# Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Saoirse</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002830</td>
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<tr>
<td>Centre county:</td>
<td>Limerick</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Brothers of Charity Services Limerick</td>
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<tr>
<td>Provider Nominee:</td>
<td>Norma Bagge</td>
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<tr>
<td>Lead inspector:</td>
<td>Margaret O'Regan</td>
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<tr>
<td>Support inspector(s):</td>
<td>Conor Dennehy</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>22</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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**About monitoring of compliance**

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
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<tr>
<th>From:</th>
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<tbody>
<tr>
<td>14 February 2017 09:10</td>
<td>14 February 2017 18:00</td>
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<tr>
<td>15 February 2017 09:30</td>
<td>15 February 2017 18:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

Background to the inspection:
This was an unannounced inspection carried to follow up on issues arising from the previous inspection which was carried out in May 2016.

How we gather our evidence:
As part of the inspection, inspectors met with 22 residents accommodated in the centre. Inspectors met with staff, the person in charge and the interim head of integrated services. Documentation such as care plans, medical records, medication files, fire safety records and reports from external auditors were examined.

In particular, inspectors observed interactions between residents and staff and between residents themselves.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. This document described the centre as one which "makes
every effort to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person”. The mission of the Brothers of Charity, as set out in its statement of purpose, is "to support and promote the wellbeing and dignity of each individual in its service”. It aims to achieve this by "person centred planning that supports life choices of service users".

Accommodation was in bungalow type, single storey house. Between one and seven residents occupied each house or apartment. Each unit had a sitting room, kitchen, single occupancy bedrooms, sanitary facilities and laundry facilities.

The centre is part of a congregated setting for people with intellectual disabilities. The campus consisted of 15 bungalow style houses. The 15 houses were grouped under three separate centres and each centre had a person in charge. The service is available to both male and female residents.

Residents were able to get out and about almost on a daily basis. The grounds were well maintained and facilitated residents to visit friends or colleagues in other houses on campus. Residents also availed of the onsite day services, swimming pool, gym and church.

Overall judgment of our findings:
Overall, residents were satisfied with the care provided to them, the facilities made available to them and the approach of staff who assisted them. The inspectors noted that since the May 2016 inspection, a number of residents were provided with improved living arrangements. For example, one resident who lived in a six-person house moved to an apartment with another resident. This provided the resident with more space and this suited the resident’s requirements. In addition, this move created extra space in the house which the resident vacated. There was a positive benefit for the five remaining residents.

The inspectors noted the improved quality of life such arrangements gave to the residents. There were fewer issues with behaviors that challenge, residents had become more independent and they appeared happier. Providing this accommodation required flexibility with rostering, cooperation from staff and a cultural awareness of how residents needs were best met. The approach taken by the Brothers of Charity in providing apartment accommodation on campus showed the potential to provide a high level of personalised care in the context of what was deemed a congregated setting. It demonstrated that residential care (both community and congregated) could be flexible and unique dependent upon user preference and care needs.

The inspectors found that care was provided in an environment in which community was an inherent part of daily life, and indeed was part of the care itself. The inspectors noted that despite inadequacies in the funding arrangements, the majority of residents had a good quality of life. The inspectors saw residents going on outings, being able to spend leisure time together and develop friendships and avail of full time nursing support. This was particularly relevant to those who had the most complex needs. Residents were offered independence while safeguarding security.
Good practice was identified in all outcomes inspected however, within those outcomes major deficits were also noted.

Significant improvements were identified as being required under:
- outcome 5 (Social care)
- outcome 6 (Premises)
- outcome 7 (Health and Safety and Risk Management)
- outcome 8 (Safeguarding and Safety)
- outcome 16 (Resources)
- outcome 17 (Workforce).

The primary underlying issue with regards to the non compliances identified, was the inadequate provision of resources to ensure accommodation and services were reaching the level required by current regulations and standards. This was an ongoing and major issue for the centre.

The reasons for these findings are explained under each outcome in the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Systems were in place for the management of complaints. Records of complaints which had been made since the previous inspection were reviewed during this inspection. There were two open complaints relating to premises issues. These had been escalated in line with the provider’s own procedures.

Arrangements were in place for residents to retain control over their clothing and personal belongings. Sufficient storage facilities, such as wardrobes and bedside lockers, were available in residents' bedrooms. Lists of residents' personal assets were maintained.

