Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	East Limerick Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	10 September 2019
Centre ID:	OSV-0004779
Fieldwork ID:	MON-0021540

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The provider described the centre as one which 'is committed to providing person centred and person directed service that support life choices of service users.' East Limerick Services provides a full-time residential service. Accommodation is in four single-storey houses. Each house has a sitting room, kitchen, single occupancy bedrooms, modified sanitary facilities and laundry facilities. Three houses are grouped together and the fourth house is approximately 16 kilometers away. All houses are on the outskirts of two rural towns in Limerick. Between three and five residents live in each house. There are staff working in the centre at all times. The service is available to both male and female adults with a diagnosis of an intellectual disability.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
10 September 2019	09:15hrs to 18:50hrs	Caitriona Twomey	Lead
10 September 2019	09:15hrs to 18:50hrs	Margaret O'Regan	Support

What residents told us and what inspectors observed

Inspectors met with 12 of the 13 residents who were in the centre on the day of inspection.

Many of the residents had limited verbal communication. Those who did speak to inspectors were generally positive about the care they received. However, one resident spoke about their upset and frustration with the current behaviour of a peer. They had made a formal complaint about this. It was reasonable to assume residents who were not verbal communicators were also affected by the same matter.

It was clear that several residents took great pride in their bedrooms and had chosen how they were decorated. Inspectors were invited to see these rooms by the persons who occupied them. Another resident invited inspectors to have a cup of tea with them and communicated their interests and upcoming activities using their own unique system of communication.

Residents looked at ease in the company of staff, approaching them regularly and appearing to enjoy these interactions. All residents were up, well dressed and had access to outdoor areas. Residents were observed listening to music, engaging with staff, arranging their bedrooms and attending to gardening. For several residents, especially those with limited verbal communication, there appeared to be minimal engagement in meaningful activities.

Capacity and capability

While progress was noted in certain areas, significant improvement was required to ensure that a safe and high quality service was provided to the residents in this centre. A number of the non-compliances with the regulations identified during this inspection have been identified in previous reports. For example, in July 2018 and again on this inspection it was identified that residents' needs were not being adequately met. There were also longstanding issues regarding compliance with the regulation relating to fire precautions. Overall given the number of not compliant findings identified during this inspection and their significance, inspectors were not confident that the provider could ensure the effective governance, operational management and administration of this designated centre.

This centre has had a number of persons in charge since the introduction of regulations in 2013. This in itself has left the centre vulnerable to maintaining robust management arrangements. At the time of this inspection HIQA had not been informed of a permanent change to the person in charge of the centre. As a result

some correspondence from an inspector had not been received by staff. Consistent with previous reports, there continued to be incidents of management not informing HIQA of certain adverse incidents in a timely manner.

The challenge experienced by the provider in ensuring that the designated centre and the services provided were suitable to meet the needs of each resident was very evident on inspection. An identified risk regarding the impact of one resident's presentation on the quality of life of other residents required urgent review. Inspectors were not satisfied that this risk and its impact on residents were accurately assessed. This will be discussed in more detail in the quality and safety section of this report.

It was not clear that the complaints procedure in the centre was effective due to the various places information was stored. A complaints log was maintained by the person in charge. There was also a local issues book in each house in the centre which contained complaints made by, or on the behalf of, residents. If complaints could not be addressed by staff in the centre, they would then be included in the log. There were three entries in the complaints log for this year, two of which related to residents' dissatisfaction with their current living situation because of a peer's presentation. During the inspection, the person in charge informed inspectors that these complaints would be escalated to senior management in the following days. The annual review contained feedback from a relative of a resident that included complaints. Although it was noted that the person in charge would meet with this person, it was not documented how the identified issues were addressed or the complainant's satisfaction with actions taken, as is required by the regulations.

