

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Le Cheile
<b>Centre ID:</b>	OSV-0002825
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Limerick
<b>Provider Nominee:</b>	Norma Bagge
<b>Lead inspector:</b>	Margaret O'Regan
<b>Support inspector(s):</b>	Conor Dennehy
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	23
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
31 January 2017 09:30	31 January 2017 18:00
01 February 2017 09:30	01 February 2017 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This inspection was carried out to monitor compliance with the regulations and standards and follow up on actions from the previous inspection.

How we gather our evidence:

As part of the inspection, inspectors met with 16 of the 23 residents. Some of the residents were able to verbally express their views of the service and facilities provided to them. Others expressed their views non verbally in the way they reacted to staff, interacted with other residents, their facial expressions and their general demeanor. Overall, inspectors formed the view that residents were happy and comfortable in the company of staff.

The inspectors noted that since the November 2015 inspection, the number of residents in the centre had reduced from 29 to 23. This reduction in number was due primarily to one unit closing. This unit was not in compliance with fire safety

arrangements and was deemed unsafe. The residents from this unit were transferred to other services run by this provider. The majority moved to other houses on the same campus.

Inspectors observed how staff interacted with residents, observed the general comfort of the environment and the atmosphere within the houses. Interactions were characterized by a relaxed, competent and caring approach from staff.

Inspectors sought the views of staff on the quality of care provided. Inspectors met with members of the management team who explained the management and oversight systems in place.

Inspectors examined documentation such as resident care plans, policies and risk management assessments and procedures. Documentation was comprehensive and generally well organised. However, not all the written care plans were reviewed annually.

Description of the service:

The provider must produce a document called the statement of purpose that explains the service they provide. The statement of purpose described the centre as one which endeavored to provide a homely environment for the residents. Overall, efforts were made to make each house within the centre as homely as possible.

This centre was campus based and the campus consisted of 15 bungalow style houses. The 15 houses were grouped under three separate centres and each centre had a person in charge. The centre which this report refers to catered for up to 24 residents. Services provided included residential care for adults, both male and female.

The service supported individuals who had a range of intellectual disability, some of whom also displayed behaviors that challenge. Many of the 23 residents had high physical support needs.

A number of residents availed of day services which were available on site.

Overall judgment of our findings:

Inspectors identified a number of areas of good practice. Staff members were seen to interact with residents in a kind and caring manner and residents appeared to be comfortable in their presence. Personal plans were person-centred; however, written care plans were not always updated annually. This is discussed under Outcome 5, Social Care Needs.

Since the previous inspection the provider had taken measures to improve the physical environment. A significant undertaking had taken place to close one unit which was not fire compliant. However, as found on the previous inspection significant upgrading work was needed to bring three of the remaining four houses up to the required standard. This is discussed under Outcome 6, Premises.

Work was ongoing in identifying areas for improvement including the manner in

which resident finances were managed. However, at the time of inspection, inspectors found deficits in this area. This is discussed under Outcome 8, Safeguarding and Safety.

There were weaknesses in the manner in which risk was managed. For example, the fire management systems in place were not adequate. This is covered under Outcome 7 of this report Health and Safety and Risk Management.

Inspectors were not satisfied that there were adequate numbers of staff on duty at all times to meet the needs of residents. For example, access to activities/day services had been curtailed for some residents due to staffing arrangements.

Other improvements required included:

- a review of the contracts of care (Outcome 4)
- provision of appropriate staff training and refresher training (Outcome 17)
- a review of the statement of purpose (Outcome 13)
- a review of the governance arrangements, in particular a review of the amount of time spent by the person in charge on administrative duties (Outcome 14).

Overall, inspectors concluded that the most significant issue for this centre was the lack of funding to upgrade the houses to the required standard and ensure the houses were compliant with current fire safety legislation. This is actioned under Outcome 16, Resources.

The action plan at the end of the report identifies improvements necessary 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 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Overall, inspectors were satisfied that the rights, privacy and dignity of residents were promoted. Residents were encouraged to make choices and these choices were respected. For example, inspectors were aware residents were consulted with regards to their preferred living arrangements. Residents were consulted through weekly house meetings and informal meetings with staff. Minutes were maintained of house meetings. Some residents attended advocacy meetings and were actively supported by staff to engage with the advocacy process.

