

**Health Information and Quality Authority  
Regulation Directorate**

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



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| <b>Centre name:</b>                                   | A designated centre for people with disabilities operated by Brothers of Charity Services Limerick |
| <b>Centre ID:</b>                                     | OSV-0004837  |
| <b>Centre county:</b>                                 | Limerick   |
| <b>Type of centre:</b>                                | Health Act 2004 Section 38 Arrangement   |
| <b>Registered provider:</b>                           | Brothers of Charity Services Limerick  |
| <b>Provider Nominee:</b>                              | Norma Bagge  |
| <b>Lead inspector:</b>                                | Mary Moore   |
| <b>Support inspector(s):</b>                          | Noelle Neville   |
| <b>Type of inspection</b>                             | Unannounced  |
| <b>Number of residents on the date of inspection:</b> | 3  |
| <b>Number of vacancies on the date of inspection:</b> | 1  |

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

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

**The inspection took place over the following dates and times**

From: 08 June 2016 09:00 To: 08 June 2016 17:30

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs                          |
| Outcome 07: Health and Safety and Risk Management      |
| Outcome 08: Safeguarding and Safety                    |
| 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 inspection was the second inspection of this centre by the Health Information and Quality Authority (HIQA). The inspection was unannounced and was undertaken to follow-up on the poor findings of the previous inspection undertaken in March 2015. Following that inspection the provider liaised with HIQA and confirmed the reconfiguration of the centre and of its governance structure. The centre was originally one of two disparate services that had been notified to HIQA as one designated centre but the service were reconfigured and subsequently returned as two separate designated centres. In January 2016 a new person in charge was appointed and the original person in charge retained responsibility for the other designated centre.

**How we gathered our evidence**

The inspection was facilitated by the person in charge, the area manager and the head of community services. Inspectors reviewed records including fire and health and safety records, complaint records, staff related records, reports from the provider's review of the service and records as they pertained to the supports provided to residents.

Inspectors met with all of the three residents who welcomed the inspectors into their home. Residents spoke openly with inspectors of what was good and what was of concern to them. Residents were clearly familiar and comfortable with the management team and provided positive feedback to inspectors on all staff. Residents spoke of a recently enjoyed holiday and how they liked living and socialising with each other.

Of primary concern to all of the residents was the delay in getting back to the house that they had had to vacate in October 2015, the house that they clearly saw as their home. Residents confirmed that they had meetings and updates from the provider on this matter but they were frustrated and anxious at the delay in both the commencement and completion of the required refurbishment works. While residents had adjusted to life in this new location they did not see it as home and said that the location impacted on the level of independence that they had enjoyed in the other more centrally located house.

#### description of the service

The premises was a domestic type two storey premises. It was well maintained, homely and welcoming in presentation. The premises was situated in a rural location where transport was required to access all amenities. Inspectors saw that a vehicle was available to staff and residents. Residential services were provided to three adult males with reported low support needs in their activities of daily living.

#### Overall findings

There was evidence of some but ultimately insufficient progress made since the previous inspection of March 2015.

There was a clearly defined management team in place, the providers own review process was comprehensive and there was evidence of action taken by the provider in response to these reviews. However, the repeat failings from inspections and reviews and the lack of evidence of the progress of required action plans was of concern to inspectors. These failings and the requirement for direct action by the provider following reviews did not provide reassurance that the governance arrangements were effective, ensured that the service provided to residents was safe, appropriate, consistently and effectively monitored and provided assurance of this to the provider.

Of the eight Outcomes reviewed by inspectors on this inspection the provider was judged to be compliant with one Healthcare Needs. Failings were identified in a further four Outcomes that were judged to be at the level of moderate non-compliance; residents rights, planning supports, governance and management and staff training.

The provider was judged to be in major non-compliance with the remaining three Outcomes. Overall inspectors concluded that the process of risk assessment particularly where a specific risk and associated risks had been identified was fragmented, inadequate, inconsistent and did not provide reassurance that risk was comprehensively and effectively identified and managed. Certificates of servicing of the centre's fire fighting equipment that included emergency lighting, fire fighting

equipment and an automated fire detection system were not available in the centre and management were unable to provide same on the day of the inspection. There were outstanding failings in medicines management that did not support safe practice.