There was insufficient staffing in the centre on the day of the inspection. In one house instead of two staff members, there was only one working. As a result residents in this house were unable to access the community, as they would have liked. One of the inspectors reviewed the staff rota for two separate weeks, selected at random, in the previous six months. It was identified that the same house was similarly short staffed on two days in that time period. The person in charge had identified a risk in the centre regarding the provision of nursing staff in line with the centre's planned rota. On four occasions in recent months there was no nurse working in the centre. Although this had been identified and actions taken to address it, it remained an ongoing risk in the centre. Throughout the inspection various examples were identified where the number of staff working in the centre had resulted in residents not accessing preferred activities and outings. It also appeared to act as a barrier to everyday activities such as residents buying groceries in the local area. It was an action from the most recent six monthly visit that a risk assessment be completed to assess the impact of staffing levels on residents' quality of life. Staffing levels had also negatively impacted on the provision of one-to-one supervision sessions, with many needing to be rescheduled. In the majority of these instances the full staffing complement had been available however competing demands, such as supporting residents to attend medical appointments, had taken priority.

It was recognised that some aspects of management of the centre had improved. These included improved care planning processes, the arrangement of more in-

house activities for residents, the person in charge spending scheduled time in all parts of the centre, and the implementation of a plan to reduce medication errors. There was also good oversight of staff training in the centre. There were three staff who required refresher training in the management of behaviour that is challenging and they had been booked to attend these sessions in the coming months. A supervision system was implemented in the centre and the feedback regarding this was very positive. As previously outlined, there was a challenge in having these sessions as regularly as planned. An annual review and two six monthly visits had been completed. These documents were comprehensive and outlined many of the issues identified on this inspection. One notable exception to this was the finding regarding fire doors being routinely wedged open. This finding prompted an urgent compliance plan and will be outlined in more detail, when discussing quality and safety, later in this report.

The provider had agreed in writing, a contract of care with residents and, where appropriate, with their representative. The contract included the care and support to be provided and the fees to be charged. An easy to read version of the contract was also available. There was positive feedback from the family of one resident who had moved into the centre in recent years. It was documented that they felt the resident had a bright future there. There was one vacancy in the centre and work was ongoing regarding a possible admission. The multidisciplinary team was involved in such decisions and the views of the person who may move into the centre were given priority. In this instance, the proposed new tenant expressed a wish to live in the city rather than the countryside, where this house was located. Therefore, it appeared unlikely that the admission would go ahead.

Regulation 15: Staffing

The registered provider did not ensure that the number of staff in the centre was appropriate to the number and assessed needs of the residents and statement of purpose of the designated centre. The information and documents outlined in Schedule 2 of the regulations were not examined during this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to mandatory training, including refresher sessions. The person in charge had arranged her working week to ensure she spent at least one day in all parts of the centre every week. A one-to-one supervision system was also in place.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was not resourced to ensure the effective delivery of care and support. The systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The person in charge was proactive in ensuring that a prospective resident was provided with an opportunity to visit the centre, as far as is reasonably practicable, before a possible admission to the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

It was not clear if the statement of purpose had been reviewed within the previous year as it was not dated. However it contained information that was no longer accurate and did not contain all of the information set out in Schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all adverse incidents were notified to the chief inspector within the timeline specified in the regulations.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider did not notify the chief inspector of the absence of the person in charge within the timeline specified in the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were recorded in various documents. It was not evident in all of these documents what the outcomes were of the complaint, what actions were taken and whether the complainant was satisfied, as is required by the regulations.

Clear expressions of dissatisfaction received as part of the annual review process were not recorded in line with the provider's complaints procedure. Following discussion with the person in charge, an inspector was assured that these issues had been effectively addressed.

Judgment: Substantially compliant

Quality and safety

Overall the quality and safety of the service provided to the residents living in the centre required further improvement. Some of the non-compliance's with the regulations identified on this inspection have been identified previously. An urgent compliance plan was issued following the inspection to address two specific issues. The findings that prompted this action are outlined below.

The provider had improved the fire safety systems in the centre. The fire alarms and emergency lighting systems had been upgraded in all four houses. These systems and firefighting equipment were serviced regularly. Fire doors were in place in three of the four houses. The provider acknowledged that there were inadequate containment measures in one house. This was a longstanding issue. Inspectors identified that the self-closing mechanisms on some fire doors were not effective. In addition, fire doors were routinely wedged open in some laundry areas. As these are high risk areas for fire, the provider was requested to urgently address this issue.

