

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004782
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	Noelle Neville
Type of inspection	Announced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 December 2015 09:30	07 December 2015 19:30
08 December 2015 09:00	08 December 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This inspection was the second inspection of the centre by the Authority. The previous inspection undertaken in January 2015 was the first inspection of the centre and based on those inspection findings three major non-compliances were identified and the provider was issued with an immediate action plan to address the night-time staffing deficit and the associated risk. The provider responded positively to the immediate action plan and an additional staffing resource was put in place.

These inspection findings confirmed that the provider had responded positively to the overall inspection findings and the action plan and the actions identified by the provider as required to address the identified failings had been substantially implemented.

In addition to addressing regulatory non-compliance the inspection findings were positive in the context of work done by staff in conjunction with members of the multi-disciplinary team to achieve good practice and enhanced quality of life outcomes for residents. This was particularly evident in the improvement noted in the quality of personal plans, in the area of communication and social well-being and integration. Given the high needs of the residents and the potential predominance of health and physical well-being this achievement by staff was acknowledged at verbal feedback by inspectors.

There were challenges to the delivery of services and the operational management of the centre but there was clear and consistent evidence that the service self-regulated, issues were identified, addressed or managed to ensure the consistency, safety and quality of the care and services provided to residents.

Prior to the inspection residents and relatives had been invited to complete on a voluntary basis questionnaires to ascertain their experience of the care and services provided. Seven relatives and three residents returned completed questionnaires and the feedback received from both was positive overall. Residents said that they "loved" living in the centre and had their needs attended to by staff that they liked and who made them feel safe. This would concur with the feedback provided directly to inspectors by residents who could provide feedback.

Relatives spoke highly of the staff and the care and attention provided to their family member and to them. Relatives derived their opinion from direct interaction with staff, their observations when in the centre and the well-being and contentment of their family member.

Of the full eighteen outcomes inspected the provider was judged to be compliant with thirteen and in substantial compliance with two. Three moderate non-compliances with three outcomes were identified; contracts for the provision of services, the maintenance of some equipment and failings in infection prevention and control procedures.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Records seen, residents and staff spoken with and feedback received from relatives surveyed indicated that resident's rights including their right to dignity and consultation were respected by staff.

House meetings were convened weekly in each house and records of these indicated that residents were consulted with as to their preferred activities for the week and their preferred meal choices. Residents agreed person centred priorities were also discussed as to their status as were issues such as safeguarding and the forthcoming inspection by the Authority. However, the robustness of the meetings would have been enhanced if agreed actions such as activities requested by residents were followed up as completed by staff at the next meeting.

Residents were seen to be given choice and control over their daily routines such as when they got up, what they wished to wear and what they wished to eat.

There was evidence that as appropriate to their needs residents were consulted with as to decisions in relation to their care and supports; records were maintained of such consultations.

A complaints log was maintained and evidenced that residents and relatives were comfortable in bringing issues to the attention of staff. There was evidence that the matters complained of were listened to, recorded, investigated and resolved or actions were in progress to resolve them. There was evidence of further action taken to support residents while awaiting completion of these actions such as visits to friends and peers.

Residents had access to an easy read format of the complaints procedure and a complaints box that they were aware of. Complaints and their management were monitored by the person in charge.

Inspectors reviewed the systems for the management of residents' finances and were satisfied that they supported transparency and accountability. Records including receipts and the purpose for which monies were used were retained, countersigned checks of balances were undertaken by staff daily and monthly reports were submitted by staff to the person in charge. No discrepancies were noted in the records seen by inspectors.

The provider operated a structured advocacy service. One resident was the local advocate; there were local weekly meetings and monthly regional meetings. Matters raised included protection policies, activities, holiday planning and concerns in relation to staff shortages and the impact this may have on the supports provided. There was evidence that concerns were addressed, services were maintained but as necessary matters were escalated to the provider nominee.

There was evidence that resident's religious choices were ascertained and facilitated by staff. Mass was said in the centre on a regular basis and the centre was in close proximity to the local church and was included in residents walks with staff if they so wished.

