Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Desmond Community Residential Houses
Centre ID:	OSV-0005178
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):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
01 August 2017 09:00	01 August 2017 19:30

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

Outcome
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This inspection was the second inspection of this centre by the Health Information and Quality Authority (HIQA). The last inspection was undertaken in September 2015. This current inspection was undertaken to further inform a registration decision.

How we gathered our evidence:
Prior to the inspection inspectors reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the original registration application, the previous inspection findings and action plans, correspondence in the intervening period, and any notice received of any incidents that had occurred in the centre.

The inspection was facilitated by the person in charge and the area manager. Tthe head of community services attended verbal feedback at the conclusion of the inspection on behalf of the provider.

Inspectors conducted the inspection across the two houses that comprised this designated centre. Inspectors spent time observing and discussing the supports and services provided to residents and reviewed and discussed with staff records

including fire, health and safety related records and records pertaining to residents, their assessed needs and required supports.

Inspectors met with the frontline staff on duty in both houses and with six of the residents living in the centre; two residents were at home on planned leave. Residents welcomed inspectors into their homes, offered them refreshments and gave them a guided tour of the house. Residents showed inspectors photographs of, and discussed the achievement of their personal priorities including holidays, cinema visits and a visit to Dublin Zoo which was "loved". Inspectors encouraged staff and residents to continue with their planned routine (the inspection was unannounced), this included a trip to the hairdressers and to the cinema. Inspectors' observations were positive; there was a relaxed atmosphere in the houses at the time of this inspection with positive engagement noted between residents and staff.

Description of the service:
The centre comprised two domestic type houses within a short commute from each other and the day service. Residential services were provided to eight residents with provision for respite for one further resident in one of the two houses.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors were satisfied that while minor amendment was required, overall the document was an accurate reflection of the services and supports to be provided.

Overall findings:
There was a clear management structure and effective governance systems. Staff had sound knowledge of residents' needs, assessed these needs on an ongoing basis and sought intervention for residents as necessary. This was not, however, adequately reflected in the records maintained and an action was issued in this regard.

The provider had failed to complete required fire safety works; the rationale provided for this was the unavailability of the required finances.

The provider had identified that the needs of residents in one house were not compatible and that the designated centre was not suited to meeting the needs of each resident's assessed needs. There was evidence of action taken by the provider including the allocation of additional staff supports since December 2016. While this had improved the situation somewhat, there was concerning evidence of negative impacts on residents' physical and psychological wellbeing. It was also of concern to inspectors that there was uncertainty as to the continuation of the additional staff supports as this was the primary risk-mitigating control. This is discussed fully in Outcome 8.

Of the eight Outcomes inspected the provider was judged to be compliant with two, in substantial compliance with one outcome and in moderate non-compliance in two outcomes. The provider was judged to be in major non-compliance with three Outcomes; Outcome 7: Health & Safety and Risk Management, Outcome 8: Safeguarding and Safety management and Outcome 18: Suitable Staffing.

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

Theme:
Effective Services

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

Findings:
The provider had recently introduced new records for assessing residents' needs and planning the supports required to meet assessed needs; inspectors found the implementation of these records to be fragmented and to not clearly demonstrate the sequential process of assessment, planning and review.

There was an assessment tool for assessing residents' needs; the tool was dependent on staff knowledge of known needs; staff in this centre were familiar with and had good knowledge of residents' needs. However, the sequence of putting a plan in place in response to an identified need did not flow and there did not seem to be an agreed template to guide staff and practice. There was much discussion as to what constituted a plan of support, a support plan and a care plan. The personal plan did not present and read as a single, comprehensive, integrated plan as referenced in the regulations and standards.

A clear example of this was in relation to a plan that detailed the interventions-supports required in response to behaviours of concern. Inspectors sought this plan based on their own observations; there was no such plan in the personal plan but there were guidelines from the psychologist found in the resident's medicines management folder; these were dated June 2016. There was a high volume of monitoring tools used by staff over a prolonged period of time; in the absence of a clear current plan that detailed the supports required, the purpose, duration and desired outcome of this monitoring was not clear.

The new records did not maximise the opportunities for staff signatures and dating.

