. These strategies are now being implemented.

| Proposed Timescale: 31/01/2016 |
| Theme: Safe Services |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that explicit safeguarding plans and the rationale for the plan and safeguarding measures were in place for residents and accessible to all staff.

While there was evidence of investigation and reported measures taken by the provider it was clear on speaking with staff and reviewing records that they (staff) and family members had ongoing safeguarding concerns for residents.

13. **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:
1. Protection Planning meeting has been held for the relevant residents in consultation with Social Worker, DP, PIC, Area Manager and Head of Community Services.
2. Protection Plan drawn up.
3. Staff in day and residential services met with the designated person who briefed both teams on the relevant safeguarding plans and how to support these individuals
4. Both residents have been referred to psychologist for support.
5. DP will meet with both individuals on regular intervals for a 6 month period when the situation will be reviewed.
6. Meetings were scheduled with families to meet with DP and Area Manager but this action will not be progressed at this time due family circumstances. An alternative date will be made available.

Proposed Timescale: 27/11/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A written report of all injuries to a resident was not provided to the Chief Inspector at the end of each quarter.

14. Action Required:
Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:
1. Notifications to HIQA are made in compliance with regulations.

Proposed Timescale: 30/11/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failing to adequately ensure that each resident had the opportunity to develop and experience new skills such as a desire to learn to tell the time, manage their own medications or enhance their communication capacity.

15. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.
Please state the actions you have taken or are planning to take:
1. A National Policy on education, training and development is in place.
2. Each resident attends a day service.
3. As part of the PCP process an Adaptive Behaviour Scale will be completed for each resident.
4. This scale will be used to support residents in identifying priorities relating to personal skill development.
5. The process of PCP development is underway in the Designated Centre, information gathering has commenced for all PCPs.
6. An assessment tool to determine a residents capacity to self medicate is currently being developed by the Services and will be administered with each resident of this designated centre.

**Proposed Timescale:** 28/02/2016

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:
The there were no policies and procedures including assessments in use to support residents in managing their own medications.

**16. 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:
1. The Medication Policy has been reviewed and the amended as per feedback from the HIQA inspection. The amended policy was taken to Policy Review Committee on the 29th October for approval but further amendments required which are in train.
2. An assessment tool for self administration of medication is currently being developed by the organisation. The time frame for this has been extended.

**Proposed Timescale:** 31/01/2016

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that residents were protected by the provider’s medication management procedures.
50% of the medication errors recorded were directly related to medication management practice by staff and indicated that while staff were vigilant in reporting errors, they were not and therefore compromised resident safety when administering and recording the administration of medications to residents.

There was no evidence to support the robust review of medication errors to guarantee learning and protect residents from further errors.

Medication management practice was not subjected to routine audit.

17. **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:**
1. The Medication Policy has been reviewed and amended as per feedback from the HIQA inspection. The amended policy was taken to Policy Review Committee on the 29th October for approval but further amendments required which are in train.
2. Medication errors were identified by the PIC as part of her management oversight of the designated centre. These errors related to recording and administrative errors.
3. The PIC spoke with each staff member following a medication error occurring.
4. Refresher Training on medication has been provided to staff in the designated centre by the Area Manager (RNID).
5. Medication errors will be escalated to the Area Manager and Head of Community Services on a monthly basis as per Medication policy.
6. Medication errors where particular risks have been identified will be documented and responded to under the risk management procedure where appropriate
7. Area Manager will conduct a monthly audit on medication in this designated centre in 2016. First audit took place on 17/11/2015

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

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**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 contain all of 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.

18. **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:**
1. The Statement of Purpose and function has been amended to reflect the requirements of Schedule 1.
2. This has been updated with the appointment of the new PIC.

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

**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:**
The issuing of the action plan from the provider's unannounced visit in May was not timely and the person in charge said that at the time of this inspection the actions were largely not implemented.

19. **Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**
1. Regular meetings between the Provider Nominee (Director of Services) and the Head of Quality to ensure the timely issuing of 6 month unannounced inspection reports to Person in Charge.

**Proposed Timescale:** 31/10/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As discussed throughout the body of this report the management systems were not sufficient in of themselves to ensure that the service provided to residents was safe, appropriate to resident's individual and collective needs, consistent and effectively monitored.

20. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
Please state the actions you have taken or are planning to take:
1. The position of the new PIC remains supernumery in the designated centre at this time. This is currently the only designated centre under this PIC. This action is being implemented outside of the approved staffing allocation for the organisation and will be reviewed on a regular basis. HIQA will be informed in advance of any change in this arrangement.
2. The PIC’s office is now based in the Designated Centre.
3. Area Manager will meet with PIC weekly with an agreed agenda.
4. Monthly Staff meeting involving residential staff, PIC and Area Manager.
5. Area Manager will meet with Head of Community on a monthly basis.
6. For all meetings agenda items will include Risk Register, Complaints and Safeguarding.
7. Actions plans from internal and external inspections will be tracked.
8. To agree process for escalating areas of concern to the relevant member to SMT.
9. The Provider Nominee met with all managers including the PIC and AM of this designated centre on the 5th and 19th November to set out the areas of management that require improvement as well as agreeing areas where improvements to processes and procedures could be developed in order to support management.
10. A meeting with the PIC’s, chaired by the Provider Nominee, will be scheduled on a bimonthly basis in 2016.

