Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0002285
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Ireland
Provider Nominee:	Una Nagle
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
12 May 2016 09:30	12 May 2016 16:30
13 May 2016 09:30	13 May 2016 16:00
19 May 2016 09:30	19 May 2016 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the second inspection of this centre which was managed by the Brothers of Charity Services.

Since the last inspection the number of residents living in the centre had increased from five to eight with the admission of an additional three residents who had been living in another designated centre that had closed at short notice. The statement of purpose outlined that the residents living in the centre “may have multiple/complex support needs. Some residents may present with behaviours that challenge including sexualised behaviours”.

An immediate action plan was issued by HIQA on the second day of the inspection. The inspector saw documentation relating to five separate incidents regarding disclosures of allegations of abuse that had been made by a resident. These incidents had been had been reported by the team leader to the person in charge.

However, a formal referral of each allegation had not been made to the designated officer, as required by the service policy on reporting of allegations of abuse. In their response to the action plan the Brothers of Charity service outlined that since this issue had been identified by the inspector each of these incidents had been reviewed by the designated officer.

Description of the service
The Brothers of Charity provided a range of day, residential and respite services in Cork. The Brothers of Charity Services was a not-for-profit organisation and was run by a board of directors and delivered services as part of a service agreement with the Health Services Executive (HSE). The centre consisted of four houses that had been refurbished to a high standard and were located in a courtyard style design. The houses were located approximately two miles from the middle of a large town.

The statement of purpose described the aims, objectives and ethos of the centre. The statement of purposed outlined that the focus was "on understanding and meeting the individual needs of each person living here by creating as homely an environment as possible. Individuals are encouraged to reach their fullest potential by participating in leisure, social and household activities".

How we gathered our evidence
The inspector met with each resident living in the centre. One resident told the inspector about his day and the he was going to the day service which was based on site across the courtyard. He also said he was "looking forward to going home on the weekend". Another resident outlined how he had moved here from another centre "last year" and said that he "liked it here".

The inspector also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. On the first day of inspection one of the residents was engaged in self injurious behaviour. Staff were observed by the inspector to support the resident by speaking to him in a calm manner, guiding him to a picture schedule and explaining the next thing the resident had planned for the day. This appeared to reassure the resident and he stopped engaging in the self injurious behaviour. These "reactive strategies" by staff were all outlined in the resident's support plan.

Overall judgment of our findings
There was evidence of good practice. For example, of the five residents who had been living in the centre since it opened, four had previously lived in a congregated setting on a campus style service. Some of these residents had been living in residential care since they were children. There was evidence that the transition for these residents had taken place in a planned and safe manner.

There had also been improvement on issues identified on the previous inspection including in relation to the complaints process and the provision of hospital "passports" for when residents had to attend hospital. Since the last inspection each resident had a residential service agreement in place that outlined the services provided to residents and the charge for residents to live in the centre.

Residents were being supported to achieve and enjoy the best possible health. In addition, improvements had been made in relation to safe medication management practices including the availability of policies and procedures on medication management. Staff who spoke with the inspector said they were very committed to supporting residents to live meaningful lives.

Of the 11 outcomes inspected five were at the level of major non-compliance:
Outcome 4: Admissions and contract for the provision of services
The Brothers of Charity service had outlined in the statement of purpose for the centre that for any emergency admission the disruption to existing service users would be considered. However, in relation to the emergency admission of an additional three residents there was no evidence of any consultation with the existing residents in relation to this increase in number of people living with them. In addition, there had not been any consideration given to the need to protect existing residents from the possibility of abuse by the newly admitted residents.

Outcome 5: Social Care needs
The designated centre did not meet the assessed needs of all residents. A forensic risk assessment had been completed for one resident which outlined that the current placement was inappropriate from a risk management point of view and from a therapeutic point of view. In response the Brothers of Charity Service had discharged this resident from the service as they were unable to meet his needs. The Brothers of Charity Service had submitted a formal request to their funder the Health Service Executive (HSE) requesting an assessment from another service provider so that the resident would be considered for alternative placement. However, at the time of inspection the resident was still living in the designated centre.

In addition, another resident required an up-to-date forensic risk assessment as the previous assessment was from 2003. This had not taken place and therefore an up to date plan was not in place to help staff to provide the interventions required to support this resident.