The process of identifying, agreeing and progressing resident's personal goals and priorities, and the resident's participation in this process was clear; there was a learning and skills development component to the agreed goals. However, while there was a process for identifying and addressing barriers to achievement, there were goals that required review in this context, for example travelling on public transport.

Records seen demonstrated that the resident, their needs, existing and required supports were the subject of review by members of the multidisciplinary team. The team reviewed the effectiveness of the plan and made necessary recommendations; these were seen to be followed through on based on other records seen.

However, the exception to this appeared to be plans to support seizure activity. Though plans seen were signed as reviewed by the person in charge the origin of the plan was unclear; the date of the most recent clinical review of the appropriateness of the plan was not specified given that neurology review and care was current.

There was some usage of obliterating fluid and paper noted on some records.

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 order.

Theme:
Effective Services

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

Findings:
The designated centre consisted of two domestic style houses within a short car commute from each other. Inspectors visited both houses and were satisfied that each was suited to its stated purpose and function and substantially compliant with regulatory requirements; however, one house would have benefitted from further upgrading.

One house had undergone an extensive refurbishment process prior to the last inspection and did present as more welcoming, comfortable and homely than the other house; some redecoration had however been completed in the second house based on the findings of the last inspection and this was evident on approach to the house. However, there were still come areas that would have benefitted from modernisation

and redecoration, for example the downstairs shower room.

Each resident was provided with their own bedroom; rooms were of a suitable size and were decorated to reflect resident's individual backgrounds and interests.

Bedrooms did not offer en-suite sanitary facilities but adequate separate facilities were provided in each house for the number and current needs of the residents living in them; privacy locks were provided.

Both kitchens were adequately equipped and were seen to be both functional and social areas with residents and staff engaging with each other at mealtime and while completing household chores. One kitchen was however compact and incorporated the dining area; the available space for the number of residents required the provision of an additional dining area in the main communal area. Adequate communal space was however provided.

Facilities were in place for the laundering of residents personal possessions.

Both houses offered adequate parking and access to a garden.

Storage space was not seen to present any difficulty; the existing storage shed in one house that was seen to be in poor condition at the time of the last inspection had been demolished and replaced.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
There were measures in place to promote and protect the health and safety of residents, staff and other persons; for example risk management policies, an emergency plan and processes for the identification and management of risk; however, the centre was not equipped with required fire safety measures.

The provider had commissioned a fire safety review of both houses the reports of which issued in January and February 2016. The required works included the upgrade of the fire detection systems (currently domestic type battery operated detectors were used),

the provision of emergency lighting in both houses, the provision of fire resistant doors and other fire-resisting works, and the use of an inner room as a bedroom; deficits were identified in some works that had been completed in the refurbished house. The works specified had not been completed and there was no timeframe for their completion; inspectors were advised that the required financial resources were not available.

There were measures in place to promote fire safety and records seen demonstrated that these were consistently implemented by staff. There was a weekly test of the existing detectors and the routine replacement of batteries; an external contractor also tested the detectors on a quarterly basis and most recently in June 2017. Fire fighting equipment was provided and was inspected in April 2017 to the required standard.

The diagrammatic evacuation plan was displayed and signage indicated the escape routes; secure key-boxes were provided where final fastenings were a manual key-lock. Staff undertook simulated evacuation drills with residents; each resident had a current personal evacuation plan (PEEP); the PEEP detailed obstacles to evacuation that may be encountered and the plan for responding to these. Reports of completed drills indicated that satisfactory evacuation times were achieved; where a difficulty was encountered this was followed up by the person in charge to ensure that staff were familiar with the PEEP.

Staff on duty were seen to walk and talk a resident admitted for respite through the evacuation procedure.

Training records of staff were reviewed and it was noted that all staff had received fire safety training but one staff member was overdue refresher training in this area.

A risk register was in place which was reviewed by inspectors. The risk register contained centre-specific risk assessments along with risks assessments as they related to individual residents. Copies of such risk assessments were also contained in residents' personal folders. While the majority of risk assessments where observed to have been recently reviewed, inspectors did note some risk assessments which were overdue a review. In addition, it was observed that some of the documentation accompanying risk assessments was cumbersome and required review to ensure ease of retrieval of the relevant current information.