The person in charge confirmed that the issue of residents exercising their right to vote as appropriate had not been explored to date by staff.

Judgment:
Substantially Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
There was evidence of significant work done and good practice achieved in the area of communication; this had been achieved by staff in conjunction with members of the multidisciplinary team.

Given the nature and extent of their disability many residents could not and did not communicate verbally. Based on their knowledge of residents, staff had created "communication dictionaries" for each resident; these effectively set out how to interpret

cues, gestures, behaviours and vocalisations so as to support staff understanding of what the resident wanted and what the appropriate staff response should be. These dictionaries were very detailed and person-centred. In addition the resident had a life story booklet that included narrative and photographic information on the resident, their life, likes and dislikes. Again these were respectful of the resident's personhood rather than their disability. Inspectors as people not known to the residents fully appreciated the benefit of both the communication diary and the life story booklet in getting to know the residents and how best to communicate and interact with them. Likewise staff who worked on a relief or part-time basis confirmed that these were working reference documents of benefit to them.

Further evidence of the use of augmentative communication strategies included the use of a visual staff roster and a visual meal/menu planner.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Having spoken with staff and reviewed records including the questionnaires completed by family members it was clear that maintaining, developing and supporting family relationships and social integration for residents was central to the provision of care and services.

There were no reported restrictions on visits to the centre and some residents continued to enjoy visits to their home and family. As both residents and their families advanced in age staff provided the necessary supports to maintain contact and deceased significant family members were seen by inspectors to be remembered in the communication passports referenced in Outcome 2.

Staff maintained a log of family contact, there was evidence that the person in charge communicated with each family in relation to any changes or requirements; family were invited to participate in personal planning meetings and reviews. Families who completed questionnaires confirmed this and described staff that were approachable and easy to communicate with.

In addition to supporting family contact there was evidence that the centre operated as part of the local community with residents facilitated to participate in local groups, attend local events, socialise locally going for coffee and dining out or simply being out and about and going for walks.

There was further evidence that residents were supported by staff to maintain friendships developed with peers in other services and the centre enjoyed links with some of the providers other centres as observed by inspectors on inspection.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There were policies and procedures including a multi-disciplinary forum that governed admission to and transfer and discharge from the designated centre.

There was documentary evidence that the suitability of admission and placement was reviewed as necessary on an individual resident basis and re-referral as made as necessary to the multi-disciplinary placement forum.

The person in charge told inspectors that contracts for the provision of services were not in place for two residents, that there were mitigating circumstances and that efforts were being made to address this.

However, while there was evidence to support the above, inspectors also noted inconsistencies in the contracts that were in place; not all contracts specified the fees to be paid for the services provided or any additional charges that may be liable for services availed of but not included in the basic fee.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall and on balance there was evidence of significant improvement in the process of assessing, planning and reviewing the supports required by each resident and their personal goals and objectives; my profile my plan. Inspectors were satisfied that this was a meaningful process as what was outlined in the written plan was as described by staff spoken with and as observed by inspectors in practice.

Each support plan seen was informed by a comprehensive assessment of each resident's holistic needs; these assessments reflected the knowledge that staff had of each resident. From this assessment the required supports and care were developed as were residents agreed priorities and goals. There was evidence that residents as was possible and family members as appropriate contributed to the person planning process. Elements of the plan were presented in a format that was meaningful to the resident and relevant information was transferred to the communication diary and life story booklet referred in Outcome 2.

The person in charge maintained a schedule for the person planning process (PCP) including the scheduling of multi-disciplinary meetings (MDT) and three monthly reviews. Overall there was evidence that recommended actions from the MDT/PCP meeting were followed up to completion and fully reflected in the plan. Records were maintained of regular "support staff meetings" and these reflected the dynamic nature of the plan and that it was reviewed and updated in line with the residents changing needs.

Residents personal priorities were clearly listed as were responsible persons and timeframes for achievement. There was evidence of their achievement or if not the reason why they were not achieved, such as a period of ill-health.