Outcome 8: Safeguarding
There was evidence that all incidents, allegations, or suspicions of abuse were not being investigated appropriately. An immediate action plan was issued by the inspector on the second day of the inspection to address this deficiency. In addition, an up to date plan was not in place to help staff to provide the therapeutic interventions required to support a particular resident

Outcome 9: Notifications
It was a requirement that all serious adverse incidents were reported to HIQA within three working days of the incident. However, the inspector saw documentation relating to five separate incidents regarding disclosures of allegations of abuse that were not reported to HIQA.

In January 2016 HIQA issued the Statutory Notifications: Guidance for registered providers and persons in charge of designated centre. This guidance document stipulated that service providers "are required to notify the chief inspector of any allegation, suspected or confirmed, of abuse within three working days". The service

had been aware of a particular allegation of abuse in February 2015 which had subsequently been confirmed. The service had informed HIQA that an incident had occurred. However, the service had not informed HIQA of the outcome of that incident.

Outcome 14: Governance
The Brothers of Charity Service failed to demonstrate that the service provided was safe, appropriate to residents needs or effectively monitored. This was evidenced by failings throughout this report particularly in relation to the way three residents had been admitted to the centre without consultation with existing residents, the non-investigation of allegations of abuse made by residents and the non-notification to HIQA of incidents as required. In addition the Brothers of Charity Service acknowledged that it couldn’t meet the needs of one resident and had discharged him pending a more appropriate placement.

In addition to the items mentioned in this summary the Action Plan at the end of the report identifies other areas where improvement was required. These included:
• a minor issue with the premises
• risk assessment
• staff training.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Two aspects of this outcome were reviewed. It had been identified on the previous inspection that the charter of rights poster relating to advocacy was not in an accessible format and that the complaints policy did not have sufficient information. Both these issues had been rectified.

Judgment:
Compliant

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:
The Brothers of Charity service had outlined in the statement of purpose for this centre that for any emergency admission the disruption to existing service users would be considered. Since the last inspection the number of residents living in the centre had increased from five to eight with the admission of an additional three residents who had been living in another designated centre that had closed at short notice. However, in relation to the emergency admission of these additional three residents there was no evidence available in the centre of any consultation with the existing residents in relation to this increase in number of people living with them. In addition, there had not been any consideration given to the need to protect existing residents from the possibility of abuse by the newly admitted residents. As discussed in more detail in Outcome 5: Social Care Needs, residents were living in the centre even though it was unsuitable and the service could not meet their needs.

At the last inspection it had been identified that there were no written agreements in place for residents. On this inspection each resident had a residential service agreement in place that outlined the services provided to residents and the charge for residents to live in the centre.

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):
No actions were required from the previous inspection.

Findings:
The designated centre did not meet the assessed needs of all residents.

The statement of purpose outlined that the residents living in the centre "may have multiple/complex support needs. Some residents may present with behaviours that challenge including sexualised behaviours". As outlined in their personal care plan a forensic risk assessment had been completed for one resident which outlined that his current placement within a non-specialist service provider was inappropriate from a risk management point of view and from a therapeutic point of view. In response the

Brothers of Charity Service had discharged this resident from the service as they were unable to meet his needs. The Brothers of Charity Service had submitted a formal request to their funder the Health Service Executive (HSE) requesting an assessment from another service provider so that the resident would be considered for alternative placement. However, at the time of inspection the resident was still living in the designated centre.

Of the five residents who had been living in the centre since it opened, four had previously lived in a congregated setting on a campus style service. Some of these residents had been living in residential care since they were children. There was evidence that the transition for these residents had taken place in a planned and safe manner. The team leader outlined that he had worked with the four residents in the congregated setting and had transferred with the residents to the new centre. Staff who the residents knew also had been involved in the move and a lot of these staff were now working in the current centre.

As outlined in their personal care plan one resident with a forensic profile had a monthly multidisciplinary risk management review with representation from psychology, social work, the person in charge, team leader and key worker. However, another resident who had a similar profile had received a psychological assessment in September 2015. This assessment outlined that he required an up-to-date forensic risk assessment as the previous assessment was from 2003. This had not taken place and therefore an up to date plan was not in place to help staff to provide the interventions required to support this resident.