Based on the findings of the March 2015 HIQA inspection, the findings of the provider's own reviews of the centre in the intervening period and these inspection findings, inspectors were not satisfied that there was a timely, robust consistent approach to safeguarding matters. Inspectors noted a high level of inconsistency in safeguarding assessment, controls and practice. Practice was inadequately supported by risk assessment and sharing of relevant information and practice was in direct contradiction to the findings and recommendations of an assessment commissioned by the provider. There was reported multi-disciplinary disagreement with the recommendations of this assessment and as to how these matters should be managed. This was evident in records seen and did not provide reassurance that residents were and would be appropriately supported.

At the conclusion of the inspection the provider was requested to provide to HIQA by 10 June 2016 details as to the actions taken and to be taken in response to the identified failings based on the verbal feedback provided of the inspection findings.

The provider reverted with the required information within the specified timeframe. The provider advised that following the inspection a meeting was held by the head of community service with the area manager and the person in charge. All action plans from the providers own reviews were to be reviewed and updated and forwarded to the head of community services by Friday 17 June 2016. Action plans were added as a standing item to the agenda for weekly area managers meeting with the head of community services.

Confirmation was received that the safeguarding assessment and report was reviewed by senior management, a full multi-disciplinary team (MDT) meeting with agreed agenda was rescheduled for 15 June 2016 and a meeting had taken place between the area manager, the person in charge, the designated officer and the social worker on 9 June 2016 to establish actions and supports that needed to be in place as outlined in the report. Relevant risk assessments were to be identified in conjunction with the MDT on 15 June 2016.

**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:**

Inspectors met with all of the three residents living in the centre. Residents welcomed the inspectors into their home, offered them refreshments and chatted openly with inspectors. One resident showed photographs on his laptop of a recent holiday abroad to inspectors and said that he had a great holiday. Another resident with a sensory disability participated effectively in the chat with inspectors by his preferred means of communication that were made known to inspectors by staff. Residents told inspectors about their holiday abroad in December 2015. They also spoke about a recent trip to the west coast and staff informed inspectors that they planned to do more day trips with residents around Ireland this year.

Residents informed inspectors that they were relatively content at the moment in this centre; however, they stated that their ultimate wish was to move back to their "home" in Limerick City. Residents told inspectors that they found the delay in the refurbishment of their home very frustrating as they were originally told that this move was required only for a very short time. Residents clearly articulated their loss of independence in this centre given its location as they could not walk to town and come and go as they pleased. Residents highlighted their reliance on staff and vehicles to access town whereas they could walk and cycle as they wished previously. Residents reassured inspectors that staff always facilitated their requests for transportation either in the service vehicle or a taxi that was secured for them.

During the morning, residents had a meeting with members of the management team regarding the proposed building works to be completed to their home in Limerick City. Residents had the opportunity to view the plans for their home and were happy to show

inspectors the plans. Management assured residents and inspectors that funding was secured for the building works but a date for completion of the works could not be confirmed. Residents told inspectors that they were happy with the meeting but they still had some evident anxiety as to when they were to actually move back into their own house which they clearly saw as home.

Inspectors reviewed records of resident house meetings which were noted to take place regularly. Issues discussed included health and safety, advocacy, complaints, activities and meal planning. House meetings provided an opportunity for residents to plan outings such as day trips and holidays at home and abroad. In addition, concerns as raised by residents during house meetings were recorded such as there being a dangerous road outside the house with no footpath, unlike what they had been used to, and being worried and upset regarding the delay in works to be completed at their home in Limerick City.

A local issues/complaints book was viewed by inspectors. The local issue/complaints form included the name of the complainant, a summary of the issues, complainant satisfaction, steps taken to resolve the issue or escalation to the line manager if it was not possible to resolve the issue locally. It was noted that records began in February 2016 and four issues/complaints had been logged to date. Inspectors were satisfied that residents were supported by staff to make a complaint and were listened to by staff and management in relation to same. One of the four complaints again related to the resident's original home and the lack of progress in relation to the required building works. Residents were listened to, were facilitated to have meetings with management including the nominated provider, were provided with feedback and were offered alternative accommodation but not stated to be not happy to accept same.

While residents were of the belief that the work would be completed by the end of August 2016, work had not however commenced at the time of the inspection and ultimately the complaint remained unresolved and residents had ongoing concerns and anxiety in relation to this matter. Residents clearly articulated these themselves to inspectors and it was also referenced regularly in records seen (records additional to the complaints and house meeting minutes). The provider had also provided updates to HIQA on this matter and did so again on inspection and subsequent to the inspection. However, in response to these inspection findings, the concerns and anxiety articulated by the residents, a time bound fully-funded plan for the residents' relocation to their house was required by HIQA in the providers response to the action plan.