Residents were consulted in the running of the centre through weekly meetings in each house. Inspectors saw a sample of minutes from these meetings where issues such as staffing, activities and meals were discussed.

Throughout the inspection positive interactions were observed between staff and residents. It was clear that staff and the person in charge strongly advocated for and on behalf of residents. One resident spoke positively of their involvement in the local advocacy group. This group was affiliated to a national advocacy agency.

Staff members treated residents with dignity and respect in the manner in which they attended to personal care and in the manner in which they maintained written documentation. Residents were encouraged to maintain their own privacy and dignity by being facilitated to lock their bedroom door.
Residents were facilitated to have contact with friends, family and significant others. For example, going out to dinner together. Residents’ personal communications were respected. For example, resident gestures were interpreted to good effect and staff knew when a resident wanted assistance, what type of assistance they needed and when they didn't want assistance.

The centre was managed in a way that maximised residents’ capacity to exercise personal autonomy and choice in their daily lives. For example, residents choose what time they got up, went to bed and what activities they got involved in.

Residents were facilitated to exercise their civil, political, religious rights and were enabled to make informed decisions about the management of their care. Residents attended Sunday mass and a number of residents voted in elections.

Residents had opportunities to participate in activities that were meaningful and purposeful to them, and which suited their needs, interests and capacities. For example, watching particular television shows, attending a day service or chatting with staff. Individual residents engaged in their own specific interests outside of the centre such as horse riding, going to the cinema and visiting the family home.

As outlined above there was a good attitude towards respecting residents; however, environmental constraints impacted on some residents’ dignity. For example, the sanitary facilities in one of the houses were institutional in layout and design, had poor accessibility and compromised resident privacy. This matter was identified in the last two reports and also by the organisation's occupational therapy department. It had not been addressed nor was a timeframe given as to when this would be addressed.

Since the last inspection the provider had facilitated a reduction in the number of occupants in one house thus creating adequate space for all residents. This resulted in a previous tension filled house being changed into a relaxed, calm and contented household.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td><em>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.</em></td>
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| Theme: |
| Effective Services |
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Residents were provided with a person centred planning process to address their needs but some improvement was required in relation to the content and review of personal plans.

A person-centred planning process was in place for residents to identify priorities for the year ahead. The process involved a period of information gathering involving the resident, their family and staff with multidisciplinary input. An initial planning meeting was then held where priorities were agreed and responsibility for achieving these assigned. These priorities were reviewed at three monthly intervals.

Inspectors reviewed a sample of these plans and found that progress was being made towards achieving residents’ goals. Reviews were taking place at regular intervals; however, the recording of these required improvement to identify progress made and the next actions. For example, one resident had a priority to go on three day trips during the year. The first review of this priority did not indicate what progress had been made in relation to this. However, from talking to staff and the resident, it was evident that one day trip was planned with the resident looking forward to this.

Other priorities identified for residents included, additional social outings, facilitating independence and increased family contact. Evidence was provided that these were progressing. Some residents had priorities which were linked to the suitability of the premises and the reviews found no timeframe was provided for when these would be addressed. For example, plans had been in place to relocate some residents to a community house. This would reduce the numbers accommodated in each house and offer residents with a choice of living arrangements. The community house was secured and registered; however, residents’ move to this house was impeded due to a reported lack of funding to staff it. The suitability of the premises to meet the needs of residents is discussed further under Outcome 6.

While many resident priorities were reviewed regularly some other parts of residents' personal plans had not been reviewed for a period in excess of one year. For example, one resident's intimate care plan had not been reviewed since January 2014. Some healthcare plans had not been updated to reflect recommendations from allied health professionals.

Judgment:
Non Compliant - Moderate

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
**Theme:**
Effective Services

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

**Findings:**
The premises consisted of bungalows which were built in the 1970s on a spacious site. The centre is part of a larger group of houses. The houses are surrounded by mature trees in a village type setting. As found on previous inspection, the premises showed signs of limited investment in upgrading them to modern day standards.

For example, one house had communal style bathing and toilet facilities, floor covering was damaged in a number of houses and as discussed elsewhere in this report, the standard of the fire safety systems were of concern. Notwithstanding that there were deficits with the premises, the inspectors did note that much effort had gone into maintaining the premises in reasonable good decorative order. The inspectors noted the homely effects in the houses such as the instillation of a fire effect appliance in the fire grate of one house. The gardens were well tended to. Each garden was private and complete with appropriate furnishings.