There were two sets of resident records; the person centred planning folder and a separate file for medical records. In the person centred planning folders reviewed by the inspector there was a summary profile of the resident. Care management plans for assessed healthcare needs were also in place. The person centred planning folder also contained a record of review by the multidisciplinary team, hospital appointment records, an annual medical health check by the resident’s doctor. The inspector saw that the communication diary and appointment record sheets were being used to coordinate healthcare appointments for residents. However, a plan of care for these identified healthcare needs was not always being developed or updated either prior to or following these healthcare appointments. For example, one resident had recently had their blood pressure monitored in hospital. While this was recorded in the hospital appointment records the care plan had not been updated.

On the previous inspection it had been identified that there were gaps in the information outlined in residents' hospital passports. A hospital passport was a document to support persons with a communication difficulty/ intellectual disability and their main carers when in contact with an acute general hospital. During this inspection the passports seen were comprehensive.

In relation to review of the personal plan by the multidisciplinary team, the person in charge outlined that it was planned to have the personal plan reviewed by the multidisciplinary team at least annually. A comprehensive multidisciplinary review had taken place for a number of residents.

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

Findings:
The centre consisted of four houses that had been refurbished to a high standard and were located in a courtyard style design. The houses were located approximately two miles from the middle of a large town.

At the last inspection two issues had been identified; the first relating to the carpet on the stairs was a potential trip hazards; and the second issue related to a toilet seat needing to be replaced. Both issues had been resolved.

However, on this inspection it was noted that the stairs in one of the houses had duct tape in place on the carpet on the steps at the top and bottom of the stairs. This tape was now coming away and presented as a potential trip hazard. The centre risk register also identified that the floor covering in one resident's bedroom required replacement.

Judgment:
Substantially 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:
The process for the management of hazards in the centre required improvement.

The centre had a risk register in place. The Brothers of Charity service outlined that "a risk register is a database of risks that face your service area at any one time and your management of them....Risk registers must act as an everyday tool in support of managers when managing risks". However, it was not clear how some risk issues relating to individual service users had been put on the risk register and other risk issues had not. For example, a resident had been deemed to be discharged from the service but this was not on the centre risk register while an issue relating to the same resident absconding was on the centre risk register.

The methodology of assessing risk on the risk register i.e. whether the risk was low, medium or high was inconsistent as in some instances it was marked used numbers, e.g. 16, and in other cases it was marked as "medium" or no score at all recorded. In addition, it was not always recorded how the hazards on the risk register were being managed and who was responsible. For example, for the hazard of "absconding" a number of actions (additional control measures) had been identified. However, there was no staff member assigned responsibility to ensure these actions were completed and there was also no "target date" recorded for completion of the actions. It was also unclear how hazards on the risk register were being escalated, if required, to the management team of Brothers of Charity Service.

The local risk management policy included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. There was also a local safety statement in place. Since the last inspection specific hazards identified by the inspector had been risk assessed including windows and latex gloves. However, on the current inspection risk assessments were not available for other readily identifiable hazards. For example, there was no risk assessment available in relation to pregnant employees.

Each resident had participated in identifying specific hazards relating to their lives. These were contained in individual risk profiles. There were also front line activity risk assessments in place for residents. This process "aims to support the person in maximising their life choices whilst recognising associated risks". For one resident this included potential hazards such as absconding and attending football matches.

At the last inspection it was found that there was inconsistency in relation to what was an "accident" and what was an "incident". Since then a new system of reporting had been introduced. The inspector reviewed the incident reporting system and saw records relating to seven incidents. All incidents had been followed up by the person in charge and were reported to senior management of the service at a regional level to review for trends.

Since the last inspection the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site.

There were three monthly fire evacuation drills being undertaken involving the residents and the records of these drills indicated that it had taken between 52 seconds and one minute and 50 seconds to evacuate the premises in drills. Each resident had a personal

emergency evacuation plan in place which indicated what supports, if any, residents needed to leave the building in the event of a fire.

At the last inspection it was found that staff required up to date knowledge in relation to control and prevention of infection. On this inspection the centre was visibly clean. Paper handtowels were available in all shared bathrooms. Each resident had their own laundry basket in their rooms and were encouraged to wash their own clothes. There were cleaning schedules in place and staff spoken with were aware of infection control principles.

Judgment:
Substantially Compliant

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

Theme:
Safe Services

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

Findings:
There was evidence that all incidents, allegations, or suspicions of abuse were not being investigated appropriately. An immediate action plan was issued by the inspector on the second day of the inspection to address this deficiency. In addition, an up to date plan was not in place to help staff to provide the therapeutic interventions required to support a particular resident.