Interactions observed by inspectors were respectful and caring. Staff had an in-depth knowledge of residents' preferences and this knowledge was recorded in the written care plans.

The inspectors saw that residents had control over their own possessions. For example, each resident had their own bedroom and own wardrobe. There was a written policy on how residents' personal property was to be managed.

The complaints policy was displayed. There was evidence of a culture of accepting complaints and in so far as possible addressing the matters identified. A number of residents communicated in a non-verbal manner. Inspectors saw that non-verbal residents appeared to be able to communicate if they were anxious, worried or in need of assistance.

Residents were facilitated to fulfil their religious rights. One resident played a significant role in assisting with liturgical activities. This was an activity which was very important

to the resident.

Residents were facilitated to be as independent as possible. For example, residents, in so far as practical showered independently. Residents walked around the grounds independently and attended religious services as they pleased.

**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):**

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

**Findings:**

Contracts for the provision of services were in place which had been reviewed since the previous inspection. During the course of this inspection it was disclosed to inspectors that some of these contracts had not been agreed to, by the residents or their representatives, as required by the regulations.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

There were systems in place to assess residents' abilities and needs. These systems informed the care plans and identified supports required by each resident. Needs were identified under three headings: my self, my world and my dreams. This information was usually collated by the resident's keyworker. It was evident that the resident participated in the planning process (and their family as appropriate).

It was identified on the last inspection that the manner in which the assessment and care planning was conducted was time consuming. Similarly on this inspection, it was a challenge for both inspectors and staff to find pertinent information. From their conversations with staff, inspectors were satisfied that residents care needs were well known to staff and care practices were altered as the residents' needs altered. However, the written care plans were not always reviewed on an annual basis. From the documentation seen and from discussions with staff the inspectors were satisfied that there was regular and easy access to the multi disciplinary team.

The activities which were available were well received. For example, residents were seen to engage in equine activities, golf and music therapy. Residents were given choice as to whether to engage in these activities or not. However, some residents' activities were curtailed due to staffing arrangements. Inspectors concluded the arrangements in place to meet the assessed needs of each resident were inadequate.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Services

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

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

**Findings:**

There had been some improvements regarding the general upkeep of the centre. However, inspectors were concerned that it remained unsuitable to meet the needs of residents.



Since the previous inspection the designated centre had been reconfigured. All resident had been removed from one building which had significant premises and fire safety defects and was no longer a part of this centre. At the time of inspection the centre was comprised of four single storey buildings, one of which was divided into apartments. The centre was based in a campus setting.

The level of cleanliness had improved since the previous inspection and attempts were made to give the centre a homely feel. All residents had their own bedrooms. Inspectors noted that they had been personalised with photos and ornaments while wardrobes and shelves were available in the bedrooms for storage.

However, some of the buildings continued to be institutional in design and there had been limited investment in upgrading them to modern day standards. For example, two buildings had communal style bathroom and toilet facilities; fire safety concerns remained, which are discussed under Outcome 7; flooring was damaged in some houses; windows were single glazed or in some instances made from Perspex. As noted on the last inspection, the upgrading work that was taking place was more remedial than part of a longer term plan. The longer term arrangements for the centre were dependent on securing funding and it was unclear how this was likely to progress.

In addition, the size of some residents' bedrooms posed a problem owing to the changing needs of residents. For example, some residents required hoisting and the size of some bedrooms made it difficult to move hoists in and out of the bedrooms. Using a hoist in one house proved particularly challenging due to a narrow corridor. The statement of purpose reviewed on inspection conceded that meeting the needs of residents was challenged by the design of the premises.

Not all houses had a room where residents were able to meet visitors in private. However, residents and their families had access to a room in the activities centre should a private meeting be required.

Hoists within the designated centre were noted to have been serviced within six months of this inspection.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective Services

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

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

**Findings:**

The provision of fire safety remained an area of ongoing concern in the designated centre.

A building, which contained significant fire safety defects, was identified on the previous inspection as being the priority fire safety issue. This priority was addressed and this house had closed since the last inspections. However, inadequacies continued to be present in the fire safety systems in the remaining operating houses. Inspectors were aware from fire safety officer reports, that the fire alarm system needed upgrading. In addition, there was limited provision for the containment of fire, such as fire doors.