Systems were in place for risks to be escalated within the centre's overall governance structure depending on the risk rating applied and inspectors saw evidence that this system was followed. There was also evidence that risks which were of a high nature were kept under close review and any risks observed by inspectors to be present in the centre during this inspection were contained within the risk register.

A process for recording accidents and incidents occurring in the centre was in place. As part of this process, certain adverse events were escalated within the centre's overall governance structure, depending on the risks associated with the events. Inspectors were told that learning from any adverse events was shared with staff through regular staff meetings. Minutes of such meetings were reviewed and indicated that such issues were discussed. However, as will be discussed in Outcome 12, the review of, and learning from medication errors required improvement.

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 were measures in place for protecting residents for being harmed or abused; these measures included policies and procedures, staffing training, risk assessments, safeguarding plans, resident education, access to advocacy, designated persons and a multidisciplinary approach to safeguarding matters. However, the designated centre was not suited to meeting the assessed needs of each resident; this had a profound negative physical and psychological impact on residents and on their quality of life.

The provider had identified that the designated centre and the supports that could be offered there were not adequate to meet the needs of a resident. It was stated that the resident's need were not suited to a model of shared residential living and required one-to-one staff support for their safety and wellbeing. These needs were not compatible with the needs of the other residents and consequently had a significant negative impact on them and their quality of life. Minutes of a recent meeting convened to discuss these matters with the funding body clearly stated that the current arrangements could not continue given the risk and significant negative impact on residents. The concerns extended to the day service (attended by the residential residents); the concerns were described in a risk assessment seen as "grave".

The somewhat atypical impact on peers was well captured by staff and included increased anxiety and frustration, low-mood, confusion and failure to successfully complete activities of daily living, disturbed sleep patterns, incontinence and "out-of-ordinary behaviours". Residents were noted at times, including during the most recent unannounced provider review, to be startled and "jump" in their seat, physically pull-away and exhibit "apprehension" in response to a peer. It was of significant concern to inspectors that experienced clinicians when asked to review residents in response to these behaviours were challenged to be definitive in concluding that there may or may not be a clinical rationale for them. Clinicians did however categorically state that

residents experienced "anticipatory anxiety" and were "overwhelmed" by the behaviours and that their environmental triggers and stressors would have to be addressed before any further clinical assessment was completed.

The provision of respite in the house was restricted with reduced access and availability as the provider could not ensure that residents would be protected from harm.

Records seen indicated that the behaviour was unpredictable, impacted significantly and created risks for the resident, the other residents and staff.

It was of concern to inspectors that it was noted that residents had "learned to largely accept the behaviour, and to "no longer complain". One resident did tell inspectors that while she liked all of her peers she did not like the shouting, there were times when she was "kind-of" afraid and liked the house when it was quiet.

One -to-one staff support was now in place from 08:00hrs to 20:15; staff reported that the consistency of this had improved and it was of benefit to the resident and peers. A substantial amount of this staffing resource was however unfunded and was not certain to continue at the time of this inspection. At the time of this inspection there was no agreed solution-plan; given the impact on the resident, fellow-residents and families this is judged to be at the level of major non-compliance.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Records seen demonstrated that staff had good knowledge of residents, were attuned to any changes and sought advice and review from the respective general practitioner (GP), the multidisciplinary team (MDT) and other health professionals as appropriate to the assessed needs. Residents had regular access to psychiatry, psychology, neurology, social work, speech and language, dietetics, dental care, chiropody and ophthalmic services; records of referrals and reviews were in place. Nursing care if required was accessed in the community or through the GP practice nurse.

Staff explained that where access to a specific healthcare service to which the resident had an entitlement was not facilitated in a timely manner, the provider had facilitated

access.

Good inter-disciplinary working was demonstrated with regular communication between the GP and other health professionals.

Staff were seen to monitor residents' body weights monthly and sought to support residents to make healthy lifestyle choices. The person in charge said that residents decided on the menu, and that she monitored the variety and quality of both the food items purchased and the meals prepared.

Residents were supported to avail of annual influenza vaccination and to participate in health screening programmes.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
All of the actions that had issued for the last inspection were not addressed; inspectors concluded that there was inadequate oversight in relation to medicines management to ensure that practices were safe and residents received medicines as prescribed.