On a day to day basis staff maintained a daily working file/record for each resident; inspectors were satisfied that this reflected the person centred plan. Staff also had access to a folder that synopsised the plan and staff who worked on a relief basis told inspectors that this was of significant benefit to them as a quick reference guide when delivering supports and care.

Judgment:
Compliant

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):

No actions were required from the previous inspection.

Findings:

The premises were purpose built and consisted of two single storey buildings in close proximity to each other; each had capacity to accommodate seven residents. The premises were well maintained, visibly clean, adequately heated, lighted and ventilated

Each resident was provided with their own personal accommodation. Rooms were of a suitable size to meet the needs of residents including residents with high physical needs. Two bedrooms, one in each house were designated for the accommodation of residents on respite care; these rooms had their own en-suite sanitary facilities. The remaining bedrooms shared en-suite facilities between each two bedrooms. Again these were designed, laid out and equipped to meet the needs of high dependency residents. While the infrastructure reflected the dependency levels, bedrooms were welcoming and personalised to reflect each resident's individuality.

Each house had a fully equipped kitchenette and there was documentary evidence that these were monitored by the relevant Environmental Health Officer (EHO).

Residents had access to one main communal area in each house; these were spacious and homely in presentation and easily accommodated specialised equipment.

One house had provision for a sensory room that residents were seen to enjoy and the day service on site offered further facilities for the provision of recreational and therapeutic activities.

Adequate provision was made for storage including personal storage for residents. There were facilities for laundering clothing but staff said that this was limited as personal clothing and linen were sent to an external laundry. These facilities are discussed again in Outcome 7; Health and Safety.

Records were available of the inspection and maintenance of equipment required by residents such as seating, beds, pressure relieving equipment and other assistive devices. Bedrooms and bathrooms were equipped with ceiling mounted hoists. The inspector noted that one ceiling hoist was not in use and been out of use since the last inspection. Staff were provided with a floor based hoist and told the inspector that this was sufficient. However, records seen indicated and the person in charge confirmed that the ceiling hoists had not been inspected and serviced within the mandatory timeframes and not since October 2014.

Less dependent residents had recently been admitted to the centre; however there was an absence of equipment to promote their independence, safety and well-being in the form of handrails in circulation areas and access to a staff-call bell system.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were measures in place for promoting the health and safety of residents, staff and other persons. These included a health and safety statement, a risk management policy, register of risks and an emergency plan that incorporated the alternative placement of residents should an evacuation of the centre be required.

Each house maintained a risk register and inspectors saw a range of completed risk assessments both centre and resident specific. These assessments indicated that the process of risk management was dynamic and risks were kept under review by the person in charge. Multi-disciplinary input was sought as necessary, for example in the prevention and management of falls and risks were escalated as appropriate and as per the providers risk management policy, for example any risk identified in relation to reduced staffing. Risk assessments were integrated into residents personal support plans, were discussed at staff meetings and the inspector saw the practical implementation of identified controls such as the eating and drinking care plans.

Risk assessments were in place for the specific risks identified in Regulation 26(1) (c) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Many of the residents were fully dependent on staff in all of their activities of daily living. Training records indicated and staff spoken with confirmed that their training requirements in movement techniques in resident care were within mandatory timeframes. Both residents and staff were seen to have the required equipment, risk assessments and support plans. There was evidence that the occupational therapist had input into the plan as necessary and staff spoken with were clear on the recommended equipment and techniques. However as discussed in Outcome 6 the ceiling mounted hoists had not been serviced since October 2014.

The centre had access to suitably adapted transport. There was documentary evidence that the vehicle was maintained on a regular basis so as to ensure its safety and roadworthiness.

Both houses were serviced by an automated fire detection system with a control panel and fitted with emergency lighting. There was documentary evidence that the emergency lighting was inspected and tested in January 2015, fire fighting equipment was inspected and tested in February 2015 and the fire detection system on a quarterly basis and most recently in November 2015.