Proposed Timescale: 31/12/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate resources available to guarantee adequate and consistent staffing resources to ensure the effective delivery of the required care and supports to each resident in line with their assessed and evolving needs and in accordance with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
1. As outlined in Part II of the Service Arrangement between the Brothers of Charity Services Limerick and the HSE this Designated Centre is funded based on 1:1 Social Care Staff with a sleepover roster.
2. A Business Case was submitted to the HSE on 3rd July 2015 requesting funding for additional support staff hours to support residents in the evening and at the weekend in order to provide a safe and quality service. Support hours, although unfunded, have been in place in this centre albeit on an inconsistent basis due to the availability of relief staffing. This has been addressed in September to ensure consistency and reliability.
These additional support hours will be maintained in the designated centre until such time as further clarity is received from the HSE in respect of this business case which was submitted in July 2015.

3. A Business Case for waking night staff has been submitted to the HSE on 1st October 2015 following the registration inspection. Following the issuing of a warning letter by HIQA a request for clarification on the status of the Business Case has been sought from the HSE. This clarification was issued by the HSE on 2nd November in respect to the funding of this business case.

The decision of the Chair of the Brothers of Charity Services Limerick and the National Chief Executive, on the basis of this letter of confirmation from the HSE, is not to sanction the introduction of waking night staff in Waxwing 1 designated centre.

The Authority did not agree elements of this action plan response with the provider and has taken the decision not to publish that element of the response.

**Proposed Timescale:** 31/10/2015

### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

Failing to ensure that there were adequate staff resources to meet the assessed needs of the residents.

Inspectors were not satisfied that the sleepover arrangement was sufficient to meet the increasing needs of the residents.

The consistency, safety and quality of supports provided to residents was negatively impacted by an overreliance of relief staff.

Records completed by some staff indicated that all staff did not have the required knowledge, skills and attitude to provide care and support to residents in an evidence based and respectful manner.

**22. Action Required:**

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

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

1. There are six residents in this house, three of whom present with complex and changing needs relating to ageing, dementia, mobility and supports around intimate care.

2. One resident, who had been waking frequently at night, has had recent medical follow up which appears to have had a positive impact. She continues to wake at night but less frequently and staff report that she is not walking around the house – only
getting up to use the bathroom. This situation will be risk assessed and monitored over the coming months to capture the extent of the residual risk.

3. Day service staff now commences duty in the designated centre at 7.30a.m. to facilitate morning routine of residents. This change in roster is cost neutral.

4. As outlined in Part II of the Service Arrangement between the Brothers of Charity Services Limerick and the HSE this Designated Centre is funded based on 1:1 Social Care Staff with a sleepover roster.

5. A Business Case was submitted to the HSE on 3rd July 2015 requesting funding for additional support staff hours to support residents in the evening and at the weekend in order to provide a safe and quality service. Support hours, although unfunded, have been in place in this centre albeit on an inconsistent basis due to the availability of relief staffing. This has been addressed in September to ensure consistency and reliability. These additional support hours will be maintained in the designated centre until such time as further clarity is received from the HSE in respect of this business case which was submitted in July 2015.

6. A Business Case for waking night staff has been submitted to the HSE on 1st October 2015 following the registration inspection. Following the issuing of a warning letter by HIQA a request for clarification on the status of the Business Case has been sought from the HSE. This clarification was issue by the HSE on 2nd November in respect to the funding of this business case.

The decision of the Chair of the Brothers of Charity Services Limerick and the National Chief Executive, on the basis of this letter of confirmation from the HSE, is not to sanction the introduction of waking night staff in Waxwing 1 designated centre.

7. Recruitment will take place to establish a dedicated relief panel for the Waxwing Management area. Interviews have taken place.

8. A dedicated relief panel to be formed for the Waxwing management area following recruitment.

9. Code of practice training attended by all staff. Medication training refresher to be provided by Area Manager. Communication training completed.

The Authority did not agree elements of this action plan response with the provider and has taken the decision not to publish that element of the response.

**Proposed Timescale:** 28/02/2016

**Theme:** Responsive Workforce

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

Complete information and documents as specified under Schedule 2 was not available for some staff files viewed by Inspectors.

**23. Action Required:**

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

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

- HR Department have confirmed that documents as specified in Schedule 2 are now on
**Proposed Timescale:** 31/10/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
A deficit was identified with regard to mandatory training including fire training, manual handling training and dealing with behaviours that challenge training.

24. **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:  
1. Mandatory training and MAPA training completed.  
2. Fire training for staff will take place following the implementation of recommendations from the review of Fire Safety measures in the Designated Centre.

**Proposed Timescale:** 31/01/2016

**Outcome 18: Records and documentation**  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The directory of residents did not include all of the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

25. **Action Required:**  
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:  
Directory of residents has been updated.

**Proposed Timescale:** 21/12/2015