The person in charge outlined that staff would support each other if a fire was to occur in any of the three houses that were beside each other. The procedure to be followed in such an event was not documented. It was not clear how the support needs of residents would be met should staff leave to help in one of the other houses. In addition, although fire drills had been completed, the evacuation times were not always noted on the record. It was therefore not possible to tell if the evacuation arrangements in the centre were adequate. It was also identified that

one relief staff member had not attended training in fire safety and prevention.

On previous inspections it was noted that, at times, residents did not get along with each other. This had resulted in a negative living experience. While those specific circumstances had been addressed, there were similar findings on this inspection. Residents who had verbal communication skills had made complaints about the situation. In the short term, the provider had arranged medical and multidisciplinary reviews, made changes to the living environment and provided periods of one to one staffing for one resident. Inspectors found that the risk assessment regarding this matter did not reflect the current situation. Although the control measures outlined were still in place, they were no longer effective. Given the significant impact of this ongoing situation on the resident and those living with them, inspectors requested that this risk assessment and associated control measures be reviewed as a matter of urgency. Other improvements were also required regarding risk management as not all hazards had been identified and assessed. Examples included the storage of oxygen, lone working, and the use of laundry equipment in a room without ventilation.

There were demonstrated efforts to make the centre homely. As referenced earlier in this report some residents took great pride in their bedrooms and belongings. Residents were involved in selecting the paint colours in various rooms throughout the centre. Portraits of residents and other photographs were on display. Parts of the premises required maintenance. For example, there was flaking paint in communal areas and some bedroom walls required areas to be plastered and painted. This matter had been identified in a 2015 inspection. It was subsequently addressed but was an issue again on this inspection, although to a lesser degree. The lack of ventilation in some of the laundry areas had also been identified previously. Although the centre appeared clean overall, cobwebs were observed in some bedrooms. There was a good variety of seating available. However, several armchairs had damaged upholstery and were in need of repair or replacement.

There were examples of progress in relation to the documented care and support that residents received. It was clear that time had been spent developing residents' personal histories, with the aim of building on their strengths and abilities. From discussions with staff, it was evident that gathering this personal information had been a valuable learning experience. It aided staff in having a good understanding and sensitivity for the residents they supported. However, this understanding alone did not always lead to residents experiencing the best possible life or achieving the goals set out in their personal plans. As previously outlined, staffing resources had a significant impact on residents' opportunities to leave the centre. Staff shortages or other pressures on staff time frequently resulted in planned activities being postponed or cancelled. One resident, for whom routine was particularity important, had a goal to go swimming on a specific day; however, the date and time of this swim was dependent on staff availability and the evidence was that at times staff were not available. A similar situation arose with the planned goals of residents to take part in equine therapy. It was not unusual for these trips to be cancelled. Overall, additional improvements were required to ensure that residents received support consistent with their personal plans.

From the documentation examined, discussions with staff and observations, inspectors concluded that any health issues that arose were recorded and appointments were made, where required, with relevant health professionals. For example, one resident with digestive system issues was referred to, and attended, a gastroenterologist in a timely manner.

The majority of residents living in the centre were non-verbal communicators. As previously mentioned one resident had developed their own unique communication system which appeared to be very effective. There were no communication systems or individual supports in place for most residents. The person in charge outlined the introduction of visual aids to support residents' understanding of which staff were on duty in one house, but this had not been implemented across the centre. With the exception of one, staff had not received training in communication methods. Staff were therefore not in a position to support residents with these substantial support needs.