The inspector saw documentation relating to five separate incidents regarding disclosures of allegations of abuse that had been made by a resident. These incidents had been had been reported by the team leader to the person in charge. However, a formal referral of each allegation had not been made to the designated officer, as required by the service policy on reporting of allegations of abuse. An immediate action plan was issued by HIQA to address this deficiency. In their response to the action plan the Brothers of Charity service outlined that since this issue had been identified by the inspector each of these incidents had been reviewed by the designated officer.

There was a service wide behaviour standards committee chaired by a clinical psychologist. This committee was available to review any restrictions that limited a resident's life. This committee's terms of reference included reviewing what restriction

was in place (for example if the restriction was an environmental restraint, chemical restraint or physical restraint). The person in charge confirmed that there were two restrictions in place for separate residents which related to the use of medication as required (PRN) to manage behaviour. The inspector saw documentation relating to the referral of one of these restrictions to the behaviour standards committee. A review request form of this restrictive practice had been submitted to the behaviour standards committee. There had been a letter from the committee in December 2015 requesting information in relation to this restriction. However, no response to this request had been submitted by the centre and a further letter from 13 May 2016 was on file from the committee requesting this information again. The behaviour standards committee outlined in the letter of May 2016 that "restrictive practices not sanctioned or reviewed are prohibited practices". It was not clear why the centre had not submitted this requested information.

There was also a service wide rights committee. Following a multidisciplinary meeting in April 2016 it had been recommended that all other restrictions in the centre would be listed and sent to the rights committee for review. Items listed included things like "a room search" when the resident was not there, the use of "monitors" and "access to the community".

The Brothers of Charity service had an adult behaviour support services department and residents received support from an intensive support worker from this department. In one example, there was a comprehensive behaviour assessment report and support plans available for the resident. The inspector noted that behavioural interventions record gave clear directions to staff on how best to prevent or appropriately respond to behaviour that challenges. This assessment report had recommended that staff receive updated training in positive behaviour support. However, records indicated that four staff had not received this updated training.

On the first day of inspection one of the residents was engaged in self injurious behaviour. Staff were observed by the inspector to support the resident by speaking in a calm manner to him, guiding him to his picture schedule and explaining the next thing the resident had planned for the day. This appeared to reassure the resident and he stopped engaging in the self injurious behaviour. These "reactive strategies" from staff were all outlined in the resident's support plan.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
It was a requirement that all serious adverse incidents were reported to HIQA within three working days of the incident. However, this requirement was not being complied with.

The inspector saw documentation relating to five separate incidents regarding disclosures of allegations of abuse that were not reported to HIQA.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Residents were being supported to achieve and enjoy the best possible health.

The person in charge outlined that residents had the option of attending a general practitioner (GP) of their own choice. The inspectors reviewed a sample of resident healthcare files and found evidence of regular GP reviews. Social care staff were recording the outcome of doctor reviews in the resident's healthcare file.

The GPs requested review of residents' healthcare needs by consultant specialists as required. There was correspondence on file following these appointments and reviews.

There was evidence that residents were referred, as required, to allied health professionals including speech and language therapy, psychology and behavioural support.

All meals were prepared by staff in the kitchen on site. Staff were knowledgeable about residents likes and dislikes. It was recorded on the centre risk register that a number of residents drank "fizzy drinks" to excess on a daily basis. There was evidence of strategies in place from the psychology department to support these residents to reduce the amount of "fizzy drinks" they were consuming.

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:
Since the last inspection improvements had been made in relation to safe medication management practices including the availability of policies and procedures on medication management.

Photographic identification was available for each resident on the medication administration record to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error.

Medication was dispensed from the pharmacy in a monitored dosage system. It was kept securely in a locked cabinet and during the two days of the inspection the cabinet was locked at all times. Staff outlined that if there were any change to the resident's prescription the monitored dosage system was returned to pharmacy and a new pack was dispensed.

The prescription sheets were pre-printed, signed and dated by the GP and contained the medication name, dosage instructions (i.e. how often in a 24 hour period) and administration times.