As noted on the previous inspection, the refurbishment work to the apartments was of a high standard and generally met the needs of the residents. However, as identified on the previous inspection a greater level of sound proofing between the apartments was needed. Residents and staff commented on this need and the inspector noted the impact of the current poor sound proofing that was in place. The provider was in the process of addressing this matter; however, the timeline for its completion was unclear.

Some larger works such as upgrading fire safety systems, replacing flooring and upgrading sanitary accommodation were identified as requiring attention. As noted on previous inspections, the upgrading work that was taking place was more remedial than part of a longer term plan. The longer term arrangements for the centre were dependent on securing funding and it was unclear how this was likely to progress.

On the previous inspection there was one house which was overcrowded. This matter had been addressed with better outcomes for all six residents. Plans were in place to further reduce the number of residents in some of the houses. However, the plan to accommodate residents away from the campus to a community house had not materialised due to funding issues.

There was access to a kitchen with sufficient cooking facilities and equipment. For the majority of residents the main meal of the day was delivered by a food catering company and residents continued to report mixed satisfaction ratings with this arrangement. To help in this matter some residents choose to buy in meals from a restaurant of their choice one or two nights each week. Such meals were paid for by the
The dissatisfaction with the meals had been identified and brought to the attention of the person in charge and the organisation's head of integrated services but limited progress had been made in addressing the matter. Staff reported that cooking meals in the house was generally more satisfactory and possibly more cost effective. Breakfast and evening meals were prepared in each house with assistance from residents where possible.

The single storey design and layout of the houses promoted residents’ safety, dignity, independence and wellbeing. Efforts were made to make the houses homely. However, one house in particular was institutional in design and layout. The sanitary facilities in this house were communal in design and did not adequately meet residents' needs in terms of dignity. An occupational health report dated March 2016, highlighted the deficiencies of the toilet and showering facilities but no progress has been made in addressing the matter.

There were sufficient furnishings, fixtures and fittings. The centre was clean albeit flooring was damaged and or worn in several places and scuffed doors and walls needed to be painted.

There was a suitable outside areas for residents. Residents had access to appropriate equipment which promoted their independence and comfort such as sensor alarms, walking frames and wheelchair adapted transport. The equipment was fit for purpose and there was a process for ensuring that equipment was properly installed, used, maintained, tested, serviced and replaced.

Staff were trained to use equipment and equipment was stored discreetly safely and securely.

**Judgment:**
Non Compliant - Moderate

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

_The health and safety of residents, visitors and staff is promoted and protected._

**Theme:**
Effective Services

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

**Findings:**
The centre had policies and procedures relating to health and safety. There was an up-to-date health and safety statement. There were satisfactory procedures in place for the prevention and control of infection. The risk management policy was implemented and
covered the identification and management of risks, the measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents.

However, some of the risks were identified as major, even with controls in place. These risks had been escalated to the Director of Services over 12 months previously and related to night time staffing and the risk of residents not evacuating in the event of a fire. While a fire safety assessment was requested by the Director of Services following escalation of this risk, and this assessment took place, the risk remained at major.

The risk was that residents were accommodated at night in unstaffed houses. It was identified that some residents in the unstaffed houses would not evacuate the house independently in the event of a fire. This was in conjunction with the assertion by fire safety personnel, that the fire alarm panel needed to be upgraded as a matter of urgency.

There were arrangements in place for responding to emergencies. For example, staff had alarms in which they could call for assistance. These alarms were regularly checked and serviced. Staff were clear on the response plan in the event of an emergency.

Reasonable measures were in place to prevent accidents. Accidents were recorded and monitored. Most incidents were as a result of residents’ ongoing medical conditions or residents behavioural needs. Measures were in place to prevent or minimise accidents such as regular risk assessments, staff training updates and regular review of behaviour support plans. The inspector noted the good detail recorded in incident report forms and the respect shown to residents in the language used to describe behavioural incidents. Staff were trained in moving and handling of residents.