Emergency lighting was present throughout centre and was seen to be operational on the day of inspection. This lighting was subject to quarterly maintenance checks. However, inspectors were told such checks in all of the buildings which comprised this centre, were delayed due to works which were taking place in one of the buildings. As a result the emergency lights had not had a maintenance check since July 2016 (over six months). Records of annual maintenance checks for fire extinguishers within the designated centre were seen by inspectors.

Fire drills were carried out at regular intervals at varying times of the day. Daily checks were recorded to ensure that emergency exits were clear. On the second morning of inspection it was noted that the fire exits in one building had been checked by one member of staff as being clear but when these were checked by the inspector later that morning it was noted that two bins were partially obstructing the exit route. Later in the day it was noted that these bins had been moved. In another building it was observed that checks on the emergency exits were not carried out every day.

The procedure to be followed in the event of evacuation being necessary, was displayed throughout the centre. Residents had a personal evacuation plan in place. On reviewing a resident's file it was noted that their file contained two different personal evacuation plans which outlined two different methods for evacuating that resident if required. This was highlighted to the person in charge.

Staff members spoken to were aware of the procedures to be followed in the event that an evacuation was required. Inspectors reviewed a copy of training lists for staff working within the centre. Although the vast majority of staff had received some fire training it was noted that a number of staff had not received fire safety training within the previous 12 months, while three members of staff were not listed as having received any fire safety training.

A risk register was in place that comprised of individual risk registers relating to each house. These risk registers were being updated at the time of inspection by the person in charge. While reviewing the risk register relating to one of the houses it was noted that there was no risk assessment in place relating to the presence of break glass units containing keys for some fire exits. Inspectors were informed by staff members that these keys were no longer in use and that the fire exits in question were now locked and unlocked with a keypad.

A record of accidents and incidents was maintained in the designated centre which was signed off by the person in charge and subject to a quarterly audit. Any learning from adverse events was discussed with staff members during monthly staff meetings which took place in each house.

Training records reviewed indicated that staff had undergone manual handling training while personal protective equipment such as gloves and aprons were available within the centre. As referenced under Outcome 6 the level of cleanliness within the designated centre had improved since the previous inspection.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

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

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

**Findings:**

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

Inspectors viewed a sample of residents' personal financial accounts and saw that there were procedures in place to ensure that their monies could be accounted for. Items purchased by residents required a receipt and their personal monies were checked by two staff members daily to ensure accuracy.

However, inspectors found that residents were purchasing items such as a bed and it was unclear how the decision was taken that the resident would pay for this. A greater level of oversight was needed to ensure resident funds were appropriately used.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

The inspectors saw that detailed health assessments were carried out. There was evidence of a good referral system in place for support health services. There was evidence of referral and access to the general practitioner (GP), psychiatrist and dentist. Where other specialist services were required such as consultation with medical specialists, these were facilitated. Discussions took place around end of life care and these were documented. Hospice care was available to support staff in caring for residents in their own house at the end of their life.

The breakfast and evening meal was prepared and cooked daily in the centre. Residents had their lunch delivered to them from a contract catering company. The inspectors saw that staff supervision and assistance was in place and that residents were facilitated to be as independent as possible. Since the previous inspection work was undertaken by the person in charge in consultation with the speech and language therapist for the provision of good quality modified meals. Staff reported residents' weights improved on these meals.

The service had recognised that their residents needs were changing due to the aging process and provision was being made to recruit a clinical nurse specialist in gerontology to ensure the service could meet the needs of all residents.

**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:**

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

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

There was a clear process for disposal of out of date or unused medication. Medications were regularly reviewed by a psychiatrist, staff and the GP. Staff had received medication management training. Medication errors were recorded.

**Judgment:**

Compliant

**Outcome 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:**

Inspectors reviewed the statement of purpose which had been recently updated. While it contained most of the information required by the regulations it lacked clarity regarding the specific care and support needs that the centre was intended to meet.

In addition the admissions criteria were not adequately described and it was not stated if the centre accepted emergency admissions or not.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

*responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The post of person in charge was full time and the person in charge had the qualifications, skills and experience necessary to manage the centre.

There was a defined management structure in place which identified the lines of authority and accountability, specified roles, and detailed responsibilities for service provision. The management systems in place helped to ensure that the service provided was safe, appropriate to residents' needs and monitored.