There were records of regularly convened simulated fire evacuation drills. The records and staff spoken with indicated that these were meaningful exercises that identified obstacles and barriers to effective evacuation, such as the impact of bedrail-protectors that were then addressed. The inspector noted that the night-time evacuation times had improved and staff said that this was due to the presence of the additional staff member. Each resident had a personal emergency evacuation plan (PEEP). There were variations between PEEPS dependent on individual resident requirements, their required equipment or room location. All staff spoken with were clear on these individual requirements and the rationale for them. The local fire service had also attended on site and liaised with staff on the actions to be taken in the event of fire.

Currently the evacuation procedure was full evacuation of the premises in the event of fire. The nominated provider confirmed that a fire safety audit of the centre had recently been completed, the report was still awaited, and pending the report and any works that may be required the provider envisioned that internal safe compartments would be provided going forward.

While there was evidence of good fire safety management practice as described above and all staff spoken with articulated good fire safety knowledge, a gap was identified in the provision of fire training to staff and staff spoken with were not aware of any procedure for internal checks of fire safety measures completed by staff on a daily, weekly or monthly basis, for example checking that doors and escape routes were unobstructed or testing the fire detection system.

Some facilities, practices and staff knowledge were not consistent with effective evidence based infection prevention and control. Inspectors saw that each house was fitted with a combined sluice/cleaning room. There was inadequate segregation of clean and dirty items such as linen, mops and buckets. There was no designated hand washing sink with staff seen to wash their hands in the sink that was also used for sluicing purposes. Staff spoken with described inconsistent knowledge of the safe

management of soiled linen; some staff described the correct use of water-soluble bags while others did not and described the manual sluicing of such items. Staff confirmed that some commodes were in use; there was no bedpan washer and staff said that they manually cleaned and stored these items in the main bathrooms.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

There were measures in place for protecting residents for being harmed or abused; these measures included policies and procedures, staffing training, and designated persons. There were no reported incidents of any alleged, suspected or reported abuse. Family members reported positive experiences and observations of care and practice in the centre. Residents who could said that they felt safe in the centre and associated this sense of security with staff.

All staff spoken with emphasised the importance of "knowing" residents who could not vocalise their concerns or worries and being alert to any changes in their behaviour or general demeanour. The person in charge said that the low turnover of staff, the relationship that developed between staff, residents and their families, training and supervision were pivotal to ensuring the safety of residents. A protection training programme specifically for persons in charge was scheduled by the provider in the week following this inspection.

Each support plan seen contained a plan for the provision of personal/intimate care to residents.

Staff were aware of the risks posed by the use of bedrails but given the resident profile the use of bedrails was identified as a necessary safety intervention to prevent falling from bed. Staff had risk assessed the use of bedrails, their initial use had been notified to the restrictive practice committee and their ongoing use was supported as necessary by occupational therapy input.

Staff had attended training on responding to and managing behaviours that challenged; further training for newly recruited staff was scheduled for January 2016.

Some residents did present with behaviours that had the potential to challenge others. Inspectors saw that detailed and person centred behavioural support plans were in use. While there was some reported difficulty in accessing behavioural supports inspectors were satisfied that the person in charge had secured in consultation with the multi-disciplinary team suitable arrangements for the review of the support plan. Staff spoken with were fully aware of this review and were implementing the required recommendations including the maintenance of ABC records (antecedent, behaviour, consequences).

Judgment:
Compliant

Outcome 09: Notification of Incidents

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

Theme:
Safe Services

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

Findings:

There were policies and procedures in place for the recording, reporting and investigation of accidents and incidents. Overall there was evidence that each incident was brought to the attention of the person in charge, corrective/preventative interventions were identified as necessary and there was evidence of their implementation. Interventions included referral to the multi-disciplinary team, for example to physiotherapy following a fall.

There was no evidence that notifications had not been submitted as required to the Chief Inspector.

Judgment:
Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

With due regard to each resident's disability and individual skills and ability, residents were facilitated to enjoy new and preferred experiences, social integration and participation, and opportunities to experience meaningful occupation.