Suitable fire equipment was provided. There was a prominently displayed procedure for the safe evacuation of residents and staff in the event of fire. The mobility and cognitive understanding of residents was accounted for in the evacuation procedure and in the day and night personal egress plans that each resident had. Staff were trained and knew what to do in the event of a fire. Two staff were due annual updates and a plan was in place for this updated training.

The fire alarm was serviced every three months and fire safety equipment was serviced on an annual basis. The policy of the centre was for staff to receive updated fire safety training yearly. All but two staff were up to date with this annual update. A staff training plan was in place for 2017 and covered training updates in fire safety.

Fire drills took place at approximately two monthly intervals and records were kept which included details of fire drills, fire alarm tests and fire fighting equipment. However, in some instances the names of those who participated in the drill was not recorded, nor were the names recorded of those who had difficulty in participating in the drill. In another fire drill record the 24 hour clock was not used which caused confusion with regards to whether the drill was carried out at night or during the day. Emergency lighting was in place.

The provider was advised by inspectors that for registration of the centre to progress,
the chief inspector would have to be satisfied that the buildings were in compliance with current fire safety standards. In this regards, there was a lack of clarity. For example, a fire alarm system was in place, staff were aware of it, it was tested weekly, it was serviced every three months, service records showed it was “in acceptable working order”. However, the service records also noted that there was “urgent need for new system” as the system was “mostly 1970’s work”.

Another example of lack of clarity around the adequacy of the fire arrangements related to the fire exits. Fire exits were seen to be unobstructed, these exits were checked on a daily basis, exits were illuminated and emergency lighting was serviced regularly. However, a fire safety survey of the buildings carried out in 2016 by an external auditor, indicated that, considering the nature and function of the premises, the centre did not comply with current fire safety legislation. Given these finding the provider was requested to submit a certification of fire compliance for the centre from a suitably qualified person.

**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):**
No actions were required from the previous inspection.

**Findings:**
There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided guidance to staff. Staff had up-to-date training in safeguarding of vulnerable adults. From speaking with staff, inspectors found them to be knowledgeable in relation to what constitutes abuse and on the related reporting procedures. The staff members were also aware that there was a designated person to deal with any allegations of abuse.

Inspectors viewed a sample of residents' personal financial accounts and saw that there were procedures in place to ensure that their monies could be accounted for. Items purchased by residents required a receipt and their personal monies were checked by two staff members daily to ensure accuracy.
However, inspectors found that residents were accessing supports services, for which they paid for. It was unclear how the decision was taken that the resident would pay for this. A greater level of oversight was needed to ensure resident funds were appropriately used.

**Judgment:**
Non Compliant - Moderate

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<th><strong>Outcome 09: Notification of Incidents</strong></th>
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<tr>
<td><em>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</em></td>
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| **Theme:** |
| Safe Services |

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

| **Findings:** |
| During the course of inspection the person in charge informed inspectors of an injury suffered by one resident which had not been notified to the Chief Inspector. A notification of this injury was submitted to the Chief Inspector following the completion of the inspection. |

| **Judgment:** |
| Substantially Compliant |

| **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:** |
| The healthcare needs of residents were provided for within the designated centre but some improvement was required in relation to the healthcare plans in place. Residents had access to a general practitioner who visited the campus, where the designated centre was located, three times a week. Residents were provided with |
vaccinations while regular checks such as weights and blood tests were carried out as required and documented. Any issues found during such checks were followed up with. Any necessary referrals were made and support was provided to residents to attend appointments with healthcare professionals.

Inspectors reviewed a sample of residents’ healthcare plans. While these were informed by input from allied healthcare professional and updated regularly some content was missing or not accurate. For example, one resident’s care plan for swallowing difficulties indicated that a texture A (soft) diet was to be provided but a speech and language therapist (SLT) assessment carried out in April 2016 had recommended a texture B (minced moist) diet. This care plan had been reviewed three times since the SLT review but still referred to a texture A diet. Staff members spoken with indicated that this resident received a texture B diet and an inspector observed a meal of the correct consistency provided to the resident.

The majority of staff members spoken to were aware of the healthcare needs of residents and how there were to be managed. However, one member of staff did not demonstrate a sufficient level of knowledge regarding the modified consistency of food for one resident as recommended by an SLT.

End of life issues related to residents were managed in a sensitive manner by staff.

**Judgment:**
Non Compliant - Moderate

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**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):**
No actions were required from the previous inspection.