However, the management systems could have been more effective. For example, as noted on the previous inspection, the person in charge spent a considerable amount of time completing administrative work. Her presence in each of the houses was limited as her time was taken up with administrative duties in an office separate to where residents were accommodated. This impacted on the person in charge's capacity to provide support, guidance and supervision to staff.

There was a comprehensive annual review of the quality and safety of care and support in the centre. This review included consultation with residents and their families.

An unannounced visit to the centre was carried out by the provider or their delegate at least once every six months. A written report on the safety and quality of care and support provided in the centre was compiled after such visits along with a plan to address any concerns regarding the standard of care and support.

Since the last inspection, arrangements were put in place to support, develop and performance manage members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering. Staff were facilitated to raise concerns about the quality and safety of the care and support provided to residents through regular staff meetings.

**Judgment:**

Substantially 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.*

<p><b>Theme:</b> Use of Resources</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p><b>Findings:</b> The centre was not sufficiently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.</p> <p>For example, as discussed under Outcomes 6 and 7 there were significant deficiencies with the upkeep and modernisation of the premises including the fire safety arrangements in place for the centre. As discussed under Outcome 5 and 17, staffing levels negatively impacted on residents' ability to access appropriate activities.</p>
<p><b>Judgment:</b> Non Compliant - Major</p>

<p><b>Outcome 17: Workforce</b> <i>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.</i></p>
<p><b>Theme:</b> Responsive Workforce</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> A committed staff team was in place; however, inspectors found that staffing levels did not ensure that residents needs were being met.</p> <p>Since the previous inspection improved reporting structures were put in place between the person in charge and night staff. Throughout this inspection, staff members were observed interacting with residents in a warm and caring manner. It was clear that staff members were committed to the residents and meeting their needs despite the challenges that were posed by the design of the premises and the changing needs of residents.</p> <p>However, inspectors found that there was not sufficient staff numbers available to ensure that residents were able to avail of activities. For example, in one house it was</p>

found that one resident was unable to attend day services due to a shortage of staff. This resulted in the resident being in their house for long periods of the day and this impacted negatively on the resident and their fellow residents. In another house, inspectors found that the demands placed on staff due to the needs of residents meant that there was not sufficient time available to provide meaningful 1:1 interaction.

Staff training records were reviewed and it was noted that all staff had received training in a number of areas including safeguarding, de-escalation and manual handling. Fire safety training had also been widely provided for but as highlighted under Outcome 7 not all staff had received a training update within the previous 12 months.

Inspectors noted during the inspection that, due to the changing needs of residents within the house, additional training should be provided in the area of dementia to ensure residents' needs were adequately met. This was discussed with the person in charge who informed inspectors that a new dementia training course had commenced in 2017 and that staff had been booked in to receive this training. A training schedule for the year ahead was also provided to inspectors.

Inspectors saw minutes of monthly staff meetings held in each house which were attended by the person in charge. inspectors also found that a system of supervision for staff had also begun to be rolled out for all staff.

Staff files relating to this centre had been reviewed at previous inspections and so were not examined at this inspection. There were no volunteers in the centre at the time of inspection.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Margaret O'Regan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
<b>Centre ID:</b>	OSV-0002825
<b>Date of Inspection:</b>	31 January 2017 and 01 February 2017
<b>Date of response:</b>	26 April 2017

### Requirements

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

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

### Outcome 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:**

Not all contracts had been agreed to by residents or their representatives.

#### 1. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the

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

terms on which that resident shall reside in the designated centre.

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

- The template for the Individual Service User agreement contracts has been updated.
- A new Individual Service User Agreement contract will be prepared for each resident in line with recent RSSMAC Legislative framework 2017.
- An easy read version of the agreement has been developed to support understanding. This will be reviewed with residents where meaningful.

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

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

The arrangements in place to meet the assessed needs of each resident were inadequate. Some residents' activities were curtailed due to staffing arrangements.

**2. Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

The Provider accepts that the Centre is not adequately resource and accepts that some residents have less access to internal and external activities based on inadequate staffing.