Residents had access to the day service on site while some also travelled to off-site services. Each resident had an activity planner based where possible on their expressed likes and dislikes and recommendations from the multidisciplinary team. Inspectors saw that residents were offered a broad range of activities including massage, reflexology, chair based exercise, access to the hydro-therapy bath, finger-puppets, sensory items and a sensory room, walks in the local community, knitting, baking, bingo and music therapy. During this inspection residents enjoyed a demonstration on seasonal cake decorating and music. Inspectors saw that the latter was very much tailored and delivered to suit each individual resident's requirements and invoked a positive response from all residents.

What was evident to inspectors on this inspection was that staff saw beyond the disability and the potential risk for imposing a medical model of care and sought to maximise potential and expose residents to new experiences. For example more independent residents attended clubs and activities in the local community while changes had been made to the established routines of more dependent residents. For example one resident now attended the local barber in the community, went on occasion with staff to the local pub and plans were in place for participation in swimming.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that arrangements were in place for assessing, planning and reviewing residents healthcare requirements.

There was consistent and collaborative evidence that staff had sound knowledge of what was recorded in healthcare related records and that the required interventions to maintain well-being were implemented in practice.

The majority of residents accessed a local General Practitioner (GP) practice but there was also evidence that residents where possible retained the services of other GP's if this was their choice. The GP routinely visited the centre three times per week and reviewed residents as and when required.

Based on the records seen inspectors were satisfied that residents had access to timely and regular medical review as appropriate to their requirements. There was evidence as appropriate that family members were consulted with. While there were some reported challenges, based on the records seen residents were facilitated to access in line with their needs other healthcare services such as psychology, psychiatry, speech and language (SALT), dietician, physiotherapy, occupational therapy, dental care and chiropody. There was evidence of a health promoting ethos to care including monitoring of body weight, regular blood profiling, optical review and diabetic screening, screening for bone mass density and the prescription of preventative medication. There were indicators of good care, for example the person in charge confirmed that despite the high dependency of some residents there was no incidence of pressure related wounds.

Inspectors met with the physiotherapist who confirmed his weekly presence on site.

There were specific health care plans in place for identified problems and the inspector saw that recommendations from other healthcare professionals were incorporated into these. Staff spoken with were fully familiar with the plans of care.

Inspectors saw that residents were supported at mealtimes in a sensitive and dignified manner. Eating and drinking plans based on SALT were in use and staff spoken with clearly described the required interventions of modified fluids and diet and correct positioning.

Overall inspectors were satisfied that the care provided to residents was consistent and evidence based. By way of recommendation inspectors recommended replacing the subjective bowel monitoring tool that was in use with an objective, evidence based tool.

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):

No actions were required from the previous inspection.

Findings:

Overall inspectors were satisfied that staff spoken with had sound knowledge of and implemented safe medication management practice. There was evidence of collaborative working with other relevant stakeholders including the pharmacist and the GP.

All medications were supplied by a local community pharmacy and that arrangement was reported to be suitable and convenient to staff and residents. Medications were largely supplied in a medication administration compliance aid; medications were checked by nursing staff once supplied and there was no reported identified pattern of errors. Staff said that the risk of errors was minimised as the prescription kardex went with the resident to all GP reviews and other appointments and any changes were immediately faxed to the pharmacy.

Medications were securely stored and staff were seen to maintain the security of medications while administering medications. Staff said that no medications that required stricter controls were in use but arrangements including the required register were in place should they be required.

Medical authorisation was in place for medications administered in an altered format (crushed) but there was also evidence that both the GP and pharmacist prescribed alternative and more appropriate formats as available.

While this was a nurse led service staff said that only prescribed medications were administered and all prescriptions were generated by the GP.

Staff were clear on the colour coded procedure for recording the administration of regular and PRN (as required) medications.

Staff were clear on the procedure for the disposal of unused and unwanted medications; there were signed, verified and dated records of their return to the pharmacy.