**Findings:**
The service was nurse led and all medication was administered by nurses. The practices observed were in line with professional guidelines.

There was little use of PRN medications (medications that are taken only when needed). When these were required details of the medication and its effect was documented.

There was a clear process for disposal of out of date or unused medication. Medications were regularly reviewed by a psychiatrist, staff and the GP. Staff had received medication management training. Medication errors were recorded.
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:
A clear management structure was in place; however, some improvement was required in relation to the unannounced visits by the provider to ensure that they effectively captured the safety and quality of care and support in the centre.

There was a suitable person in charge in place who was supported in their role by the interim head of integrated services. The person in charge had frequent contact with this senior manager. Audits were carried out in relation to issues such as health and safety, medication errors and residents’ personal finances. The person in charge was also supported by four clinical nurse managers 1 (CNM1) who provided supervision throughout the houses in the centre.

However, these CNM1s were not supernumerary and therefore had limited time to fulfil managerial duties. Inspectors were informed that two CNM1s had recently left their positions with other staff acting up in their absence.

The person in charge was based in an office separate to where residents were accommodated. The person in charge's presence in the different houses was limited due to demands of administrative duties. This impacted on their ability to provide support, guidance and supervision to staff. Inspectors were informed that the recruitment of an administration manager to reduce the burden on the person in charge, was at an advanced stage.

Links with night-time staff had improved in the past 12 months and a system of staff supervision was in the process of being rolled out. To improve oversight within the centre, the person in charge had commenced weekly staff meetings in each house. Each resident was discussed at these weekly meetings. Inspectors saw minutes of such meetings, where issues such as residents’ medical needs were discussed. While the person in charge was not able to attend all of these meetings, minutes of meetings were
provided to the person in charge for review. In the absence of the person in charge a CNM1 usually attended meetings.

Since the previous inspection an annual review had been carried out which included input from residents and their families. The annual review was also informed, in part, by the reports of the six monthly unannounced visits.

Reports of the unannounced visits were maintained which included an action plan to address any issues found. However, inspectors noted that the unannounced report did not sufficiently capture issues related to the quality and safety of care and support within the designated centre. For example, the most recent unannounced visit, carried out in December 2016, involved visiting one apartment within the centre and focused primarily on the personal plan of one resident. As the designated centre was made up of eight houses; apartments and accommodated 22 residents, this did not provide a representative view of the centre as a whole. In addition, issues relating to premises and fire safety were not sufficiently covered in these unannounced visit reports.

Judgment:
Non Compliant - Moderate

<table>
<thead>
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<th>Outcome 16: Use of Resources</th>
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<tr>
<td>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</td>
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Theme:
Use of Resources

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

Findings:
The centre was not sufficiently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

For example, as discussed under Outcomes 6 and 7 there were significant deficiencies with the upkeep and modernisation of the premises including the fire safety arrangements in place for the centre. As discussed under Outcomes 5 and 17, staffing levels negatively impacted on residents' ability to access appropriate activities.

The provider had taken measures to upgrade the facilities and the premises. For example, at the time of inspection, one house was being renovated. Aside from redecorating works the house was also being supplied with fire safety doors and was being compartmentalised from a fire safety perspective. There was a recognition by the provider that this work was needed throughout i.e. in all other houses that made up this centre, but there was no specific timeframe for when this would be done.
The limitation on funding was given as the primary reason for the inability to be clear on the timeframes for upgrades and redecoration. The provider had risk assessed the corporate risk of having an “inadequate maintenance budget” resulting in the organisation being unable to “fund the level of upgrade required to maintain accommodation to an appropriate standard” This was rated at very high risk and this level of risk had been the situation since at least May 2015.

**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):**
No actions were required from the previous inspection.

**Findings:**
There were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents during the day and evening time. However, night time staffing levels needed to be reviewed in terms of the risk posed by leaving houses unattended.

For example, the arrangements in some apartments were that between the hours of midnight and eight am, they were unstaffed. Hourly checks were carried out by staff from a neighbouring house. While the checks were being completed, the house with night staff was unattended. Given that it was identified residents would not be in a position to evacuate independently and that the fire safety systems were in need of upgrading, these night time staffing arrangements were inadequate.