As an example of good practice there was a protocol on the management of pro re nata (PRN or as required) medication. When a resident's GP prescribed a PRN medication a form was completed and added as an appendix to the resident's health care plan and a copy kept with the resident's prescription sheet. The form included the reason for the prescription of the PRN medication, symptoms to be identified before administering the PRN medication, possible side effects and instructions about when to see the GP and any other special instructions in relation to the use of this medication. A record of each use of PRN medication was maintained. Records for five residents showed that in 2015 PRN medication had been used 58 times.

The person in charge confirmed that medication management training had been given to all staff.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The Brothers of Charity Service failed to demonstrate that the service provided was safe, appropriate to residents needs or effectively monitored.

The provider of the service was the Brothers of Charity who provided a range of day, residential and respite services in Cork. The Brothers of Charity Services was a not-for-profit organisation and was run by a board of directors and delivered services as part of a service agreement with the Health Services Executive (HSE).

The person in charge was a social care worker with a degree in social care from Cork Institute of Technology. He had worked for the Brothers of Charity since 1999 in various roles. The person in charge was suitably qualified and experienced to discharge his role, in accordance with the regulations. The person in charge reported to the sector manager, who in turn reported to the director of services. There were two team leaders both of whom were identified as a person participating in the management of the service. Both team leaders were experienced healthcare professionals, one of whom was a qualified social care worker and the second was a registered nurse. Both had significant experience of supporting persons with an intellectual disability and had worked for the Brothers of Charity for over 15 years.

However, it was not demonstrated that the governance and management arrangements were satisfactory as the person in charge's level of participation was inadequate to ensure the suitable governance operational management of the centre. The person in charge had a remit for six designated centres, in addition to three day services. The person in charge confirmed he came to the centre on a monthly basis. However, he also attended multidisciplinary meetings off site regarding residents of this centre.

The Brothers of Charity Service failed to demonstrate that the service provided was safe, appropriate to residents needs or effectively monitored. This was evidenced by failings throughout this report particularly in relation to the way three residents had been

admitted to the centre without consultation with existing residents, the non-investigation of allegations of abuse made by residents and the non-notification to HIQA of incidents as required. In addition the Brothers of Charity Service acknowledged that it couldn't meet the needs of one resident and had discharged him pending a more appropriate placement.

An annual review of the quality and safety of care of the service dated July 2015 had been completed. The review looked at issues in each house separately and not the overall centre. This review looked at a limited number of issues namely:
- residents' rights
- personal care planning
- risk management (including fire safety)
- safeguarding/safety
- education/training opportunities for residents

The provider had ensured that two unannounced visits to each house within the designated centre had been completed to review safety and quality of care provided. These had taken place in June 2015 and January 2016. As with the annual review not all issues relevant to quality and safety in the audit tool were reviewed.

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

Findings:
Based on observations by the inspector, a review of the roster and inspection findings, it was demonstrated that the staff numbers were appropriate for the number of residents living in the centre.

Following a risk assessment of one resident's needs in 2013 it had been found that staff did not have the appropriate qualifications and skills to adequately support this resident. At that time it was recommended that staff needed to be upskilled in terms of their knowledge on specific risk factors associated with behaviour of one resident. It was also recommended that staff needed support on how to best engage with the resident. It

was also outlined that staff be given the opportunity to debrief with a psychologist. The area manager confirmed that these recommendations had been implemented at that time.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Kieran Murphy
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[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0002285
Date of Inspection:	12 May 2016
Date of response:	7 July 2016

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 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:
In relation to the emergency admission of three residents there was no evidence of any consultation with the existing residents in relation to this increase in number of people living with them.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
1. The Services Admissions Policy has been amended to ensure that residents are consulted with in relation to the impact of all new admissions. Any concerns on how this may impact on the organisation and running of the centre will be considered in the assessment of the suitability of the proposed new admission. [15 July 2016]
2. The Admission Pack has been updated to include a risk assessment form to be completed following consultations with residents and/or their representatives as appropriate regarding new admissions. [15 July 2016]
3. An updated risk assessment on the impact of the three new admissions on the organisation of the Centre will be completed, having consulted with the other residents [22 July 2016]

Proposed Timescale: 22/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission practices did not take account of the need to protect residents from abuse by their peers.

2. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
1. We will fully document the risk management issues which were considered by management prior to making the decision to transfer the three new admissions with their staff team, to separate facilities in the Centre. [8 July 2016]
2. The Services Admission Procedure has been amended to ensure that all Service users' safety risk assessments will be continuously assessment from date of admission [8 July 2016]
3. An updated impact risk assessment on the safety of all residents will be conducted in consultation with the monthly multidisciplinary Team meetings in the Centre [18 July 2016]
4. A relocation of the new admissions will be considered based on the outcome of the updated impact safety risk assessment at 3 above.

Proposed Timescale: 18/07/2016

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:
One resident required an updated forensic risk assessment.

3. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
1. A Clinical Risk Assessment will be carried out in September 2016 by appropriate members of the multidisciplinary team.
2. The Person in Charge, Sector Manager and the Provider Nominee will develop a comprehensive time-framed action plan to address the recommendations of this assessment. The action plan will be notified to the Authority.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre did not meet the assessed needs of all residents.

4. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
1. The Services will continue to seek an appropriate Service provider to meet the assessed needs of the resident who is in process of discharge. [31 July 2016]
2. Given the difficulties to date in advancing this discharge together with the recognition by the Executive of gaps in such provision nationally, the Services will seek guidance from the Provider and the HSE at National level on how to finalise this issue.
3. A detailed Action plan will be submitted to the Authority following these discussions.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector saw that the communication diary and appointment record sheets were being used to coordinate healthcare appointments for residents. However, a plan of

care for these identified healthcare needs was not always being developed or updated either prior to or following these healthcare appointments.

5. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The health care management plan format has been revised. A healthcare management plan is now in place for all medical conditions and this is updated following all appointments/reviews.

Proposed Timescale: 01/07/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The stairs in one of the houses had duct tape in place on the carpet on the steps at the top and bottom of the stairs. This tape was now coming away and presented as a potential trip hazard. The centre risk register also identified that the floor covering in one resident's bedroom required replacement.

6. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The floor covering has been replaced in the bedroom.
The visual aids strips will be replaced by colour contrasted carpet.

Proposed Timescale: 15/07/2016

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:
The process for the management of hazards on the organisation risk register required review. In addition, the process for risk assessment was not robust as there were readily identifiable hazards which did not have risk assessments in place.

7. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. The existing risk registers will be reviewed and updated to ensure all identified risks are included and have time framed action plans as appropriate. The two existing registers will be consolidated [22nd July 2016]

2. Further training will be provided to the Team on
- risk identification and scoring
- management of risk including risk elevation

Proposed Timescale: 30/09/2016

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:
In one assessment report it had been recommended that staff receive updated training in positive behaviour support. However, records indicated that four staff had not received this updated training.

8. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
The 4 awaiting updated training in positive behaviour support training are scheduled for training in September 2016.

Proposed Timescale: 23/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that all incidents, allegations, or suspicions of abuse were not being investigated appropriately. An immediate action plan was issued by the inspector on the second day of the inspection to address this deficiency.

9. 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. Concerns raised which were being monitored have now been formally referred to the Designated Person and have investigated under the Services procedures. [19/5/2016]
2. We have reviewed our Incident Management and Reporting System to ensure that all incidents are logged and reported. The incident log will be reviewed on a weekly basis to ensure that policies are being adhered to.

Proposed Timescale: 08/07/2016

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:
The inspector saw documentation relating to five separate incidents regarding disclosures of allegations of abuse that were not reported to HIQA. The inspector requested that retrospective notifications be submitted.

10. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1. All notifications have been submitted to the authority by the Person in Charge. [10/06/2016]
2. We have reviewed the Authorities Guidance Document in relation to notification of incidents of Challenging behaviour and have revised our Incident Management and Reporting System to ensure that all incidents are logged and reported to the Authority as appropriate. [8/07/2016]
3. We will ensure that all Notifications are reviewed on a regular basis to ensure that the Authority is updated on any significant issues arising therefrom. This will be done on review of incident logs and during the quarterly notification process in place for the Person in Charge.

Proposed Timescale: 08/07/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management arrangements across a wide type and variety of services could not ensure effective governance, operational management and administration of the designated centre concerned.

11. 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:
The Person in Charge areas of responsibility have been reduced and will be kept under review to ensure effective governance, operational management and administration of the Centre.

Proposed Timescale: 01/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not an ongoing programme of training and support to staff to help them to adequately meet the needs of residents.

12. 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:
The staff Training schedule will be updated following the recommendation of the updated Clinical Risk Assessment in relation to training needs of staff.

Proposed Timescale: 30/09/2016