A medicines management policy was in place which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines, dated May 2016. The area manager and the person in charge advised that the policy was currently under review following feedback received from staff; the policy was described as "ambiguous" in some areas.

Medicines were seen to be stored securely. The person in charge confirmed that medicines that required stricter controls were not in use and no resident required medications to be administered in an altered format; crushed.

Medicines and pharmaceutical services were provided by a local community pharmacy. The pharmacist delivered medicines to the centre on a weekly basis; it was discussed with the person in charge how this arrangement could be maximised so as to facilitate the pharmacist to meet their obligations under relevant legislation and guidance issued

by the Pharmaceutical Society of Ireland.

A sample of prescriptions, administration records and monitored dose systems were reviewed. Prescriptions were seen to be legible; the instructions on the monitored dose system concurred with the prescription.

All staff had received medicines management training including the administration of prescribed rescue medicines. However, inspectors concluded that the training provided was not sufficient to equip staff with adequate knowledge and skills to administer medicines as prescribed. It could not be demonstrated that medicines were administered as prescribed due to the documentation practices in the centre. Staff continued to document 'blister pack' on the medicines administration record and therefore did not document the dosage, the name of the medicine and the method of administration as required by Schedule 3. It was again stated to the inspector that some staff had concerns as to their role and responsibility in ascertaining the accuracy of the content of the compliance aid as administered by them as they believed that it was not within the remit of their scope of knowledge and practice.

Medication related incidents were identified and reported on an incident form; medication related incidents were reviewed by the person in charge. However, based on a small sample of such incidents reviewed by the inspector there was a pattern to these medicines incidents; the failure by staff to administer the prescribed medicine at the same prescribed time (08:00hrs). The review of these incidents did not satisfactorily explore all possible causal factors for these repeat similar failings and focussed solely on individual staff accountability.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Management systems were in place to ensure that the centre was effectively governed and that action was taken to ensure that the service provided was safe, appropriate to

residents' needs, consistent and effectively monitored.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre; staff spoken with were clear on their respective roles, responsibilities and reporting relationships; staff had sound knowledge of residents, their needs and required supports.

The person in charge was employed fulltime and was suitably qualified and experienced. The person in charge had completed studies in both intellectual disability nursing and management. This was the only designated centre that the person in charge was responsible for.

However, the provider operated two designated centres in the locality and the area manager and both persons in charge worked in a collaborative and supportive manner. For example, the persons in charge worked opposite each other and worked alternate weekends; the area manager and both persons in charge operated an on-call system for staff; the person in charge said that this on-call did not impact on her substantive role of person in charge.

The area manager and both persons in charge were based in the adjacent day-service, met and spoke as necessary and met formally each Friday to discuss the operational management and administration of each centre. The area manager met weekly with her line manager, the head of community services.

The provider representative had commenced further meetings to which managers including the persons in charge were invited and could request items for discussion to be added to the agenda.

There were systems of audit and review within the centre itself, for example the review of accidents and incidents and the review of resident's personal plans for completeness. Arrangements were also in place for the completion of the annual review of the quality and safety of the care and supports provided and the six monthly unannounced visits as required by Regulation 23; reports were available to inspectors. The annual review incorporated feedback from residents and their representatives. The provider's own reviews as Required by Regulation 23 reported good practice, positive feedback and the degree to which previous actions had been implemented but also areas that were of concern such as the incompatibility of residents' needs as discussed in detail in Outcome 8. Where it was within her scope of responsibility, the person in charge recorded the action taken to address identified deficits.

Judgment:
Compliant

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:
Though the provider had taken action, inspectors were not satisfied that there were appropriate staffing levels to meet the needs of each resident; there was a requirement for one-to-one staff support that was not ordinarily available and that did not extend to night-time. Planned and actual rosters were not properly maintained in the centre.

Inspectors were not satisfied that there were appropriate numbers of staff to meet the needs of each resident. Since the previous inspection and in response to an escalation in residents' needs an additional staff member had been put on duty in the centre at specific times; this had assisted in addressing but not resolving the challenges faced by the incompatibility of residents' needs in one unit. Records seen recorded that there had been difficulty in putting and sustaining a consistent arrangement as agency staff contributed to this arrangement; this inconsistency was now reported to be addressed. However, much of the one-to-one staffing was unfunded and inspectors were advised that it was possible that it would not continue.