The inspector did note that some prescription records while current had numerous amendments and alterations and ideally should have been rewritten. The person in charge confirmed that this was being addressed in consultation with the GP; a draft prescription template had been devised that would going forward be generated and maintained by the GP.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose satisfied the requirements of Regulation 3 and contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

While there had been some diversification in the profile of residents accommodated since the last inspection, the statement of purpose was an accurate reflection of the service currently provided in the centre.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors were satisfied that since the last inspection arrangements were put in place that facilitated the person in charge to fulfil her role and her regulatory responsibilities; the person in charge concurred with this finding. The person in charge was person in charge for two designated centres but was now supported by a Clinical Nurse Manager 1 (CNM1) in each centre. The person in charge and the CNM1 described working arrangements that supported the management of each centre in the absence of one or

the other; weekend cover was provided by the CNM1. The person in charge also stated that she was well supported in her role by her line manager, the head of integrated services; they met formally on a weekly basis. All staff spoken with were clear on the management structure, roles, responsibilities and reporting relationships.

The person in charge was suitably qualified for the stated purpose and function of the centre. The person in charge was a registered nurse in intellectual disability, also held postgraduate qualifications in health services management and there was further evidence of ongoing professional development including basic life support, the provision of palliative care and the management of epilepsy. The person in charge worked full-time and divided her working week between the two centres. There was extensive evidence that the person in charge was actively engaged in the administration and operational management of the centre.

There was documentary evidence of challenges and deficits within the service in areas such as staffing or access to the multi-disciplinary team but the overall evidence supported a centre that self regulated, identified, managed and addressed issues to ensure that quality and safe care and services were provided to residents at all times.

Arrangements were in place for both the annual review and the six monthly unannounced visits to the centre as required of the provider by Regulation 23. Reports from both were available for the purposes of this inspection. Inspectors saw that the process involved consultation with residents and their families, it identified areas requiring improvement, actions, responsible persons and completion timeframes were identified. The quality improvement plan was followed up to completion by the person in charge; the actions recorded as taken were evidenced in practice by inspectors.

Judgment:

Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge confirmed that she had not been absent from the centre for any period of time that required notification to the Chief Inspector. Suitable arrangements were in place for the management of the centre in the absence of the person in charge. The CNM1 was the primary person participating in the management of the centre

(PPIM), worked in the centre, had sound knowledge of the residents, the operational management of the centre and had a good understanding of the roles and responsibilities of the PPIM.

Judgment:
Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

No actions were required from the previous inspection.

Findings:

Based on these inspection findings there was no evidence to indicate that inadequate resources impacted on the care and supports required by each resident. There was evidence of challenges such as access to some allied health professionals and the maintenance of staffing and skill mix but also evidence that these were monitored and managed on an ongoing basis.

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:

The major non compliance identified at the time of the last inspection was addressed. The roster indicated and staff spoken with confirmed that an additional staffing resource

at night was in place and maintained at all times.

Inspectors saw a planned and actual roster; this was prepared and maintained by the person in charge.

The person in charge told inspectors that challenges had arisen in the service in maintaining staffing levels and skill-mix due to normal expected and unexpected human resource issues. There was explicit evidence that this was monitored and actively managed by the person in charge in conjunction with the provider and the human resource department. There was evidence of the actions taken in response to staff absence including shifts worked by staff, a recruitment initiative and discussions on the use of agency staff. Staff spoken with confirmed these challenges but articulated their confidence in the person in charge to manage each situation as it arose. Staff said that the needs of the residents were always prioritised and they were not aware of any negative impact on residents. Staff said that they planned the day to match the available resources. Inspectors did not find any evidence of any negative impact on the care and services provided to residents as a result of inadequate staffing or skill-mix.

The person in charge had access to relief staff that were reported to work only in the two designated centres managed by the person in charge and were therefore familiar with the residents and their needs.

There was documentary evidence that persons working in the centre but not employed by the provider were vetting and trained appropriate to the role that they performed in the centre.

