Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Liosmor
Centre ID:	OSV-0002869
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

From:	To:
19 September 2017 09:15	19 September 2017 18:00
20 September 2017 09:15	20 September 2017 15:00

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

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 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection was undertaken in October 2014; the last inspection was in February 2017.

Given the poor and concerning findings of the May 2016 and February 2017 inspections, HIQA convened two meetings with the provider in February and April 2017. However, given the concerning inspection findings and the response received from the provider, the Chief Inspector proceeded in July 2017 to issue the provider with notice of proposal to cancel and refuse registration of the designated centre. In accordance with Section 54 of the Health Act 2007 the provider submitted written representation to the notice of proposal to cancel and refuse registration.

This inspection was undertaken to establish what action the provider had taken and the impact of these actions on the quality and safety of the supports and services delivered to residents.

How we gathered our evidence
Prior to the inspection, the inspector reviewed the information held by HIQA in

relation to this service. This included the previous inspection findings and the provider’s response to the action plan, the representation received from the provider and any notifications submitted of adverse events and incidents that had occurred in the centre.

The inspection was facilitated by frontline staff and one of the clinical nurse managers 1 (CNM1) who was deputising for the person in charge who was on planned leave. The inspector spoke with the nominated provider representative.

The inspector met and spoke with all of the front-line staff on duty over the course of the two days of inspection. The inspector reviewed records including resident related records, fire, health and safety related records, records of consultation with residents and of any complaints received.

The centre was home to nine residents, all of whom engaged and spoke regularly with the inspector over the two days. The inspector observed the delivery of care and supports to residents and staff and resident interactions. The inspector saw that residents looked well, were at ease with staff and readily and regularly sought out staff and assistance from them. There were no observed restrictions placed on residents who had ready-access to staff and the staff office.

Description of the service
The premises was purpose built and designed to meet the needs of residents with higher physical needs. Residential services were provided to nine adult residents. The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The statement reviewed by the inspector was updated in January 2017. Given the actions taken by the provider, the inspector found that overall the service and supports provided to residents was as described in that document. However, some review and update was required of the statement of purpose.

Overall judgment of our findings
The inspector found that the provider had implemented the actions committed to in the representation submitted to HIQA in response to the notice of proposal to cancel and refuse registration of the centre. Pivotal to these actions was the provision by the provider of additional staff support hours and the reinstatement of staffing withdrawn prior to the February 2017 inspection. While matters were not fully resolved, the positive impact of this staffing decision on the quality and safety of the supports and services delivered and the quality of life of residents was clearly evidenced.

Residents were relaxed, engaged and eagerly looking forward to planned excursions; these trips were now supported in full by the provider and at no additional cost to the residents. Residents' access to structured day services had been reinstated.

Residents still presented with behaviours of concern and risk to themselves and others. However, all staff spoken with confirmed that the additional staff resources now facilitated them to implement the positive behaviour support plan. There was consequent consistent positive feedback on both the reduced frequency and reduced

intensity of the behaviours exhibited.

These interim measures put in place by the provider had reduced the safeguarding risk to residents; however, a long-term plan was required to ensure that the centre was suited to all residents' needs and expressed wishes. At the time of this inspection the suitability of the centre to meet the needs of two residents was under review

The maintenance of records had improved. There was no evidence of incidents that should have been reported to HIQA but were not.

However, the level of regulatory non-compliance evidenced over the course of inspections, the failure of the provider to ensure the quality and safety of the supports and services provided to residents and the failure of the provider to respond to HIQA action plans in a proactive manner was not indicative of effective management systems and governance that could and would sustain and assure the improvement noted on this inspection. This is discussed further in the body of the report in Outcome 14: Governance and Management.

The centre was fitted with emergency lighting, an automated fire detection system, fire fighting equipment and fire resistant doors. However, a fire safety survey commissioned by the provider in June 2016 had identified deficits in these measures and other infrastructural deficits. It was stated that a significant portion of the required remedial works were required to upgrade the premises to the required standard. It was confirmed that these works had not been completed as the required resources were not available.