The night-time staffing arrangement was a one staff, sleeping-staff arrangement; there were recorded instances of staff and residents been awoken from 06:00hrs onwards; staff spoken with confirmed this. Once awake one resident required one-to-one staffing whereas there were four residents to be supported in the house.

Rosters in the centre were reviewed by inspectors. It was noted that neither a planned nor an actual roster was properly maintained showing all the staff members that were on duty in the centre. Specifically the roster did not show the additional staff member that had been added to the centre as highlighted above in paragraph two.

Inspectors reviewed training records of all staff working in the centre. It was recorded that staff had received up-to-date training in key areas such as safeguarding, de-escalation and intervention techniques in response to behaviours of concern, fire safety and manual training. However as noted under Outcome 7, one member of staff was overdue updated fire safety training. Training was also provided to staff in areas such as first aid and food safety.

Staff meetings were held on a monthly basis where issues such as residents' needs, complaints and health and safety were discussed. Since the previous inspection a formal system of supervision had been implemented. As part of this formal supervision meetings were now being provided to staff on a three monthly basis; minutes were available for review.

Staff files and the arrangements around volunteers had been reviewed at the previous inspection and were found to be appropriately managed; they were not reviewed during this inspection.

During this inspection positive interactions were observed between residents and staff.

Judgment:
Non Compliant - Major

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-0005178
Date of Inspection:	01 August 2017
Date of response:	12 September 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plan did not clearly demonstrate the sequential process of assessment, planning and review. The personal plan did not present and read as a single, comprehensive, integrated plan as referenced in the regulations and standards.

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 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
• All files now have clear references at the beginning of each section and it is also referenced in the personal information guide section of the My Profile My Plan (MPMP), indicating where specific documents are located within the file.
• Where documents are removed from the MPMP, to allow for easier accessibility for staff, the location of this document is clearly referenced at the beginning of each section of the MPMP.

Proposed Timescale: 12/09/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While there was a process for identifying and addressing barriers to achievement, there were goals that required review in this context, for example travelling on public transport.

The date of the most recent clinical review of the appropriateness of plan was not specified given that neurology review and care was current.

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:
• The PCP has been reviewed and the process includes the opportunities to address barriers. This will be monitored by the PIC on an ongoing basis.
• Barriers will be identified in a timely fashion.
• All epilepsy care plans have since been reviewed by Epileptologist's CNS & findings discussed with PIC. All epilepsy care plans have been signed off by resident's GP & kardex's reviewed to reflect details in epilepsy care plan.

Proposed Timescale: 12/09/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Some works had been completed; however, some areas in one house would have benefited from further modernisation and redecoration.

3. 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:
• An alternative residence for this house was purchased on 31st August to replace this house.
• This house will be upgraded so that it is compliant with fire regulations and will provide a new, safe and comfortable home for the residents. Tender for upgrade works will take place in October 2017.
• HIQA will be notified when the new house is ready so that it can be inspected
• It is planned that this house will be ready for occupation by 31st March 2018.

Proposed Timescale: 31/03/2018

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:
Some risks were overdue a review while the documentation around some risks assessments required review to ensure ease of retrieval of the relevant current information.

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

Please state the actions you have taken or are planning to take:
• These three risks have been reviewed on 30th August 2017.
• A plan is now in place that all risks will be scheduled to be reviewed one month prior to review date to prevent overdue reviews.

Proposed Timescale: 12/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Required fire safety works including the provision of emergency lighting had not been completed and there was no timeframe for their completion; inspectors were advised that the required financial resources were not available.

5. 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:
• CAS funding was been secured on 31st August 2017 to purchase a new house & relocate residents of above one house. New house will be fully compliant with Fire Regulations and will offer residents a comfortable and high standard of accommodation in advance of the residents moving to this new house. This is planned to take place by 31st March 2018.
• L1 Fire System, Emergency Lighting and a number of essential Fire Door Sets will be installed in the second house in the designated centre by 31st October 2017.
• Fire Safety measures are consistently carried out in the Designated Centre to ensure the safety of residents in the centre in relation to fire. This includes daily checks by staff, weekly checks by the person in charge as well as weekly tests of the fire alarm. Staff carry out drills monthly and all fire related equipment is tested quarterly including one deep sleep drill a year.
• House specific evacuation plans have been devised for the houses in the designated centre.