Staff files were made available for the purposes of inspection; the sample reviewed by inspectors was substantially compliant with the requirements of Schedule 2. However, there was one historical and unexplained employment gap in one employment history.

Evidence of current registration with their regulatory body was in place for each nurse employed.

Inspectors reviewed the records of training completed by staff and saw that the content reflected mandatory requirements, the needs of residents and the services provided. Completed training included fire safety, manual handling, responding to behaviours that challenged, safeguarding, medication management including the administration of specific medications, the management of dysphagia (impaired swallow), infection prevention and control and food hygiene. One gap was identified in fire safety training and this is addressed in Outcome 7.

Records were maintained of regular staff meetings; resident related and operational issues were discussed.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Overall and on balance inspectors were satisfied that the records listed in Part 6 of the Regulations were in place and were maintained in a manner that ensured their completeness, accuracy and ease of retrieval.

Policies and procedures were specific to the organisation and the majority were current and within their agreed review date.

There was documentary evidence that the provider was insured against accidents to residents, staff and other persons.

The residents guide was presented in an accessible format.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004782
Date of Inspection:	07 December 2015
Date of response:	01 February 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The issue of residents exercising their right to vote as appropriate had not been explored to date by staff.

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

1. Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

Application forms are being completed with residents for inclusion on the register of electors.

Proposed Timescale: 29/02/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

All residents did not have a contract. All contracts did not specify the fees to be paid for the services provided or any additional charges that may be liable for services availed of but not included in the basic fee.

2. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Of the 4 outstanding contracts discussions are taking place with the resident/families on updating the existing agreement and a referral to Social Work Department has been completed for follow up of the 2 outstanding agreements;

Legal advice has been sought by the Provider Nominee in relation to cases where the person does not have the capacity to sign or the person has no family member that is able to and willing to sign.

Legal advice has recommended engaging with the HSE for clarity under the Service Arrangement.

Proposed Timescale: 30/04/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The ceiling hoists had not been inspected and serviced within the mandatory timeframes and not since October 2014.

3. Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

- At time of inspection, the Medical Equipment Contract was being tendered and a successful candidate has now been selected;
- The contractor has now been appointed since 1st December 2015.
- All hoists/equipment in the designated centre have been scheduled for service to be completed by 29/02/16;
- Hoists/equipment will be serviced 6 monthly as per regulation.

Proposed Timescale: 29/02/2016**Theme: Effective Services****The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was an absence of equipment to promote independence, safety and well-being in the form of handrails in circulation areas and access to a staff-call bell system.

4. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

A request for an environmental assessment has been sent to the Occupational therapist to assess the relevant assistive technology, aids and appliances which will benefit and promote the full capabilities and independence of residents.

This assessment will be completed by 25/03/16.

Proposed Timescale: 25/03/2016**Outcome 07: Health and Safety and Risk Management****Theme: Effective Services****The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some facilities, practices and staff knowledge were not consistent with effective evidence based infection prevention and control.

5. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

External cabinets are being sourced to store the buckets and mops Feb 29/02.2016
Staff training on Infection control on 04/02/16 & 25/02/16
Costing to be sought for separate designated hand washing sink in laundry room

Proposed Timescale: 30/03/2016**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A gap was identified in staff attendance at fire training.

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:

Two days have been selected for training 08/03/2016 & 10/03/2016;
Any outstanding staff who require this training will be facilitated with another training date by end of March;
Fire drills continue on a two monthly basis.

Proposed Timescale: 30/03/2016**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff spoken with were not aware of any procedure for internal checks of fire safety measures completed by staff on a daily, weekly or monthly basis, for example checking that doors and escape routes were unobstructed or testing the fire detection system.

7. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Fire Audit completed by Fire Safety Engineer and PIC awaiting report;
Following this a procedure will be drawn up with regards to daily, weekly and monthly fire checks

Proposed Timescale: 29/02/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was one historical and unexplained employment gap in one employment history.

8. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Following contact with the HR Department they will ensure that any unexplained employment gaps in employees files are followed up on.

Proposed Timescale: 31/03/2016