**Judgment:**  
Non Compliant - Moderate

**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:**

Each resident had a plan, My Profile My Plan (MPMP) that set out each resident's strengths and abilities and areas where support was required from staff and the multidisciplinary team to ensure the residents ongoing well-being and welfare. The person in charge told inspectors that on her appointment she had invested significantly in the review of these plans. Improvement was noted by inspectors in both the content and presentation of the MPMP.

Inspectors saw that each plan was based on a dated comprehensive assessment of each residents abilities and where support was required; assessments were within the required minimum annual timeframe.

Information was available in the plan in relation to residents' holistic needs and included details of all referrals, reviews and recommendations.

There was a process for identifying and agreeing residents' desired goals and objectives, timescales and responsible persons were identified, progress was monitored and barriers to progress were identified. The feedback provided by residents indicated that identified goals were generally realised.

Some of the information contained in the plan was presented in a format that was accessible and meaningful to the resident. There was evidence that residents were supported to participate in the review of their plan and in decisions pertaining to their well-being and supports.

However, as discussed in Outcome 8 there was no co-relation between one plan, risk assessments and practice particularly in relation to identified risks and resident priorities and goals with inconsistent practice noted by inspectors. For example one goal recorded as not progressed on the basis of risk was seen to have been progressed elsewhere but this decision was not reflected in or reflective of the support plan. It was not clear to inspectors how and by whom this decision had been made and there was no evidence that the decision was based on a review of the support plan or that the support plan

was reviewed consequent to this decision, or that the decision itself was reviewed in the context of the support plan.

Furthermore, though support plans were signed as reviewed the relocation of the residents and the impact that this had on their supports and as relayed by residents themselves such as their discontent and loss of independence was not evident in the support plans.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective Services

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

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

**Findings:**

A national policy on risk management approved in May 2014 was viewed by inspectors. It was noted that the provider's risk assessment matrix allowed for three bands of risk, low (one to five), medium (six to 12) and high (15 to 25).

The person in charge provided inspectors with three folders of risk assessments, one contained risk assessments for residents, one was centre specific and the third was the person in charge's copy of all risk assessments. Risk assessment forms included sections for information on the existing controls listed, risk rating, status, additional controls required, the person responsible and a due date for action. It was noted by inspectors that risk assessments were reviewed and updated regularly. There was also evidence of additional actions taken based on the risk assessment such as training for residents. Areas risk assessed included safeguarding, independence, falls, fire, abuse and infection.

However, overall inspectors concluded that the process of risk assessment particularly where a specific risk and associated risks had been identified was fragmented, inadequate, inconsistent and did not provide reassurance that risk was comprehensively and effectively identified and managed. A full review of risks and risk assessments was required in light of the findings and recommendations of a recent safeguarding assessment. For example there was a closed safeguarding related risk assessment that should not have been closed as it was of particular relevance to this report.

Some identified controls seen while relevant were overarching or high level such as the input of the multidisciplinary team and did not provide clear practical guidance for staff on a day to day operational basis. A risk assessment reviewed and completed with immediate effect by the provider following the provider's review of the centre in

February 2016 was to have a multi-disciplinary review in mid March 2016 if the required care package was not in place. The care package was not in place and there was no evidence based on the records seen by inspectors that the review of the risk assessment had taken place as required.

Inspectors viewed the local operational risk management procedures approved in May 2015. These contained templates of specific measures and actions in place to control unexpected absence of a resident, accidental injury to residents, visitors or staff, aggression and violence and self-harm. However these templates had not been completed as required by regulation 26 (1) (c).

Inspectors reviewed incident and accident records for the centre and noted that there was a low incidence of such events in the centre. It was noted that incidents were reviewed and followed up on as necessary by the area manager within one to seven days following an incident. In light of the significance of a recent incident in May 2016 which was not reviewed for three days inspectors formed the view that the review of incidents should be linked to relevant risk assessments. For example, when an incident relates to an identified risk, a time frame should be specified for its review. The timeframe for reporting and reviewing specific incidents as they pertained to specific issues and support plans was not risk based and not included in relevant risk assessments and support plans.