The inspectors saw that residents received assistance, interventions and care in a respectful, timely and safe manner. There was an actual and planned staff rota. It was displayed on the notice board in the centre.

The education and training available to staff enabled them to provide care that reflected contemporary evidence-based practice. For example, staff working in this centre received advanced training in managing behaviours that challenge. Education and training provided reflected the statement of purpose. For example, the statement of purpose stated care was delivered to residents with an intellectual disability.
This was a nurse-led service and staff were trained and qualified in intellectual disability. Staff were competent to deliver care and support to residents because their learning and development needs had been met. Comprehensive details of staff training was maintained and a staff training plan for 2017 was in place. However, inspectors noted that one member of staff had insufficient knowledge of the type of diet the resident for whom the staff was caring needed.

Staff were aware of the policies and procedures related to the general welfare and protection of residents. Staff had a good awareness of the regulations and standards. A copy of the regulations and standards were available in the centre.

Staff were supervised appropriate to their role. The supervision provided was good quality and improved practice and accountability. For example, staff reported having good support from the person in charge and being free to discuss any matter with her in an open and constructive way. Inspectors saw minutes of monthly staff meetings held in each house which were attended by the person in charge.

Staff files were held securely in a different location to this centre. They had been reviewed at previous inspections and found to be in compliance with the requirements of Schedule 2 of the Regulations. Nursing staff had an up-to-date registration with the relevant professional body.

**Judgment:**
Non Compliant - Major

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**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:**

Margaret O'Regan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Brothers of Charity Services Limerick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002830</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>14 and 15 February 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26 April 2017</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The sanitary facilities in one of the houses were institutional in layout and design, had poor accessibility and compromised resident privacy.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
• The Brothers of Charity Services Ireland Limerick Region accepts that the sanitary facilities in one of the houses in the designated centre is institutional in layout and design, has poor accessibility and compromises residents’ privacy. This situation is further compounded by the aging population in the centre and their changing needs as outlined in the internal OT report completed in March 2016 which identifies the necessary upgrade works required for the upgrade of bathrooms in this house.
• The Brothers of Charity Services Ireland Limerick Region does not have a capital budget to upgrade bungalows where there is significant cost. Nor is there capital funding available from the HSE as the HSE has advised that capital funding is prioritised for decongregation.
• Each resident in the house where institutional layout compromises privacy and dignity has their own bedroom. This affords the resident a personal space and residents are encouraged and supported to carry out as much of their personal care as possible in the privacy of their bedrooms.
• MDT review, including OT and Behaviour support clinicians, of morning and evening personal care routines to ensure privacy and dignity for each resident is maximised will be conducted and updated intimate care plans developed. The complexity of residents in this centre and their established routine is reflected in the proposed timescale allocated to this action.

Proposed Timescale: 31/10/2017

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:
Some parts of residents' personal plans had not been reviewed for over one year while the review of identified priorities required improvement to adequately reflect progress that had been made.

2. 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:
• A full review of the one resident’s personal plan (My Profile My Plan) has taken place on 13/03/2017.
• This will streamline the current system with the overall aim to ensure that only the necessary documents are contained in the plan and to avoid duplication.
• Following successful implementation of the My Profile My Plan in one residence, this
will be replicated throughout the designated centre.
• The priorities identified for one resident have been updated to reflect the current situation.

**Proposed Timescale:** 31/07/2017  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some healthcare plans did not reflect recommendations made by allied health professionals.

**3. Action Required:**
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

**Please state the actions you have taken or are planning to take:**
• The Health Care Plan for each resident will be updated with reference to the allied health professional's recommendations and based on the current environment.  
• Any risk assessment indicated will be completed

**Proposed Timescale:** 30/06/2017

**Outcome 06: Safe and suitable premises**  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Parts of the premises were in need of repair. For example, floor covering needed to be replaced, scuffed doors and walls needed to be painted, sanitary facilities needed to be modernised and the fire alarm system needed to be upgraded.

