

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sonas
Centre ID:	OSV-0002831
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Provider Nominee:	Norma Bagge
Lead inspector:	Margaret O'Regan
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
23 February 2017 07:15	23 February 2017 17:45
28 February 2017 14:00	28 February 2017 20:00

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

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 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

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 26 of the 28 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 demeanour. 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. Overall, inspectors formed the view that residents were happy and comfortable in the company of 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 and their plans for improvement.

Inspectors met with the night managers on the morning of the first day of inspection and on the evening of the second day's inspection. An inspector observed the handover process and the exchange of information that took place.

Inspectors examined documentation such as resident care plans, policies and risk management assessments and procedures. Documentation was extensive; however, there was significant duplication which made it difficult to find accurate information. This posed a risk in terms of the reliability of the paperwork. There were also aspects of the documentation which was not up to date such as care plans.

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. However, limited upgrading and modernisation had been carried out on these houses since they were built in the 1970's.

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, catered for up to 28 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 behaviours that challenge. Many of the 28 residents had high physical support needs.

A number of residents availed of day services which were accessible 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 and the provision of meaningful activities was inadequate. This is discussed under Outcome 5, Social Care Needs.

The maintenance and upgrading of this centre has been an ongoing issue. The lack of resources has been given as the primary reason for this. However, inspectors acknowledged that since the previous inspection the provider had taken measures to improve the physical environment. For example, one resident was provided with an enlarged redecorated bedroom, a new vehicle was purchased, the heating system was upgrading in one house, a sensory garden was developed in a house to facilitate the specific needs of a resident and a bathroom was renovated in another house. At the end of this inspection the provider made available to the inspector, documentation detailing the capital investment plans to facilitate new

accommodation for residents within this centre and the other two centres on this campus. These plans were devised in conjunction with the funding authority, the Health Services Executive. However, while welcoming the recent improvements, issues remained at the time of this inspection in relation to the premises. This is discussed under Outcome 6.

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 a greater level of oversight was needed in this area. This is discussed under Outcome 8, Safeguarding and Safety.

There were discrepancies and concerns in relation to the adequacy of the fire safety arrangements. For example, the fire alarm system, although it was in acceptable working order was also deemed to be in "urgent need of upgrading".

Management systems in place were not adequate. For example, much time was spent in administrative duties at the cost of more on site staff supervision, support and monitoring. This is covered under Outcome 14, Governance and Management.

Other improvements required, included the provision of appropriate staff training and refresher training (Outcome 17, Workforce)

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 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):

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

Findings:

On the last inspection the inspector found that not all resident service agreements were signed. This had been addressed and all resident service agreements were maintained by the person in charge in her office.

Details of the communication the organisation had with residents and their families around the new service arrangements expected to be in place by mid 2017 were maintained in resident files.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Residents were provided with person centred plans; however, for some, personal plans had not been appropriately reviewed or updated.

A personal centred planning process was in place for residents to identify priorities for the year ahead. The process involved a period of information gathering carried out by residents' keyworkers which involved the resident, their family and staff, including the multi-disciplinary team. After this information gathering, a planning meeting was held where priorities were agreed and responsibility for achieving these assigned.

Inspectors reviewed a sample of residents' personal plans and while some were noted to be current and reviewed at regular intervals, some were not. As a result, for some residents, it was not clear what progress had been made or what further action was necessary. Some parts of residents' personal plans had not been reviewed for periods in excess of one year. For example some residents' intimate care and communication plans had not been reviewed since 2014.

Inspectors discussed with staff members the out of date personal plans and overdue assessments. While some information gathering was underway, staff informed inspectors that they did not have the time to update such plans as their time was largely taken up with meeting resident's basic health and intimate care needs.

Apart from deficits in documentation around care planning, the arrangements in place did not adequately meet the assessed social needs of residents. For example, one resident was identified as needing to be in an environment where their peers were of similar activity levels to them. Plans were put in place to achieve this which included, a) alternative accommodation, b) partaking in specific activities and c) keeping a log of resident activities. The resident's alternative accommodation had not materialised; however, improvements were made to the night time staffing arrangements which benefitted the resident. A log was maintained of the resident's activities but the specific activity was not engaged in as planned nor was an adequate alternative facilitated. There was a number of reasons for this (including staffing arrangements) but overall this resident was not engaged in activities which best met their needs.

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:

Some works had been carried out in the centre but some improvement was still required in relation to the general maintenance of the houses.

The centre was comprised for five single story houses. Although one of the houses was institutional in nature, attempts had been made to make it homely. For example, the main living area was carpeted; residents bedrooms were painted in bright colours and a music/sensory/activity room had been put in place.

The other four houses were chalet style bungalows accommodating four to six persons. Some renovations had recently been carried out in one of them while another had had a new hallway floor put down and bedroom doors widened to accommodate residents who required the use of a hoist.

The houses were generally clean on the day of this unannounced inspection albeit there was scope for a structured system of deep cleaning to be put in place.

Parts of the houses required maintenance. For example, some floor covering in residents' bedrooms was missing, paint work was damaged in several areas and some of the sanitary facilities were outdated and institutional in design and layout.

Inspectors saw a sample of maintenance records for hoists, boiler and assistive technology devices and noted that they had been serviced at the required intervals.

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):

No actions were required from the previous inspection.