An emergency action plan folder was viewed by inspectors. This included a fire emergency procedure, evacuation plan and a weekly check list for smoke alarms. Personal emergency evacuation plans (PEEPs) completed in January 2016 were in place for each resident. These included details of the level of assistance required by each resident to evacuate the centre. Assistive technology required for the safety of particular residents in the event of fire had been procured and was in use.

A schedule of fire drills was reviewed together with fire drill reports. However, completion of fire drills still required review in relation to the provider's own review of the centre carried out in March 2016 and the recommendations of that review. This review stated that the frequency of fire drills should be reviewed in line with the provider's policy of quarterly drills and provision made for night-time drills to ensure that drills reflected all possible fire scenarios. On the day of inspection there was no evidence of night-time fire drills having been conducted in the centre.

Inspectors noted from fire extinguisher labels that they had been serviced in March 2016. A monthly safety inspection check list was conducted by staff and included checks of escape routes, fire fighting equipment and exit doors.

However, certificates of servicing of the centre fire safety measures and controls that included emergency lighting, fire fighting equipment and an automated fire detection system were not available in the centre and management were unable to provide same on the day of the inspection. The area manager informed inspectors that certificates would have to be provided following the inspection. However, confirmation for the fire-fighting equipment only was confirmed. Based on these inspection findings it was confirmed that the emergency lighting system was to be inspected on 9 June 2016 and the fire alarm system on 11 June 2016.

**Judgment:**  
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**  
Safe Services

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

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

**Findings:**

The person in charge told inspectors that she was not aware of any alleged, suspected or reported abuse within the centre, safeguarding was discussed with residents on a regular basis and there was an open culture between staff and residents. The person in charge said that she was confident that residents would tell staff if they were unhappy and would and did contact her directly if they had any concerns and worries. Inspectors noted that residents were comfortable in the presence of staff and spoke openly with inspectors in relation to their life in the centre, of staff and how staff supported them on a daily basis. The feedback provided to inspectors by residents was positive.

Photographic identification and the contact details of the designated person were prominently displayed.

Training records indicated that staff had attended training on safeguarding adults and responding to behaviours that challenged.

There was evidence that residents were supported by the MDT team to develop safeguarding awareness, knowledge and skills.

However, based on the findings of the March 2015 HIQA inspection, the findings of the provider's own reviews of the centre in the intervening period and these inspection findings, inspectors were not satisfied that there was a timely, robust consistent approach to safeguarding matters. Matters of a safeguarding nature initially discussed in March 2015 were still not sufficiently addressed or managed at the time of this inspection so as to provide safeguarding reassurance to the Chief Inspector. The details and specifics of these matters were discussed in detail at verbal feedback at the end of this inspection.

Inspectors noted a high level of inconsistency in safeguarding assessment, controls and practice. Practice was inadequately supported by risk assessment and sharing of relevant information and practice was in direct contradiction to the findings and recommendations of an assessment commissioned by the provider. There was reported multi-disciplinary (MDT) disagreement with the recommendations of this assessment and as to how these matters should be managed. This was evident in records seen and did not provide reassurance that residents were and would be appropriately supported.

Premature safeguarding decisions had been made prior to the receipt of this report, for example decisions in relation to access to social media and unsupervised independent social outings.

Inspectors were not reassured as to the use of the term "consequences" by staff to residents in response to an incident and as recorded on records seen. No details were provided as to what this meant or what consequences were relayed to the resident. The resident's negative response was however recorded as was the resident's fear of a loss of independence.

Strategies for the management of behaviours that challenged or posed risk were outlined in a manner that was meaningful to the resident and that reflected the residents own language. However, there was no one clear consistent plan in place for managing all behaviours that posed a risk to the resident and others, a plan that provided clear guidance for both the resident and staff.

Inspectors were informed that the report from the commissioned assessment was received in the days prior to this inspection. Given the recommendations of the report and the inconsistency noted between its recommendations and safeguarding practice in the centre, the provider was requested at verbal feedback to review the report as a matter of priority and provide reassurance to HIQA by 10 June 2016 as to the action to be taken by the provider based on the recommendations made. Confirmation was received that the report was reviewed by senior management, a full MDT meeting with agreed agenda was rescheduled for 15 June 2016 and a meeting had taken place between the area manager, the person in charge, the designated officer and the social worker on 9 June 2016 to establish actions and supports that needed to be in place as outlined in the report. Relevant risk assessments were to be identified in conjunction with the MDT on 15 June 2016.