The provider was requested to prioritise a review of the meals provided to residents, the quality of which was reported and seen to be poor.

The inspector reviewed nine Outcomes. Eight of these Outcomes were judged to be at the level of major non compliance at the time of the February 2017 HIQA inspection. The provider was now judged to be in compliance with two and in substantial compliance with two Outcomes. One Outcome was judged to be at the level of major non-compliance given the fire safety deficits discussed above. The remaining four Outcomes were judged to be in moderate non-compliance with regulatory requirements.

The evidence to support these judgements is found in the body of the report in each respective Outcome. The regulations breached and the actions required of the provider are detailed in the action plan at the end of 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:
The provider had addressed the concerning failings identified at the time of the last inspection.

Staff said that the resident who acted as the local advocacy representative was facilitated to attend the advocacy meetings. The resident confirmed this and shared the minutes of the recent advocacy meeting with the inspector. The resident was aware of the next scheduled meeting and was eagerly looking forward to it. Staff confirmed that plans were in place for the resident to attend the upcoming national advocacy conference.

The provider had reinstated access to the day service for a resident as committed to on admission to the centre.

The provider had ceased the sourcing of an external home-care provider funded by residents to support access to activities and social engagement. The provider committed to reimburse residents any monies owed to them.

While not fully established, a system was now in place to utilise the additional staffing resources in a manner that befitted residents equitably, individually and collectively. The inspector saw a white-board on which there was a plan of excursions and staff allocations. On the morning of the second day of inspection there were only two residents left in the centre as seven residents attended either the provider’s day service or the local community day service. There were planned activities and later excursions for the remaining two residents.

Staff spoken with clearly articulated their personal satisfaction in their ability to now support residents to leave the centre on a regular basis. The importance of this activity to residents and their enjoyment of it were clearly evident; they spoke about it, they were seen to prepare themselves for it and to get momentarily disquieted when they thought the bus had left without them. All of this was possible only since the 21 August 2017 and there were some challenges, for example, the amount of preparation that was required given residents' high needs and the amount of time that was available to achieve something purposeful. This will require ongoing monitoring and local discussion to ensure that the maximum benefit is achieved.

The inspector reviewed the log of complaints received since the last inspection in February 2017. Four complaints were logged since the last inspection. The records seen demonstrated that residents were listened to and that the complaint was managed by staff and the multidisciplinary team in consultation with the resident and as they wished. Three matters complained of were resolved; one was in process.

The inspector saw that there was consistent communication between staff and residents. Residents knew each staff member by name, asked who was coming on duty and told the inspector that they liked staff. In addition to this evidenced communication, staff convened weekly house meetings with residents. The minutes maintained were detailed and meaningful and it was clear that the majority of residents engaged and participated in this process. The minutes indicated and staff spoken with confirmed that these meetings were also used as a forum to discuss residents' individual and collective rights and the general operation of the designated centre.

For example, the inspector saw that residents were advised of when the person in charge would be on holidays and if staff from the staff agency were due to work in the centre. It was clear from the minutes that actions emanated from these meetings; however, it was not always clear if actions had been met or if not why not. For example, the inspector saw one repeat request from one resident. Staff spoken with advised that this request was not always met but gave a reasonable rationale for this, this was not however evident from the subsequent minutes.

Staff said that they were currently exploring how they could better support residents to access religious observance in the local church.

Judgment:
Substantially Compliant

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

services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
The inspector reviewed a representative sample of residents' personal plans; improvement was noted. However, the residents' participation in their plan, the review and update of the plan in response to changing needs, were not always evidenced.

The inspector saw that the format of the plans had been revised and refined since the last inspection. Each resident had been appointed a key worker, staff had received training in the completion and maintenance of the personal plan, oversight was maintained by the person in charge or the clinical nurse manager. This oversight was not complete but was evident from the sample of plans seen as deficits such as missing information were highlighted to each key worker for correction.