The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources as outlined as follows:-

In November 2015 the Chief Officer of the HSE CHO3 (Mid West) issued the following in relation to funding and prioritization:-

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

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

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

"The HSE had noted the top ten agencies as identified red flag by the regulator and

made provision in the 2016 service plan to begin addressing these within resources available and BOC Limerick was not rated as such. That is not to say it does not require attention.”

This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.

A full review of day services in “The Hub” and evening entertainment has commenced with a view to providing meaningful activities for residents on campus and to re-establish an optimal level of activities with reference to the approved staffing in the centre. This review commenced on 6th March 2017 and will be completed by 30th September 2017.

Statement of Purpose is to be reviewed to include specific care and support needs and emergency admissions criteria.

The following processes are in place in order to maximize the use of existing resources:-

- Each resident has a Person Centred Plan with identified priorities.
- The organisation’s risk assessment process supports prioritization in the context of limited resources.

Proposed Timescale:

30/09/2017 for actions that can be progressed within the control of the Provider Nominee

**Proposed Timescale:** 30/09/2017

**Theme:** Effective Services

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

The residents' written personal plans were not always reviewed annually.

**3. Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

- At time of inspection 2 out of 23 person centred plans (PCP) out of date.
- These plans are at the information gathering stage of the process.
- These plans will be reviewed quarterly.
- Software installed to notify PIC when plans are due for review
- Specific health care plans are to be updated/reviewed annually or as required by keyworker and link worker where required.

**Proposed Timescale:** 31/05/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The premises were not designed to meet the needs of residents.

**4. Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

- Requested quotations for remodelling bedrooms in one house which caters for wheelchairs/hoist – reduce 3 rooms in to 2 rooms to provide appropriate space.
- Funding has been approved for the remodelling and it is expected to take 10 days to complete the work.
- The works will commence once an internal short term emergency admission has been discharged back to community residential services.
- The Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.
- Several submissions have been made to the HSE in respect of capital funding to maintain the premises to an acceptable standard. The most recent submission was made in 2015 for €890,000 based on an engineer's report. This included upgrades to windows, floors, painting, electrics and plumbing. No funding has been allocated for this submission.
- The Services does not have a sufficient budget to meet the maintenance costs arising in this centre which was built in the 1970's. This will continue to be raised with the HSE as part of the Service Arrangement engagement process.
- A plan for de congregation of Bawnmore was submitted to the HSE in 2014.
- No revenue funding to date has been awarded by the HSE to support the movement of people from Bawnmore to the Community.
- The HSE confirmed in 2016 that Bawnmore is not a prioritized centre under the Social Reform funding.
- In December 2016 a submission for capital funding was made in respect of 5 projects that will support de congregation all referenced in the Bawnmore Plan 2014.
- On 21st February 2017 confirmation was received from the HSE for funding of these capital projects.
- Plans will be put in place to progress these capital projects during 2017. One capital project is a new build and will not be completed until early 2019

Proposed Timescale:

30th June 2019 for actions within the control of the provider nominee.

**Proposed Timescale:** 30/06/2019

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

**Theme:** Effective Services

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

The presence of break glass units which contained keys for fire exits had not been risk assessed.

**5. Action Required:**

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

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

- Risk assessment completed for all areas where a break glass unit is in situ.
- The break glass unit is a control in the event of a systems failure of the maglock system.

Proposed Timescale:

Complete

**Proposed Timescale:** 26/04/2017

**Theme:** Effective Services

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

The provision of fire safety systems remained an area of ongoing concern in the designated centre. For example the fire alarm system had been identified as requiring an upgrade.

**6. Action Required:**

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

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

- The fire alarm system currently in place is operational.
- It is certified quarterly by a competent person and receives a Certificate of Servicing/ Testing of Fire Alarm System.
- Last Certificate received 12/04/2017. The certification notes that the Fire safety system requires upgrading.
- Fire drills are frequently engaged in on site and the fire alarm system is noted to work accordingly.
- In the interim ongoing fire safety mitigations are in place in the designated centre:-
  - o Fire Safety training for staff (mandatory)
  - o Alarms are serviced quarterly
  - o Fire Drills taking place
  - o Fire Safety equipment is serviced annually
  - o Emergency lighting

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

Proposed Timescale:

Complete for actions within the control of Provider Nominee.

**Proposed Timescale:** 26/04/2017

**Theme:** Effective Services

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

Emergency lighting had not had a maintenance check since July 2016.