The number of activities available in the centre had increased in the previous year. These included regular sessions of art, music and dog therapy. As a result, some residents had identified new interests. Despite these new opportunities, levels of participation in meaningful activities appeared low. On the day of inspection, many residents were observed sitting in various parts of the centre, seemingly not engaged in any activity. This had also been noted in the most recent six monthly visit report completed by a representative of the provider. Access to day service had improved for one resident; however, another resident's day service had ended (due to health and safety issues at the centre). Another appropriate day service for this resident had yet to be arranged. This change, and therefore absence, of service was believed to contribute to an increase in behaviours that were challenging for the resident concerned, other residents and staff. Overall residents' access to facilities for occupation and recreation was inadequate.

Regulation 10: Communication

The registered provider had not ensured that each resident was assisted and supported at all times to communicate in accordance with their needs. As a result opportunities for residents to actively participate in many aspects of their lives, including decision making, were limited.

Judgment: Not compliant

Regulation 11: Visits

Residents were facilitated to receive visitors in accordance with their wishes.

Judgment: Compliant

Regulation 12: Personal possessions

As far as reasonably practicable, residents had access to and retained control of personal property and possessions. Where necessary, support was provided to manage their financial affairs. There was demonstrated good practice regarding the management of residents' funds.

Judgment: Compliant

Regulation 13: General welfare and development

Residents access to facilities for occupation and recreation were inadequate. The lack of engagement in meaningful activity observed during this inspection indicated a poor quality of life for many residents living in the centre. This was compounded by the limitations to residents leaving the centre to access other activities or their local community.

Judgment: Not compliant

Regulation 17: Premises

Parts of the premises were not maintained in a good state of internal repair and decoration. Cleaning in some areas also required improvement. Suitable ventilation was not provided in all laundry areas.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider failed to ensure that the system in place for the assessment, management and ongoing review of risk was effective. An urgent compliance plan was issued regarding the need to review and update one risk assessment due to the high risk it posed to residents' wellbeing.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had not made adequate arrangements for containing fires in the centre. An urgent compliance plan issued regarding the routine practice of wedging fire doors open in some laundry areas. It was not clear that the arrangements in place for evacuating all persons were adequate. The procedures to be followed in the event of a fire were not readily available. One relief staff member had not attended training in fire safety and prevention.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Arrangements in place to meet the needs of each resident were inadequate. Despite an improved care planning process and enhanced participation from residents and their representatives, there was evidence that implementation of these plans was inconsistent.

Judgment: Substantially compliant

Regulation 6: Health care

Medical care was provided to residents in a timely manner.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant

Compliance Plan for East Limerick Services OSV-0004779

Inspection ID: MON-0021540

Date of inspection: 10/09/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• It is the intention of the PIC to cover all approved rosters for this designated centre.
• While challenges remain in terms of filling the roster at all times the following is in place to address this challenge:
o Efforts are being made on an ongoing basis to recruit staff. The latest round of interviews for Care Assistant staff took place on 28th September 2019 and a number of individuals have been offered contracts of employment. This will increase the pool of relief staff to cover rosters. New staff will be in place in December 2019.
o Back to work interviews are used in an effort to support staff positively on return to work from sick leave and to address the level of sick leave in the centre.
o PIC engages with managers from the wider service who assist with staff support when their rosters allow.
o Director of Services has sanctioned Agency staff for both nursing and care assistant lines if rosters cannot be filled. This can be inconsistent in terms of reliability of sourcing agency staff.
o Risk assessments are now completed in terms of supporting residents in hospital and priority is given to maintaining the roster in the designated centre.
o Arrangements are in place to cover the roster in relation to nursing cover with the cooperation of a larger service area with the wider services.
o Where relief nursing is not available a risk is in place to manage the skill mix deficit. This is reviewed on a quarterly basis.
o Risk Assessment has been completed in respect of the risk of not filling the funded roster and its impact on quality of life on residents.
o Once this risk is mitigated and the roster is being filled on a consistent basis the Person in Charge will then consider the requirement to complete a risk assessment in respect of additional staffing over and above the funded levels if there continues to be an impact on the quality of life of residents.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Statement of Purpose and function is currently being updated to accurately reflect the governance and management of the centre and to ensure it contains all the information required in Section 1.
• The responsibility of the PIC has reduced from 2 designated centres to 1 designated centre from 1st April 2019 to enhance the governance structure.
• Acting CNM2 is currently PIC of the centre. Following the inspection this arrangement has been notified to HIQA by the Provider Representative.
• Permanent full-time CNM2 PIC role is currently advertised. Closing date for applications is 10/10/19. Once recruited, this will bring consistency to the governance and management of the centre.
• In the event that PIC is on leave CNM1 provides local governance and management oversight and has access to the PPIM for guidance and direction as required.
• On call support is available 24/7 via Bawnmore management at times when center management are off shift.
• All staff are scheduled for support and supervision.
• Training has been scheduled for CNM1's in order to enable them to support the CNM2 in the provision of support and supervision for all staff. This training will be completed by 31st November 2019.
• On a monthly basis the PIC attends a meeting of the wider PIC group where learnings from HIQA inspections, unannounced inspections and other relates areas are shared.
• PIC attended monthly meeting with Management Team of 3 other designated centres for peer support in October. The attendance at this monthly meeting will be prioritized into the future.
• Clerical Officer will audit Fire Safety Registers on a monthly basis and report findings to PIC.
• Fire Safety engineer has been requested to provide guidance and support to the PIC in relation to the fire drill process.
• System that is in place for monitoring training by the PIC will be updated to ensure the information is accurate and up to date.
• Risk assessments identified during the HIQA inspection have been completed and will be reviewed as part of the quarterly review process.
• System for monitoring complaints on a monthly basis will be developed to ensure all complaints are follow up and escalated where required if they have not been addressed to the satisfaction of the complainant.
• PIC will introduce a system for overseeing the level of activities (both individual and group) taking place for residents and the extent to which planned activities are taking place.
• PIC will introduce a system for monitoring of the cleaning of each house.

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • PIC is currently updating the Statement of Purpose for East Limerick Service and ensure same is dated and reviewed at least annually. This will be completed by 31st October 2019.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Clerical Officer has access to HIQA portal to input information. • In the event that PIC is on leave, Clerical officer will access HIQA portal and CNM, acting up, will complete relevant notification within the required timeframe.	
Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent: • Provider Representative has now forwarded the NF30A in respect of the PIC. • Any future periods of absence or changes to the PIC will be notified to HIQA within the timeframe.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The Person in Charge placed a visible Easy to Read Complaints policy up in the hallway of each house in the designated centre following the inspection.	

• The Complaints procedure requires that the staff involved in the management of a complaint sign off to confirm that the complaint has been handled to the satisfaction of the complainant or that the complainant has been provided information and support to escalate the complaint as appropriate. The PIC will ensure that this takes place as part of their oversight of the centre.
• The complaints procedure requires the PIC to complete a summary of informal complaints in their area on a monthly basis. The PIC will use this review to ensure that the complaints procedure is being implemented appropriately.
• Complaints identified through other sources of engagement e.g. Annual Review Process will be channelled through the complaints procedure. This has been communicated to all PICs as part of monthly engagement between the provider and the persons in charge.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Communication supports will be discussed as part of the MDT process over the next year to ensure that all individuals are supported in this area to the greatest extent. The appropriateness of referring for a private SLT evaluation for communication needs will be discussed for each resident who communicates non-verbally. Outcome of discussion will be reflected in MDT meeting minutes and recommended follow up actions taken. This will be rolled out in line with the organisations Personal Assets policy.
• All non-verbal individuals who use the service have a communication passport. All communication passports will be reviewed and updated by the keyworker by January 2020.
• Guide to communication (Mencap), will be distributed to all keyworkers to ensure that relevant information is expanded on in communication passports when being reviewed. This is an information piece on communicating with people with a learning disability and will be used to support staff. This will be discussed at the next staff meeting.
• Reconfiguration for one post into two posts one in SLT and one OT has been agreed by Senior Management. A business case was discussed with the funder at a business case meeting on 11th October 2019. Business case is under consideration.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• As reflected in the report significant effort has been made in the past 12 months to increase the level of activities available to residents. To this end a number of in house