The plans were presented in a detailed and personalised manner and generally did reflect residents' needs and their required supports in a succinct manner. However, the multidisciplinary review of the personal plan including the follow-through on required actions, was inconsistently demonstrated. For example, one plan had been comprehensively reviewed by the multidisciplinary team in June 2017; actions emanated and a further meeting was scheduled for August 2017. It was not evidenced that this meeting had taken place. A multidisciplinary review had taken place for another resident in November 2016, but had focussed solely on a safeguarding matter. The third file clearly evidenced sequential multidisciplinary review of the resident and their supports in 2017.

The personal plan included the process for identifying, agreeing and progressing residents' personal goals and priorities. Overall, improvement was noted in the records maintained and in practice it was clearly evident that the recently allocated staff resources supported residents to enjoy increased activity and social engagement. However, it was not clear if one resident had actually participated in their own personal plan. An identified goal was not progressed in a manner that was suited to the resident's needs as it conflicted with their day service.

Staff were proactively utilising the recently allocated staff resources to the benefit of residents. However, a review of each resident and their individual needs, interests, skills and abilities was required. Further to this review, each resident required an updated, explicit individual personal plan that reflected their wishes, interests and abilities and promoted their ongoing personal development.

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

Findings:
The centre was fitted with fire safety measures; however, remedial works were required to these and these works had not been completed. Improvement was required in the identification, assessment and ongoing review of risks to ensure adequate compliance with Regulation 26 (1) (a). Improvement was required in the recording and review of accidents, incidents and adverse events.

The centre was fitted with emergency lighting, an automated fire detection system, fire fighting equipment and fire resistant doors. There were records seen that attested to the inspection and testing of these measures in September 2017, July 2017 and April 2017 respectively. Since the last inspection electromagnetic hold-open devices had been fitted to the fire resistant door sets and no door was seen to be held open by a door-wedge. Escape routes and final exits were unobstructed.

However, the inspector reviewed the report of a fire safety survey undertaken on behalf of the provider in June 2016. This survey had identified deficits in the existing fire safety measures and other infrastructural deficits. It was stated that a significant portion of the required remedial works were required to upgrade the premises to the required standard. It was confirmed that these works had not been completed as the required resources were not available.

Given the identified deficits including deficits in cross-corridor fire-resistant door-sets, a full evacuation of the premises was required in the event of fire. Since the HIQA inspection of February 2017 a centre-specific evacuation plan had been implemented, each resident had a personal emergency evacuation plan dated August 2017 and four simulated evacuation drills had been completed. However, it had taken five minutes to evacuate all of the residents during the most recent drill and no drill (based on the records seen) adequately simulated a night-time scenario. Nine residents had been evacuated by two staff but all residents were stated to be in the main dining room at that time; that room had ready-access to an external exit.

The person in charge had completed a good range of resident-specific risk assessments and had kept these and the identified controls under review. The inspector saw that relevant risks such as the risk posed by behaviours that challenged had been reviewed post the allocation of staffing resources in August 2017. The decision to reinstate

staffing resources mitigated the identified level of risk in the designated centre and promoted resident safety. However, the register of risks required review to ensure that it adequately encompassed hazard identification and assessment of risks throughout the designated centre such as environmental and work related risks, for example the space available in some sanitary facilities, the sharing of such facilities and any risk posed to resident privacy and safe moving and handling.

Since the last inspection accidents, incidents and adverse events were recorded and stored electronically. The inspector reviewed a representative sample of these records particularly in relation to behaviour related incidents and saw that most were comprehensively completed by staff. Some of these records were not however comprehensively completed and would not support review of the incident so as to identify any causal factors and any learning required. For example one record seen (a random sample was reviewed) suggested that a causal factor may have been a failure by staff to adhere to a behaviour management guideline in relation to facilitating a resident's requirement for refreshment.

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:
While the matters of concern identified at the time of the last two inspections were not resolved, the provider had taken action that reduced the level of risk posed and that improved the safeguarding of residents from harm and abuse.