**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):**

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

**Findings:**

The person in charge reported that in general, residents enjoyed good physical health. Staff supported residents as necessary to access their preferred choice of general practitioner (GP) and each resident had an annual medical review. This was evidenced in the records seen by inspectors.

There was documentary evidence that residents had access to dental and optical review. One resident told inspectors that he had a dental appointment on the day of inspection and that this was not a source of concern or anxiety for him.

The person in charge said and there was documentary evidence that residents had as appropriate to their needs access to the support of the multi-disciplinary team. These supports included psychiatry, psychology, behaviour support and social care input. records of referrals, reviews and recommendations were maintained.

**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):**

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

**Findings:**

There was evidence of failings outstanding from the previous inspection of March 2015.

Two residents were in receipt of long-term prescribed medications. The person in charge confirmed that residents were fully supported by staff in the management of their medicines.

Medicines were supplied to residents by a community pharmacy in compliance aids. Medicines were seen to be securely stored. The person in charge said that residents accompanied staff on visits to the pharmacy, for example when collecting their supply of medication and that residents had medicines awareness, for example of the administration times of their prescribed medications. However, the person in charge confirmed that there was still no assessment or systems in place to assess resident

capacity and willingness so as to support residents as appropriate to manage their own medicines.

Each resident had a medicines prescription record and an administration record. However, one resident had two prescription records in place, one of recent compilation and another older prescription; the latter had three medicines on it that were not signed and dated as discontinued. The instructions of the label and the medicines supplied in the compliance aid reflected the instructions of the older prescription and not those of the prescription currently in use.

There was further information in the medicines folder as to prescribed medications that did not concur with the current medicines prescription.

Staff continued to sign for the administration of the "blister pack" only and not for each individual medicine as identified on the prescription. The inspector also noted that staff signed only for the receipt of the compliance aid when medicines were supplied to the centre. Again, the inspector was not satisfied as to the robustness of this practice in terms of reinforcing staff accountability to adhere to the seven rights of medication administration as outlined in the provider's own medicines management policy dated May 2015. This concern was reinforced by the findings of this inspection as staff had signed for the administration of a blister-pack, the contents of which did not concur with the current prescription on file in the centre. There was no evidence that the discrepancy between the current prescription dated 2 March 2016 and the instructions and content of the blister pack had been identified by staff prior to this inspection.

The medication management procedure approved in May 2015 was viewed by inspectors. It had been updated to reflect the required frequency of staff training and stated with regard to staff training, that "all staff in community services with responsibility for medication administration, ordering and storage will receive initial training when taking up post. Refresher training will be given every two years". However, training records indicated on-going significant training deficits and these are discussed in Outcome 17: Responsive Workforce.

**Judgment:**  
Non Compliant - Major

#### **Outcome 14: Governance and Management**

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

**Theme:**  
Leadership, Governance and Management

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

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

**Findings:**

There was evidence of action taken by the provider since the last inspection to enhance the governance of this centre. These actions included the reconfiguration of the centre into a stand-alone designated centre.

There was a clear management structure comprised of the person in charge, the area manager and the head of community services.

The person in charge worked full-time and was the person in charge for this and another designated centre. The person in charge was appointed to this role in January 2016. The person in charge said that her office was based in the other designated centre but she was present in this centre a minimum of two days per week or as required and was available to staff as needed. Residents were clearly familiar with the person in charge and staff confirmed the availability of and accessibility to the person in charge. The person in charge had relevant core qualifications and there was evidence of further education and training completed relevant to the role including the management of complaints and managing staff performance. The person in charge readily answered any questions in relation to residents and their required supports.

The person in charge said that she continued to work as a member of the frontline team in the other designated centre one day per week. The person in charge also participated in the on-call rota operated by the provider. The person in charge said that her current working arrangements were conducive to her exercising her person in charge role and responsibilities. The person in charge said that as a member of the frontline team she and all staff were clear that she was the person in charge but this allowed her to have beneficial direct contact with residents and staff and allowed her to evaluate the quality of supports provided.

The person in charge said that the provider had amended the on-call system so that it now included an on-call support. The on-call support was directed by the person in charge and provided whatever practical support and assistance was required in a centre and not the person in charge as had previously been the case. The person in charge said that this allowed her to attend to both the on-call and her person in charge duties.

The person in charge confirmed that she had formal weekly meetings with her line manager, the area manager, but he was also available to her as required.