activities have been sourced and are provided on a sessional basis (e.g. Pet therapy, music therapy, mindfulness, art therapy, crafts/clay modelling).
• On occasion residents choose to opt out of activities. This choice is supported but the services continue to explore and offered activities that may be of interest.
• As adequate staffing is key to supporting activities on a consistent basis on-going recruitment has taken place with a view to ensuring consistency in staffing and skill mix in line with the agreed roster.
• A weekly schedule of activities is in place for each resident.
• Going forward the PIC will seek feedback from staff on the extent to which planned activities are carried out to feedback on any activities missed and rationale for same. This will be discussed at staff meetings with a view to maximizing the use of existing resources in order to facilitate activities to the greatest extent possible.
• Following the HIQA inspection the PIC has sourced information on the 'Hanging out Programme' for people at risk of isolation.
• The PIC will bring this programme to the attention of staff in the area and the multidisciplinary team with a view to considering if it's implementation in the designated centre would be beneficial in supporting increased interactions and activations for residents who communicate non verbally.
• Pending agreement from staff and MDT that this would be a positive initiative the programme will be piloted for a 3-month basis following which a decision will be made, again in consultation with staff and MDT on the benefits of same to residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Following verbal feedback as part of the inspection immediate action was taken to remove Cobwebs from bedrooms and ensure all parts of centre are clean.
• Facilitated Manager is aware of issues with plastering on walls in some areas as a result of damage to roof. This is currently being explored with the builder who managed the project with a view to getting this corrected. A meeting has now been agreed for 24th October 2019.
• Repair damage to paintwork and review with maintenance manager to query putting a protective barrier in place (damage caused by wheelchair)
• All broken/damaged furniture will be repaired/replaced by the 31st December 2019.
• Cleaning schedules to be reviewed and cleaning inspections to be carried out for a period of 3 months to ensure full implementation.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The risk in relation to the impact of one resident's presentation on other residents' quality of life was identified on 26/11/18 following a number of complaints as evidenced in local issues book and informal complaints process; and increasing incidents of challenging behavior as evidenced on AIRS forms. • As noted in the report the interventions introduced to support residents were effective in minimizing the impact to peers as evidenced by marked decrease in incident reporting and decrease in administration of PRN medication which is given at times of acute distress and agitation. • The resident's presentation deteriorated in August 2019 following a number of significant changes outside of the organizations control. • With input from CNSp Positive Behaviour Support, Psychology, CNM's, day service staff and frontline staff, the following recommendations were implemented: o Resident seen by GP on two occasions o Psychiatry review o Dental review o Supporting family engagement to adjust to new family circumstances o Amending activity timetable and a clear focus on activities of preference o Identifying triggers of behaviours of concern (e.g. transition periods) and putting supports in place. o Daily physical exercise o Complaints have been escalated to the complaints officer by PIC on 12th September 2019. o Director of Services met with PIC on 11th September as part of a scheduled support and supervision meeting in order to support the PIC and to witness the behavior of the resident. o Director of Services met with a number of residents and staff to provide assurances and acknowledge the difficult situation. o Appointment with Consultant has been arranged for individual on 16th September 2019 in the designated centre. o Emergency MDT meeting called after this appointment on 16th September 2019 to review current actions and consider further mitigations. o MDT will explore the possibility of making recommendations in terms of internal transfers within the designated centre that will alleviate the current risk. o If contingency is not implementable a business case for an individualised service will be submitted to the funder for priority consideration seperate to the designated centre. o Senior Psychologist met with a number of residents on 13th September to discuss the current situation to validate how they were feeling and to acknowledge how difficult the current situation is for them. o On behalf of peers, the following has been implemented: o On-going support from frontline staff o Peers are supported to return to their homes and a quieter area during periods of loud vocalization in order to minimize the impact. o Psychology support on a weekly basis o Complaints Officer visited the Centre on 30/09/19 and met with one of the complainant's. • Further MDT review took place on 03/10/19. It was noted that there is a significant	

improvement in the presentation of the individual and the impact on the other residents has reduced. This has been evidenced through engagement by psychology with residents on 4th October 2019.
• OT sensory assessment scheduled for 10/10/19 has commenced and the timeline for the conclusion of this assessment is 24/102019.
• If recommended a business case for an alternative residential model of service will be submitted to the funder.
• Risk Assessments in respect of Lone working, staffing levels in the context of quality of life of residents, and management of oxygen have been completed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: In consultation between DOS, Facilities Manager and Fire safety engineer, the following has been agreed and actioned:

• All wedges have been removed with immediate effect from the doors of the laundry and any signage stating that the doors are to be left open have been removed.
• Staff have been advised how to close the doors to the laundry properly so as to ensure that they are effective as fire doors. Person in Charge completes checks to ensure that staff are closing the doors properly. This will be further reinforced at staff meetings.
• Initially it was confirmed to HIQA as part of an immediate plan that new fire doors sets would be ordered for the laundry rooms. It has since been confirmed by the fire safety engineer that the doors in place are fire doors and the requirement to close them properly. Staff have been advised and the fire safety engineer is visiting the centre on 16th October to provide support.
• Facilities Manager visited the houses on 13/09/19 to review the laundry rooms with a view to exploring the possibility of installing a vent through the wall or roof in order to provide ventilation. Further consultation required to identify optimal solution. Planned solution will be agreed by 18th October 2019 and implementation will be completed as a priority.
• Staff will be reminded not to use Dryers and washing machines after 8pm in the Centre.
• Clerical Officer will audit Fire Safety Registers on a monthly basis and report findings to PIC. This review will be discussed at staff monthly meetings to ensure compliance.
• Fire Safety is discussed at staff meetings on a monthly basis.
• Fire drill reports will include exact evacuation times. This was discussed at staff meeting on 26/09/19. Any identifiable risks will be discussed also and mitigations put in place. Local operational fire drill will be reviewed and distributed by end of November 2019.
• PEEPS will be reviewed for all residents by end of November 2019.
• Fire Safety engineer will support the PIC in the strategy around fire evacuations and fire safety procedures in the designated centre. This engagement will take place on 16th October 2019.

• The PIC has engaged with the training department and has confirmed that all staff are currently trained in fire safety. The maintaining of the local log of training will be updated to ensure that it is accurate and real-time. • While three of the bungalows are fully certified as being fire compliant by a fire safety engineer one bungalow remains not in compliance. This bungalow will be included as part of the HSE fire safety review currently in progress within the Brothers of Charity Services Ireland Limerick Region. While queries have been raised with the HSE in respect to when the review of community houses will taken place (the bungalow in this designated centre comes under this grouping) the date for this review has not been confirmed by the HSE.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Each resident is supported to develop a Person Centered Plan on an annual basis. • Staff work with residents to achieve their priorities. • Plans are reviewed quarterly and going forward staff have been advised to link with the PIC in the event that there are challenges to supporting priorities. • Where a challenge is identified PIC will work with staff and residents to explore alternative means of supporting the priority for the resident (e.g. changing time table of activities, use of natural supports to support an activity etc.). • As adequate staffing is key to supporting priorities on a consistent basis on-going recruitment is underway with a view to ensuring consistency in staffing and skill mix.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/11/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	31/12/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2019
Regulation	The registered	Substantially	Yellow	31/12/2019

13(2)(c)	provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Compliant		
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	31/12/2019
Regulation 15(1)	The registered provider shall 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.	Not Compliant	Orange	31/12/2019
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	11/10/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	30/11/2019

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	11/10/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Red	31/10/2019

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	31/12/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	16/10/2019
Regulation 28(4)(a)	The registered provider shall 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.	Substantially Compliant	Yellow	11/10/2019
Regulation 28(5)	The person in	Not Compliant	Orange	11/10/2019

	charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/10/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/10/2019
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	11/10/2019
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the	Not Compliant	Orange	11/10/2019

	registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the information referred to in paragraph (2).			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	11/10/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2019
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs	Not Compliant	Orange	31/12/2019

	of each resident, as assessed in accordance with paragraph (1).			