Staff spoken with told the inspector that they had no knowledge of any allegations of abuse against staff and no concerns were articulated by staff spoken with. Staff spoken with were clear that all such allegations were reported in line with the provider's safeguarding policy; staff were clear that no allegations fell outside of this reporting procedure. Staff were aware of their reporting responsibilities.

Staff said and the minutes of meetings seen, indicated that each resident’s right to a safe environment free from harm and abuse was discussed at the weekly house meeting. Staff said that residents were aware of their rights and would and did speak up if they were not happy. One resident was recorded as having stated at one recent meeting that there was to be 'no fighting in the house'. Another resident showed the inspector in a very purposeful manner the discussion of safeguarding at the advocacy meeting but raised no specific concerns or worries. Staff said that residents had not raised any recent concerns for their personal safety and well-being. The inspector spent time with each resident over the two days of inspection and residents reported that things were fine.

Residents continued to exhibit behaviours of concern and risk to themselves and others. However, all staff spoken with confirmed that the frequency and intensity of the exhibited behaviours had reduced. Staff attributed this to the provision of one-to-one supports, the reinstatement of staffing resources and additional staffing resources at the weekends. Staff said that the current staff allocation allowed staff to follow and implement the strategies of the behaviour management guidelines so as to reduce the risk of, or prevent the escalation of behaviours.

The reported reduction would concur with records seen by the inspector. Thirty-three behaviour related incidents had been recorded since the last inspection; 60 had been recorded in a comparable period prior to the February 2017 inspection. The new incident reporting system allowed for a five point severity rating, level one being the lowest and level five being the highest (behaviour of such intensity that serious injury was caused). Staff had rated 13 incidents as at level one, 19 at level two and one as a level three incident (potential to cause serious injury).

The inspector saw that residents were content in each other’s company, wished peers well as they left for their day service, and articulated sympathy and empathy for peers who had experienced recent loss and bereavement.

There was one exception to this in June 2017 where a resident had exhibited behaviours of concern and risk to themselves and others. While the causes may have been multi-factorial, it was also clearly identified that the behaviours exhibited had been triggered by the behaviours of the peer. Ultimately while the provider had put interim measures in place to manage the safeguarding risks, a long-term plan was required to ensure that the centre was suited to all residents' needs and expressed wishes. At the time of this inspection the suitability of the centre to meet the needs of two residents was under review.

Behaviour management guidelines pivotal to these and previous inspection findings were clearly filed in the personal plan. Staff had signed as having read the guidelines, staff spoken with described to the inspector the strategies detailed in the guidelines for preventing and responding to behaviours of concern. Minutes of a multidisciplinary review stated that the guidelines were to be updated by September 2017; the guidelines were seen to have been updated and reissued to the centre on the 2 September 2017.

Residents continued to have regular support from psychology, psychiatry and behaviour support.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
The records seen by the inspector indicated that the person in charge had fulfilled her statutory obligations in relation to the submission of accidents, incidents and adverse events to HIQA

Judgment:
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:
Review was required of the plans for responding to seizure activity. The arrangements in place for the provision of residents' main daily meal required review.

Given the stated purpose and function of the centre, residents did have specific healthcare needs and requirements. The inspector saw that staff monitored these healthcare needs and facilitated access for residents to the required healthcare. The inspector saw that residents looked well and they reported feeling well.

Medical review and treatment was provided by a local general practitioner (GP). On the day of inspection, the GP spent significant time in the centre attending to residents and

their needs, including the provision of seasonal influenza vaccination.

Nursing assessment and input was available in the centre on a daily basis. Residents had access to other required healthcare services including physiotherapy, psychiatry, psychology, neurology, occupational therapy, speech and language therapy, behaviour therapist, social work, dietician, dental care, ophthalmology services and chiropody. Records of referrals and reviews were maintained and there was evidence of good interdisciplinary communication.

Where a resident refused treatment, this was respected and there was evidence of action taken by staff and the GP in such situations to support resident health and well-being.

Some residents had plans of support to manage seizure activity; the plans included the administration of a rescue medicine; records seen indicated this medicine was administered. Residents had ready access and were supported to attend regular appointments with a consultant neurologist. The neurology service offered support and advice to staff as required the details of which were seen in residents' individual plans. However, the seizure activity management plans seen did not always outline clear guidance to staff on the recovery times and when and why the assistance of emergency services may be required.