The person in charge convened monthly staff meetings in the centre, there was a planned schedule for these and the person in charge was seen to reschedule a meeting with staff deferred due to this inspection.

There was a system in place for the monitoring and review of the safety and quality of the supports and services provided to residents as required by Regulation 23. Reports were available for inspection of three visits to the centre by the provider or a person

nominated by them and inspectors reviewed the two more recent reports from October 2015 and February 2016. The reports indicated that this was a comprehensive review process that included follow-up of the actions that issued from the previous review.

However, it was of concern to inspectors particularly in light of the poor March 2015 HIQA inspection findings that the provider itself in October 2015 found lack of evidence of co-ordinated multi-disciplinary (MDT) inputs for residents and impact of MDT inputs; further action was taken by the provider to address this. Likewise based on the findings of the providers review of the centre in February 2016 the provider was required to take immediate follow-up actions in the days following the unannounced visit to clarify and address the extent of safeguarding concerns identified. The provider was not satisfied that actions pertaining to safeguarding findings from the providers October 2015 review had been progressed.

Therefore there was a clearly defined management team in place, the providers review process was comprehensive and there was evidence of action taken by the provider in response to review failings. However, the repeat failings from inspections and reviews, the lack of evidence of the progress of required action plans and the requirement for direct action by the provider following reviews, was of concern to inspectors and did not provide reassurance that the governance arrangements were effective and ensured that the service provided to residents was safe, appropriate, consistently and effectively monitored.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

At the time of the last inspection the provider was judged to be in major non-compliance with this Outcome but deficits in the other house that formed part of the centre at that time had contributed to that judgement; these deficits no longer applied.

Residential services were provided to three residents. There was one staff assigned to the house at times when the residents were present i.e. when they were not attending their respective day services. The person in charge informed inspectors that the staff would begin their shift at approximately 16.30 hrs when residents returned from the day service. The staff would then assist the residents in various activities of daily living such as cooking, cleaning or accompanying them on social outings and activities. The staff member was then present in the house from 23:00hrs to 07:30 hrs in a sleepover capacity. The staff would subsequently work until 09.30 hrs at which point they would leave with the residents for the day service.

These were the staffing arrangements observed by inspectors and there was no evidence available to inspectors that these staffing numbers and arrangements were not sufficient to meet the assessed needs of the resident. The person in charge confirmed that relief staff were recently recruited and were to work only within a prescribed group of centres so as to facilitate the consistency of supports for residents. Agency staff was not employed.

A planned and actual staff rota was maintained, circulated electronically to staff and reissued as changes arose.

Inspectors observed an easy rapport and respectful familiarity between residents and staff. Residents provided spontaneous positive feedback on staff to inspectors.

Staff files were made available for the purpose of inspection. These files were well presented and the information required by regulation was easily retrieved. However, there was no evidence that gaps in employment history had been explored and explained. While these particular gaps were historical, the safeguarding rationale for providing an explanation for all such gaps was reiterated at verbal feedback.

Staff training records were made available at the conclusion of the inspection and reviewed by inspectors post-inspection. These records indicated that staff had attended mandatory training on safeguarding, client and manual handling, responding to behaviours that challenged and fire safety. However, as also identified at the time of the last inspection, there was no recorded attendance at medication management training for two staff including the person in charge. The last recorded attendance at medication management training for the third staff was February 2010.

The person in charge articulated a positive attitude to and the benefits of the formal supervision of staff. The provider did not however operate any formal system of staff supervision and performance management.

**Judgment:**

Non Compliant - Moderate

## 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<sup>1</sup>

|                            |  |
|----------------------------|--|
| <b>Centre name:</b>        | A designated centre for people with disabilities operated by Brothers of Charity Services Limerick |
| <b>Centre ID:</b>          | OSV-0004837  |
| <b>Date of Inspection:</b> | 08 June 2016   |
| <b>Date of response:</b>   | 28 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 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:**

Residents were of the belief that the work would be completed by the end of August 2016, work had not however commenced at the time of the inspection and ultimately the complaint remained unresolved and residents had ongoing concerns and anxiety in relation to this matter. In response to these inspection findings, the concerns and anxiety articulated by the residents, a definitive time bound fully-funded plan for the

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

residents' relocation to their house is required by HIQA.