**4. 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 Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.  
• Several submissions have been made to the HSE in respect of capital funding to maintain the premises to an acceptable standard. The most recent submission was made in 2015 for €890,000 based on an engineer’s report. This included upgrades to windows, floors, painting, electrics and plumbing. No funding has been allocated for this submission.
• The Services does not have a sufficient budget to meet the maintenance costs arising in this centre which was built in the 1970’s. This will continue to be raised with the HSE as part of the Service Arrangement engagement process.
• A plan for decongregation of Bawnmore was submitted to the HSE in 2014.
• No revenue funding to date has been awarded by the HSE to support the movement of people from Bawnmore to the Community.
• The HSE confirmed in 2016 that Bawnmore is not a prioritized centre under the Social Reform funding.
• In December 2016 a submission for capital funding was made in respect of 5 projects that will support decongregation all referenced in the Bawnmore Plan 2014.
• On 21st February 2017 confirmation was received from the HSE for funding of these capital projects.
• Plans will be put in place to progress these capital projects during 2017. One capital project is a new build and will not be completed until early 2019.
• Fire Safety Strategy has been submitted to the HSE in 2016 for funding in order to achieve compliance over time with regulations.

Proposed Timescale: 30/06/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk control measures were not proportional to the risk identified. i.e. hourly checks of unstaffed houses. Inadequate consideration was given to the possible adverse impact such measures might have on resident’s safety in the event of a fire.

5. 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:
• Fire Safety Strategy was developed in 2016 that identified the requirement for extensive investment in upgrades to properties in Bawnmore. The Fire Safety Strategy was completed by a qualified Fire Safety Engineer. Progressing this fire safety strategy and determining a timeframe is dependent on funding from the HSE.
• Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million. The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy
• Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings.
• The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment. As this is outside of the control of
the services it is not possible to determine the time frame.

- A comprehensive risk assessment will be completed as a priority (date to be agreed) on the unstaffed houses at night which will identify control measures proportional to the risk. Mitigations that can be implemented will be implemented. Mitigations that are outside of the control of the BOCSI Limerick Region will be escalated as a priority to the HSE.

- The following fire safety measures are in place in this designated centre:
  - Hourly checks between 12 midnight and 7.30am (when bungalow is unstaffed) specifically in relation to fire.
  - Regular Fire Drills during the day and night
  - Fire safety equipment in place
  - Fire safety equipment serviced annually
  - Emergency lighting in place
  - All residents have personal egress plans. These will inform the risk assessment process that will take place with the fire safety engineer.
  - No fires or candles in use in the designated centre

Proposed Timescale: 15th May 2017 (for actions within the control

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**Proposed Timescale:** 15/05/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire safety management systems need to be upgraded and certified by a suitably qualified person that they comply with current legislative requirements.

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

**Please state the actions you have taken or are planning to take:**
- The fire alarm system currently in place is operational.
- It is certified quarterly by a competent person and receives a Certificate of Servicing/Testing of Fire Alarm System.
- Last Certificate received 12/04/2017. The certification notes that the Fire safety system requires upgrading.
- Fire drills are frequently engaged in on site and the fire alarm system is noted to work accordingly.
- In the interim ongoing fire safety mitigations are in place in the designated centre:
  - Fire Safety training for staff (mandatory)
  - Alarms are serviced quarterly
  - Fire Drills taking place
  - Fire Safety equipment is serviced annually
  - Emergency lighting
  - Fire safety checks
- Fire Safety Strategy was developed in 2016 that identified the requirement for
extensive investment in upgrades to properties in Bawnmore. The Fire Safety Strategy was completed by a qualified Fire Safety Engineer.

- Included in the Fire safety Strategy is the requirement to upgrade the Fire Safety management system.
- Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million. The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy
- Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings.
- The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment. As this is outside of the control of the services it is not possible to determine the time frame.

Proposed Timescale: Complete for actions within the control of the Provider Nominee

Proposed Timescale: 27/04/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In some instances the names of those who participated in the drill was not recorded, nor were the names recorded of those who had difficulty in participating in the drill. In another fire drill record the 24hour clock was not used which was a little confusing with regards to whether the drill was carried out at night or during the day.

7. 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:
- All staff who conduct fire drills have been advised to include the names of those who participate and those who don’t on the fire drill reports.
- All staff who conduct fire drills have been advised to use the 24 hour clock in fire drill reports.

Proposed Timescale: Completed

Proposed Timescale: 27/04/2017

Outcome 08: Safeguarding and Safety
Theme: Safe Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that residents were accessing supports services, for which they paid for. It was unclear how the decision was taken that the resident would pay for this. A greater level of oversight was needed to ensure resident funds were appropriately used.