Previously, staff in this centre had freshly prepared residents' meals daily. In an attempt to maximise the available staffing resources the provider had since the February 2017 inspection, made a decision to externally source the residents' main daily meal. The quality of the meal provided on the first day of inspection and the overall dining experience was poor; this would concur with feedback provided by all staff spoken with and records seen including provider reviews of the service.

Residents were required to express their meal choices on a weekly basis, that is decide on Saturday what they wished to eat each day for the coming week; meals were ordered and supplied on that basis. Staff said that if a resident declined to eat on any given day what they ordered the previous Saturday, they had a range of foods available to them to offer an alternative such as cold meats, eggs or frozen products. The inadequacies of this system had been highlighted in the provider's own reviews of 15 August 2017 and 29 August 2017; negative feedback had been provided by both residents and staff. The inspector saw on this inspection, that the main meal provided was not appetising either in appearance or on tasting; two residents did not eat the meal provided. Descriptors used by staff to describe the meals provided included inconsistent, hit-and-miss and awful.

Residents had access to both speech and language and occupational therapy review. Some residents were seen to be provided with assistive equipment to support their independence at meal times such as modified cutlery and cups. However, the dignity of the dining experience for some residents would also have been enhanced by the provision of devices to prevent food-spills from their plates.

The provider's representative was requested to review the provision of meals to residents as a matter of priority and ensure that the food provided to residents was

nutritious, appetising and offered choice that was meaningful.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
A revised statement of purpose was submitted to HIQA in January 2017. However, in the context of the staffing resources allocated in August 2017, the statement required review and updating so as to be an accurate reflection of the centre as it was currently configured and the supports and services that are and would be provided to residents living in the centre.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Assurance was required by HIQA that management systems were sufficient to maintain

the improvement evidenced on this inspection and to ensure that the quality and safety of the care, support and services provided to residents was effectively and consistently monitored.

The provider had failed to submit a satisfactory response to the HIQA action plan of February 2017; the response did not sufficiently address or demonstrate how it would address pertinent failings and matters of concern to the Chief Inspector. Given the provider's failure, a notice of proposal to refuse and cancel the registration of the centre was issued in July 2017. Despite this regulatory activity, it was of concern to HIQA to note that an unannounced provider review of the centre on 15 August 2017 had still identified a number of issues that required immediate action; the inspector reviewed the report and saw that over 30 actions emanated from this review. This did not demonstrate satisfactory progress made on foot of HIQA inspection findings, action plans and escalatory activity.

The provider commissioned a further unannounced review on 28 August 2017; this report indicated that progress had been made in the intervening period, however; a significant action plan still issued.

Notwithstanding the improvement noted on this inspection, collective HIQA inspection findings, required regulatory escalation actions and the provider's own very recent reviews, did not reflect management systems that had the capacity to ensure regulatory compliance and that the care, support and services provided to residents was safe, of an appropriate standard, appropriate to residents' needs, consistent and effectively monitored.

Staff spoken with articulated their reservations as to the capacity to provide sufficient oversight including clinical oversight. A record seen reflected concerns raised by the person in charge in relation to the difficulties in ensuring adequate supervision of staff on a 24 hour basis. Governance was discussed with the provider representative at the conclusion of this inspection; it was agreed that given the number of residents and the complexity of their needs, change was required to the existing governance arrangements.

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

Findings:
In the representation received by the office of the Chief Inspector, the provider advised that it had from the 21 August 2017 allocated additional staff support hours to meet the individual and collective needs of the residents. The positive impact of this decision on both residents and staff was evident and is reflected in these improved inspection findings.

The inspector saw that the staffing resource that had been withdrawn from the designated centre in early 2017 to support residents' access their day service was reinstated; one-to-one support for day service access was also facilitated. In effect, residents now had the staff support they required to meet their assessed needs and implement their plan of support.