**1. Action Required:**

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

- Area Manager meets with residents about their concerns every Friday in their day service.
- Person in Charge meets with residents twice per week to discuss their concerns regarding their house.
- Head of Community Services and area manager met with residents on 18.07.16 to inform them that the works are to start on August 8th 2016. The projected time frame for the works is 18-22 weeks. The builder and fire engineer met on July 20th to discuss all works and agreed same. Residents have been told that they will move back at this time. Funding has been approved for the extra works including kitchen.

**Proposed Timescale:** 28/02/2017

**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:**

There was no co-relation between one plan, risk assessments and practice particularly in relation to identified risks and resident priorities and goals with inconsistent practice noted by inspectors. For example one goal recorded as not progressed on the basis of risk was seen to have been progressed elsewhere but this decision was not reflected in or reflective of the support plan.

Though support plans were signed as reviewed the relocation of the residents and the impact that this had on their supports and as relayed by residents themselves such as their discontent and loss of independence was not evident in the support plans.

**2. 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:**

Evidence based interim safeguarding plans have been drawn up 01.07.16.

Following considered assessment period between June 3rd 2016 and July 1st 2016, a comprehensive, evidence based, interim safeguarding plans were drawn up. This was

following an MDT on June 15 where an action plan was put in place in consultation with the author of the independently commissioned assessment report (as seen by inspector on the day of the unannounced inspection). A full MDT of psychology, behaviour support, social worker, designated officer, Person in charge, area manager, day service managers and social care staff were present and agreed with the action plan.

The interim safe-guarding plans were presented on the 01.07.16. Following agreement on the 26.07.16 these were fully agreed and adopted by MDT and are now subject to regular review bi monthly or earlier if necessary.

28.07.16 MDT developed Risk Assessments and developed the rationale behind each of the support/supervision decisions regarding various aspects of residents' life. Arising from the review of the safeguarding plans holistic risk assessments are being drawn up to ensure consistency.

Following this action, residents' priorities will be reviewed.

**Proposed Timescale:** 01/10/2016

## **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 of risk assessment particularly where a specific risk and associated risks had been identified was fragmented, inadequate, inconsistent and did not provide reassurance that risk was comprehensively and effectively identified and managed.

A full review of risks and risk assessments was required in light of the findings and recommendations of a recent safeguarding assessment. For example there was a closed risk assessment that should not have been closed as it was of particular relevance to this report.

Some identified controls seen while relevant were overarching or high level such as the input of the multidisciplinary team and did not provide clear practical guidance for staff on a day to day operational basis.

There was no evidence based on the records seen by inspectors that the review of a particular risk assessment had taken place as required.

The timeframe for reporting and reviewing specific incidents as they pertained to specific issues and support plans was not risk based and not included in relevant risk assessments and support plans.

### **3. Action Required:**

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to

the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

Person in charge has completed the risk assessments listed in regulation 26 (1) (e) and are in the person in charges' risk register in the designated centre. .

In light of the safeguarding plans risk assessments were completed on 28-07-16 by all members of the MDT, including Provider Nominee, PIC and PPIM. Furthermore rational behind risk assessment documented.

**Proposed Timescale:** 16/08/2016

**Theme:** Effective Services

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

The completion of fire drills required review further to the provider's own review of the centre carried out in March 2016 and the recommendations of that review. This review stated that the frequency of fire drills should be reviewed in line with the provider's policy of quarterly drills and provision made for night-time drills to ensure that drills reflected all possible fire scenarios. On the day of inspection there was no evidence of night-time fire drills having been conducted in the centre.

**4. Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

Two night time fire drills has taken place since the inspection. All residents evacuated the designated centre in under 90 seconds. All residents are aware of how to evacuate at night time. Both day and night fire drill will now take place bi-monthly. There is a planned diary in place for staff to complete fire drills. Person in charge will monitor that these planned drills have taken place on a monthly basis and this will be added to the monthly house meetings.

**Proposed Timescale:** 16/08/2016

**Theme:** Effective Services

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

Certificates of servicing of the centre's fire fighting equipment that included emergency lighting, fire fighting equipment and an automated fire detection system were not available in the centre and management were unable to provide same on the day of the inspection. The area manager informed inspectors that certificates would have to be

provided following the inspection. However, confirmation for the testing of the fire-fighting equipment only was confirmed.

**5. 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:**

The testing of the fire system occurred on 11/06/2016 and certificates are maintained in the designated centre. This testing of the system will occur quarterly. Emergency Lighting System inspected June 9th 2016, report to follow. Fire extinguishers & fire blankets serviced February 2016, report now available in designated centre.