**7. Action Required:**

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

- Emergency lighting maintenance checks carried out and completed in Le Cheile on the 23/02/2017 and will continue to have maintenance checks carried out quarterly

Proposed Timescale:

Complete

**Proposed Timescale:** 26/04/2017

**Theme:** Effective Services

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

There was inadequate provision for the containment of fire in the designated centre.

**8. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

- The BOCSI Limerick Region accepts that there are deficits in the Fire Safety Management System.
- Fire Safety Strategy was developed in 2016 that identified the requirement for extensive investment in upgrades to properties in Bawnmore. The Fire Safety Strategy was completed by a qualified Fire Safety Engineer.
- Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million. The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy
- Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings. The timeline for this is dependent on funding.
- The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment. As this is outside of the control of the services it is not possible to determine the time frame.
- In the interim ongoing fire safety mitigations are in place in the designated centre:-
  - o Fire Safety training for staff (mandatory)
  - o Alarms are serviced quarterly
  - o Fire Drills taking place
  - o Fire Safety equipment is serviced annually
  - o Emergency lighting

Proposed Timescale:

Complete for actions within the control of the Provider Nominee.

**Proposed Timescale:** 26/04/2017

**Theme:** Effective Services

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

Not all staff had received fire safety training and a number of staff had not received updated training for over 12 months.

**9. 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:**

- Training dates have been allocated to all staff
- PIC to review to verify that all training has been attended and to follow up on any outstanding training

**Proposed Timescale:** 28/04/2017

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

The measures in place did not adequately show how decisions were taken to spend residents' monies.

**10. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

- Policy on handling of personal assets of individuals who use the service is under review
- Applications for funding for Aids and appliances are being submitted to the HSE for consideration

**Proposed Timescale:** 19/06/2017

### **Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The specific care and support needs that the centre was intended to meet lacked clarity, admissions criteria were not adequately described and it was not stated if the centre accepted emergency admissions or not.

**11. Action Required:**

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

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

Statement of purpose is to be reviewed to include specific care and support needs and emergency admissions criteria. Updated statement will be forwarded to HIQA

Proposed Timescale:  
Complete

**Proposed Timescale:** 26/04/2017



## Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

The management systems could have been more effective. For example, the person in charge spent a considerable amount of her time completing administrative work in an office separate to where residents lived. This resulted in her having limited time to be with residents or staff.

**12. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

- Post for office administrator advertised on 24/01/2017
- Interviews scheduled for 22/02/2017
- Successful candidate has been notified

**Proposed Timescale:** 30/07/2017

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

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

**13. Action Required:**

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

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

- The Provider accepts that the Centre is not adequately resource and accepts that some residents have less access to internal and external activities based on inadequate staffing.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources as outlined as follows:-
- In November 2015 the Chief Officer of the HSE CHO3 (Mid West) issued the following in relation to funding and prioritization:-  
"While it is accepted that over a period of time there would be a desirable progression

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

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

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

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

- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.

- A full review of day services in “The Hub” and evening entertainment has commenced with a view to providing meaningful activities for residents on campus and to re-establish an optimal level of activities with reference to the approved staffing in the centre. This review commenced on 6th March 2017 and will be completed by 30th September 2017.

- Statement of Purpose is to be reviewed to include specific care and support needs and emergency admissions criteria.

- The following processes are in place in order to maximize the use of existing resources:-

- o Each resident has a Person Centred Plan with identified priorities.

- o The organisation’s risk assessment process supports prioritization in the context of limited resources.

**Proposed Timescale:** 30/09/2017

## **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There were not sufficient numbers of staff to ensure that residents were provided with adequate activities.

### **14. Action Required:**

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

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

- The Provide accepts that the Centre is not adequately resource and accepts that some residents have less access to internal and external activities based on inadequate staffing.

- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources as outlined as follows:-

- In November 2015 the Chief Officer of the HSE CHO3 (Mid West) issued the following in relation to funding and prioritization:-

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

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

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- Statement of Purpose is to be reviewed to include specific care and support needs and emergency admissions criteria.

- The following processes are in place in order to maximize the use of existing resources:-

- o Each resident has a Person Centred Plan with identified priorities.

- o The organisation’s risk assessment process supports prioritization in the context of limited resources.

**Proposed Timescale: 30/09/2017**