The inspector saw that before a staff member left the centre to go to the day service with a resident another staff member came on duty in the designated centre. Additional staff resources were also available each evening up to 20:00hrs and for three hours each Saturday and Sunday. From 08:00hrs to 20:00hrs there was a minimum of three staff on duty; there were four staff on duty from approximately 16:00hrs to 20:00hrs.

Some of these additional staffing resources were in response to one individual plan of support but benefitted all residents.

When asked to articulate the benefits of the revised staffing levels, all staff immediately referenced the benefits to residents. Staff said that they now had time to give one-to-one time to residents, they could adequately and appropriately implement behaviour management strategies and they could support all residents to access meaningful community engagement and inclusion. All staff spoken with said that they were satisfied that the current staffing levels were sufficient to meet the current assessed needs of residents in a safe and appropriate manner.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate **Action Plan**

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0002869
Date of Inspection:	19 & 20 September 2017
Date of response:	12 October 2017

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 quality of residents' meetings was good and it was clear from the minutes that actions emanated from these meetings; however, it was not always clear if actions had been met or if not why not.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
Agenda format has been agreed including the review of minutes of the last meeting and follow up on the status of actions.

The PIC will ensure that the actions from each meeting are clearly documented and followed up on at start of each meeting.

Where actions have been met these will be documented in the minute.

Where actions have not been met the reason will be documented and the corrective action outlined clearly.

Proposed Timescale: 14/10/2017

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:
It was not clear if one resident had actually participated in their own personal plan. An identified goal was not progressed in a manner that was suited to the resident's needs as it conflicted with their existing day service.

In the context of the revised staffing resources each resident required an explicit updated, individual personal plan that reflected their wishes, interests and abilities and promoted their ongoing personal development.

2. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The Person Centred Planning process recommends the inclusion of each individual in the development of their personal plan.

The involvement of the person in their plan will be documented.

All residents will be included in the next round of planning meetings due to commence in November.

All residents personal plan will reflect their wishes interests and abilities.

The additional staffing resources in the centre will be used to support the achievement of each individual's wishes as reflected in their plan.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The multi-disciplinary review of the personal plan including the follow-through on required actions was inconsistently demonstrated.

3. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
All agendas for MDT meetings now include review of previous meetings and actions.

If actions have not been achieved the reason will be documented as well as the corrective action to take place to address how the barrier to achievement of the action will be addressed.

This process has commenced since September 2017.

Proposed Timescale: 12/10/2017

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 register of risks required review to ensure that it adequately encompassed hazard identification and assessment of risks throughout the designated centre.

4. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
•Risk assessment re one resident with mobility needs was carried out and mitigations to address the identified risk are now in place.

•Risk assessments are reviewed on a quarterly basis.

•Any hazards that are identified in the designated centre will be risk assessed in line with the organisations Risk Assessment procedure.

Proposed Timescale: 12/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some accident and incident records were not comprehensively completed and would not support review of the incident so as to identify any causal factors and any learning required.

5. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Accident /incident forms are reviewed by the PIC and PPIM as they are reported.

Where it is deemed by the PIC and PPIM that the accident and incident form is not adequately completed the staff member will be met in order to support them to complete the paperwork correctly.

The PIC will also review accidents and incidents on a monthly basis.

A summary of accidents/incidents are brought to MDT meetings for the relevant service user for discussion. This commenced in September 2017.

Accidents and Incidents for the previous month are discussed at staff meetings in order to share learning. This commenced at the staff meeting on 10th October 2017.

Accidents and Incidents will be forwarded to Psychology and Behaviour Support on a quarterly basis for analysis for this designated centre.

Proposed Timescale: 12/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It had taken five minutes to evacuate all of the residents during the most recent evacuation drill and no drill (based on the records seen) adequately simulated a night-time scenario. Nine residents had been evacuated by two staff but all residents were stated to be in the main dining room at that time; the room had ready access to an external exit.

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

Please state the actions you have taken or are planning to take:
•Simulated night drill is scheduled to be carried out over the weekend of 14th October 2017.