**Proposed Timescale:** 16/08/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Inspectors were not satisfied that there was a timely, robust consistent approach to safeguarding matters. Matters of a safeguarding nature initially discussed in March 2015 were still not sufficiently addressed or managed at the time of this inspection so as to provide safeguarding reassurance to the Chief Inspector.

Inspectors noted a high level of inconsistency in safeguarding assessment, controls and practice.

Practice was inadequately supported by risk assessment and sharing of relevant information and practice was in direct contradiction to the findings and recommendations of an assessment commissioned by the provider. There was reported multi-disciplinary disagreement with the recommendations of this assessment and as to how these matters should be managed.

Premature safeguarding decisions had been made prior to the receipt of this report.

Inspectors were not reassured as to use of the term "consequences" by staff to residents in response to an incident as recorded on records seen.

There was no one clear consistent plan in place for managing all behaviours that posed a risk to the resident and others, a plan the provided clear guidance for both the resident and staff.

**6. Action Required:**

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed

for self-care and protection.

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

Following review on June 15th 2016 a common approach was agreed by the MDT. Each person in the review team agreed to actions on issues which were identified by the external consultant (and agreed by external consultant). These actions are now in the designated centre along with minutes of meetings, safeguarding plans and pending risk assessments.

The plan will be reviewed bi monthly at team meetings. The external consultant remains working with the BOCL and will continue to attend team meetings bi annually. In light of the safeguarding plans, risk assessments were completed on 28-07-16 by all members of the MDT, including Provider Nominee, PIC and PPIM. Furthermore rational behind risk assessment documented.

**Proposed Timescale:** 16/08/2016

**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:**

There was no assessment or systems in place to assess resident capacity and willingness so as to support residents as appropriate to manage their own medicines.

**7. 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:**

Medication Self-Assessment tool has been drafted, it is due to be presented to Policy Review Group on September 14th 2016.

Following approval from the Policy Review Group, the tool will be implemented with all interested service users.

**Proposed Timescale:** 01/10/2016

**Theme:** Health and Development

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

One resident had two prescription records in place, one of recent compilation and another older prescription; the latter had three medications on it that were not signed and dated as discontinued.

The instructions of the label and the medicines supplied in the compliance aid reflected the instructions of the older prescription and not those of the prescription currently in use in the centre.

Staff had signed for the administration of a blister-pack, the contents of which did not concur with the current prescription on file in the centre. There was no evidence that the discrepancy between the current prescription dated 2 March 2016 and the instructions and content of the blister pack had been identified by staff prior to this inspection.

**8. Action Required:**

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

New policy in place which directs the AM & PIC to complete 6 weekly audits on medication management in each designated centre. The first audit completed 20.07.16.

Training on the new policy will take place on 27.07.16 to PIC and AM. Medication training will be rolled out to all staff in August 2016.

Following the inspection the medication kardex was reviewed and corrected by S.H.O.

**Proposed Timescale:** 16/08/2016

**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:**

Repeat failings from inspections and reviews and the lack of evidence of the progress of required action plans was of concern to inspectors. These failings and the requirement for direct action by the provider following reviews did not provide reassurance that the governance arrangements were effective and ensured that the service provided to residents was safe, appropriate, consistently and effectively monitored.

**9. 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:**

All internal and external reports have been reviewed by PIC & AM. All issues under their control have been addressed. Same further reviewed with Head of Community Services

27-07-16 and outstanding issues addressed.

**Proposed Timescale:** 16/08/2016

**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 no evidence that gaps in employment history had been explored and explained. While these particular gaps were historical, the safeguarding rationale for providing an explanation for all such gaps was reiterated at verbal feedback.

**10. 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 has contacted the staff concerned and requested clarification of this gap.

**Proposed Timescale:** 30/08/2016

**Theme:** Responsive Workforce

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

The provider did not operate any formal system of staff supervision and performance management.

**11. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Supervision policy has been approved by Senior management. It will be rolled out to all staff commencing in September 2016.

**Proposed Timescale:** 30/09/2016

**Theme:** Responsive Workforce

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

There was no recorded attendance at medication management training for two staff including the person in charge. The last recorded attendance at medication

management training for the third staff was February 2010.

**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:**

New medication management training will take place for all PIC's, PPIM on 03-08-16 and training for frontline staff will commence August 2016. Staff from this centre will be prioritised.

**Proposed Timescale: 30/08/2016**