Proposed Timescale: 31/03/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One staff member was overdue refresher training in fire safety.

6. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
• Person in Charge has been booked in for Fire Safety Training on 21st September 2017.

Proposed Timescale: 21/09/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The designated centre was not suited to meeting the assessed needs of each resident; this created risk and had a profound negative physical and psychological impact on residents and on their quality of life.

7. 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:
• Consistent 1:1 support staff is in place with one particular resident from 8am-8.15pm since Jan 2017.
• Additional hours will be allocated from 19th September 2017 to fully support the resident in the morning when the resident is awake and throughout the time in the evening until the resident retires to bed.
• Risk assessments & Safeguarding plans are in place for the residents who are at risk & all staff working with them are aware of these plans & risks.
• The BOCSIL reviewed the delivery of respite in this house as part of the Admission Discharge and Transfer process and it was agreed that the delivery of the Respite service would be limited to a time that the resident presenting with challenges was not in residence.

The Provider is currently reviewing the appropriateness of placements and an action plan will be submitted to the Deputy Chief Inspector by 27th October 2017.

Proposed Timescale: 27/10/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate oversight in relation to medicines management to ensure that practices were safe and residents received medicines as prescribed.

The medicines management policy was described by staff as "ambiguous" in some areas.

The training provided was not sufficient to equip staff with adequate knowledge and skills to administer medicines as prescribed.

It could not be demonstrated that medicines were administered as prescribed due to the documentation practices in the centre.

The review of medicines incidents did not satisfactorily explore all possible causal factors for repeat similar failings and focussed solely on individual staff accountability.

8. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable

practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
• Medication Management Policy was reviewed following the last HIQA inspection. The revised policy will be submitted for approval to the Policy Review Group 19/09/17.
• Medication Management Training has been reviewed in light of the revised policy. 3 staff have been booked into Train the Trainer training in relation to medication management (SAMS). Dates of this training September 27th, 28th and 29th, October 19th and 20th and November 14th and 15th 2017.
• Following completion of this "Train the Trainer course" revised medication management training will be commenced for all non nursing staff in 2018.
• Monthly audits carried out by the Area Manager will continue in the centre.
• PIC will carry out monthly audit of PRN medication.
• PIC will carry out monthly review of PRN administration chart.
• PIC has instructed staff in the designated centre that medication must be checked prior to signing.
• In additional clear instruction has been placed in medication press to inform staff to double check that medication has been administered, prior to signing for medication.
• PIC has instructed staff in the designated centre that it is their responsibility to visually identify each tablet matches kardex prior to administration
• In addition clear instruction has been placed in medication press to inform staff of their responsibility to visually identify each tablet matches kardex prior to administration.
• A protocol to be developed in line with the revised Medication management policy due for review on 19th September 2017 that will ensure learning from medication errors.

Proposed Timescale: 30/06/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Rosters did not show all staff that were working in the designated centre.

9. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
• Both actual & planned roster will include the 1:1 support staff member who works in the designated centre.

Proposed Timescale: 12/09/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that there were appropriate staffing levels to meet the needs of each resident; there was a requirement for one-to-one staff support that was not ordinarily available and that did not extend to night-time.

10. 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:
- Consistent 1:1 support staff is in place with one particular resident from 8am-8.15pm since Jan 2017.
- Additional hours will be allocated from 19th September 2017 to fully support the resident in the morning when the resident is awake and throughout the time in the evening until the resident retires to bed.
- Risk assessments & Safeguarding plans are in place for the residents who are at risk & all staff working with them are aware of these plans & risks.
- The BOCSIL reviewed the delivery of respite in this house as part of the Admission Discharge and Transfer process in 2016 and it was agreed that the delivery of the Respite service would be limited to a time that the resident presenting with challenges was not in residence.

Proposed Timescale: 19/09/2017