•This will be overseen by the PPIM.

•Simulated night drill will be completed annually.

Proposed Timescale: 22/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire safety survey had identified deficits in the existing fire safety measures and other infrastructural deficits. It was stated that a significant portion of the required remedial works were required to upgrade the premises to the required standard. It was confirmed that these works had not been completed as the required resources were not available.

7. 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 Provider is submitting a plan to HIQA in respect of Fire Safety compliance by 27th October 2017.

This plan will include Lios Mor Designated Centre.

The timeline for achievement of compliance will be reflected in the plan.

Proposed Timescale: To be confirmed with reference to plan

Proposed Timescale: 27/10/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A long-term plan was required to ensure that the centre was suited to all residents' needs and expressed wishes. At the time of this inspection the suitability of the centre to meet the needs of two residents was under review.

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:
The Provider approved the allocation of additional staffing resources to the centre on 21/08/2017 in order to support the residents and meet their needs.

These additional resources are having positive impact on the residents in supporting them with their specific needs and wishes.

The Services is currently reviewing the inappropriate placement of one individual in the centre and this person will be included in a plan currently being developed for the Provider for HIQA. The deadline for the return of this plan is 27th October 2017.

The second individual has expressed a wish to transfer from the centre has been referred to the Admissions, Discharge and Transfer Committee. There is no suitable alternative placement for this person at this time. This request will be kept under review.

Proposed Timescale: To be confirmed with reference to plan.

Proposed Timescale: 27/10/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The seizure activity management plans seen did not always outline clear guidance to staff on the recovery times and when and why the assistance of emergency services may be required.

9. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
All epilepsy management plans have been reviewed and clear guidance is available to all staff on when to administer the emergency medicine and when to call for the emergency services.

All staff have been trained on the administration of the emergency medicine.

All Nurses have been trained on the use of oxygen as well as a number of care staff.

All night staff have been trained on the use of oxygen.

Proposed Timescale: 12/10/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were required to express their meal choices on a weekly basis. The main meal provided was not appetising either in appearance or on tasting.
The dignity of the dining experience for some residents would also have been enhanced by the provision of devices to prevent food-spills from their plates.

10. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
•The outsourcing of the meals has been reviewed by the PIC. It has been decided to provide the meals in house. This change will take place from 16th October 2017.

•Meals will be prepared by the night staff and cooked by the day staff in order to ensure that day staff's time is maximized with supporting the residents.

•Input is being provided by the speech and Language therapist and a dietician to support staff in the preparation of meals for residents.

•Specific cutlery has been provided for one individual and plate guards will be purchased for other individuals that require them.

•The importance of the proper presentation of food for residents has been discussed with staff and will be supervised by the PPIM and PIC.

Proposed Timescale: 16/10/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In the context of the staffing resources allocated in August 2017 the statement required

review and updating.

11. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose and Function has been reviewed and adapted to include the additional staffing resources allocated in August 2017.

Proposed Timescale: 12/10/2017

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:
Collective HIQA inspection findings, required regulatory escalation actions and the provider's own very recent reviews did not reflect management systems that had the capacity to ensure regulatory compliance and that the care, support and services provided to residents was safe, of an appropriate standard, appropriate to residents' needs, consistent and effectively monitored.

12. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Provider has approved the appointment of a full time Person in Charge for this designated centre for a period of 6 month in order to embed effective management systems and ensure regulatory compliance in the designated centre.

After 6 months the situation will be reviewed by the Provider Nominee in consultation with the Provider.

It is anticipated that following a period of 6 months the PIC's roster will reflect both front line hours in supporting the residents and sufficient supernumery hours to ensure the centre is managed effectively and achieving regulatory compliance.

Proposed Timescale: 31/12/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Concerns had been raised in relation to the difficulties in ensuring adequate supervision of staff on a 24 hour basis.

13. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Fortnightly unannounced visits at night to commence beginning 16/10/2017 involving the PIC and PPIM in order to ensure proper supervision of the service at night.

Proposed Timescale: 16/10/2017