8. 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:
• A working group to further clarify appendix 10 of the policy has been set up, this commenced on 15th March 2017. The work of the group is set to be completed by May 2017.
• Applications for funding for Aids and appliances are being submitted to the HSE for consideration.

Proposed Timescale: 19/06/2017

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:
An injury had not been notified to the Chief Inspector within the required timeframe.

9. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
• The notification was given to the inspectors during their Inspection on the 14th and 15th February 2017. The Person in Charge has emailed the notification to HIQA.

Proposed Timescale: 27/04/2017

Outcome 11. Healthcare Needs
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One member of staff did not demonstrate a sufficient level of knowledge regarding the modified consistency of food for one resident as recommended by a speech and language therapist.
10. **Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

**Please state the actions you have taken or are planning to take:**
- All staff in this residence have completed HSE land course on EDS for Adults with an Intellectual disability.
- SALT met with the staff to provide support and identify any further training needs.
- EDS plans are now readily accessible and only relevant accurate and up to date information is present.

**Proposed Timescale:** 27/04/2017

### 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 ability of the person in charge to be involved in the management systems of the centre was negatively impacted by administrative duties while two out of four CNM1s had left their posts.

**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:**
- Post for office administrator advertised on 24/01/2017
- Interviews held on 22/02/2017
- Successful candidate has been notified
- The management structure is being reviewed in conjunction with HR.

**Proposed Timescale:** 30/06/2017

### Theme: Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The reports of six monthly unannounced visits had a narrow focus and did not sufficiently capture issues related to the safety and quality of care and support within the designated centre as a whole.

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

**Please state the actions you have taken or are planning to take:**
- In future each inspection report will reflect not only the findings from the visit which focuses on aspects of quality of care and support which can be addressed within resources but also the corporate level issues which impact on safety and quality of care that have been documented and escalated to the HSE as part of the annual Service Arrangement process.
- There is an expectation that recommendations made and learning from the 6 month unannounced inspection process in the designated centre are generalised to other areas of the designated centre.

**Proposed Timescale:** 30/04/2017

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### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The designated centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

**Please state the actions you have taken or are planning to take:**
- The following processes are in place in order to maximize the use of existing resources:
  - Each resident has a Person Centred Plan with identified priorities.
  - The organisation’s risk assessment process supports prioritization in the context of limited resources.
  - Activities for each resident will be reviewed on an ongoing basis.
- The Provider accepts that some residents have less access to internal and external activities based on inadequate staffing.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources as outlined as follows:
  - In November 2015 the Chief Officer of the HSE CHO3 (Mid West) issued the following in relation to funding and prioritization:

  “While it is accepted that over a period of time there would be a desirable progression...”
to improving standards there cannot be an immediate response to every issue of regulatory compliance and feedback. These have to be prioritised and scheduled in a way that allows the state to achieve compliance over time in its own direct provision and through provider agency, such as the Brothers of Charity. This involves a constant process of prioritisation within available resources.”

• The HSE issued further clarity during 2016 to the Provider Nominee in respect of use of resources:

  “no additional expenditure can be incurred without approval and if such occurs without approval the HSE will not under any circumstances enter into discussions on funding same.”

“The HSE had noted the top ten agencies as identified red flag by the regulator and made provision in the 2016 service plan to begin addressing these within resources available and BOC Limerick was not rated as such. That is not to say it does not require attention.”

**Proposed Timescale:** 31/12/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The night time staffing levels needed to be reviewed in terms of the risk posed by leaving houses unattended.

14. **Action Required:**

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

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

• All decisions regarding the use of rostered staff at night across all 3 designated centres in this Centre are informed by a risk assessment process.
• These risk assessments will be revisited in conjunction with a Fire Safety Engineer to consider if additional mitigations are required. Concerns of HIQA inspectors will inform this discussion.
• A meeting with the Fire Safety Engineer is currently being scheduled as a priority.
• In the interim ongoing fire safety mitigations are in place in the designated centre:-
  o Fire Safety training for staff (mandatory)
  o Alarms are serviced quarterly
  o Fire Drills taking place
  o Fire Safety equipment is serviced annually
  o Emergency lighting
• Fire Safety Strategy has been submitted to the HSE for funding in 2016 and forms
part of ongoing HSE engagement.

**Proposed Timescale:** 15/05/2017