Findings:

The centre had policies and procedures relating to health and safety including a health and safety statement. There were satisfactory procedures in place for the prevention and control of infection.

The risk management policy was implemented and covered the identification and management of risks, the measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. The records showed the level of risk reduced with the control measures that were put in place. For example, in February 2016 the risk of poor cleaning practices was rated at 20; at the time of this inspection it had reduced to 8. Inspectors found this to be an accurate assessment of this situation. The risk of poor elder care practices decreased from 20 to 10 in a twelve month period by providing staff with training updates in this area. It was also noted that some risks remained high; in particular the corporate risk of outdated premises not meeting the needs of residents.

Reasonable measures were in place to prevent accidents. Accidents were recorded and monitored. Measures were in place to prevent or minimise accidents such as regular risk assessments, staff training updates and regular review of behaviour support plans. Staff were trained in moving and handling of residents, albeit two staff were identified as being due updates in this area.

Suitable fire equipment was provided. There was a prominently displayed procedure for the safe evacuation of residents and staff in the event of fire. The mobility and cognitive understanding of residents was accounted for in the evacuation procedure and in the day and night personal egress plans that each resident had. Staff were trained and knew what to do in the event of a fire. However, from the records viewed, three staff had not had fire safety awareness training.

The fire alarm was serviced every three months and fire safety equipment was serviced on an annual basis. Fire drills took place at approximately two monthly intervals and records were kept which included details of fire drills, fire alarm tests and fire fighting equipment. Emergency lighting was in place. However, records were not available to show it was serviced every three months.

There was a lack of clarity with regard to whether or not the centre was in compliance with current fire safety standards. For example, there was a fire alarm system in place which;

- * was tested weekly
- * was serviced every three months
- * had records available to show it was "in acceptable working order"
- * staff were familiar with.

However, the service records also noted that there was "urgent need for a new system".

Another example of lack of clarity around the adequacy of the fire arrangements related to the fire exits. Fire exits were seen to be unobstructed, these exits were checked on a daily basis, exits were illuminated and fire fighting equipment was in place. However, a fire safety survey of the buildings carried out in 2016 by an external auditor, indicated that, considering the nature and function of the premises, the centre did not comply with current fire safety legislation. Given these findings the provider was requested to submit a certification of fire compliance for the centre from a suitably qualified person.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

There 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. Staff were also aware that there was a designated person to deal with any allegations of abuse.

There were procedures in place to ensure that residents 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.

Inspectors noted residents were purchasing the services of personal assistants. This was of immense benefit to residents. However, a greater level of oversight was needed to show that using resident funds in this way was appropriate.

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 healthcare needs of residents were provided for within the designated centre but some improvement was required in relation to accessing speech and language therapy (SALT).

A general practitioner (GP) visited the centre three times a week. Any issues affecting residents were brought to the attention of the GP. Documentation was available to confirm medical reviews took place. Any necessary referrals were made by nursing and medical staff. Support was provided to residents to attend appointments with medical consultants and allied healthcare professionals.

Routine monitoring of resident weights was undertaken and suitable specialised equipment was available to weight non ambulant residents. Regular blood profiling was carried out by a qualified staff member with expertise in phlebotomy and expertise in seeking the cooperation of residents. Seeking and acquiring resident cooperation negated or minimised the need for a restrictive practice to be used while blood was being taken. Results of blood profiling informed decisions around resident care, in particular management of residents' medication.

Staff spoken with demonstrated a good level of knowledge regarding residents' healthcare needs. Inspectors reviewed a sample of residents' healthcare plans. Some of these were difficult to locate. The same information was spread across three folders which had different dated care plans for the same issues. This is referenced under Outcome 18. The reviewed health care plans were noted to have been informed by nursing staff with input from residents, their families and allied healthcare professionals.

Staff informed inspectors that they had been trying to get a speech and language therapy (SALT) assessment for a resident but this had yet to happen at the time of inspection. Inspectors saw records of requests for this assessment going back to September 2016. Inspectors were informed and documentation confirmed, that referrals to speech and language therapy (SALT) was waitlisted, with priority given to attending to residents with swallowing difficulties and up skilling staff in relation to this matter.

While awaiting a SALT review, clinical nursing staff in conjunction with specialist dietetic advice from the national centre that manages the resident's condition, supervised the provision of a modified consistency diet for the resident. The SALT department was provided with updates by the nursing staff on the resident's progress (which was satisfactory) and reminders that a SALT assessment continued to be required.

In another care plan, an inspector saw that communication was made with SALT a number of months previously for support with developing communication tools for a resident who communicated non verbally. This was part of the resident's person goals and no significant progress had been made in this area nor was there any record that the resident had been seen by a speech and language therapist. The inspector was informed and shown the tools, including a suite of guidance documents, put in place by the SALT department to assist staff in the provision of appropriate communication strategies with residents.

The inspector was informed by the provider that they had initiated contact with the

Health Services Executive (HSE) for speech and language therapy support. However, challenges remained as specialist SALT support to attend to residents with intellectual disability was not readily available within the HSE.

While providing speech and language reference tools was very helpful, and while every effort was made by clinicians to manage the priorities in relation to SALT referrals, improvements were needed in terms of the provision of timely access to this service to all residents.

Judgment:

Non Compliant - Moderate

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 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:

A clear management structure was in place but some improvement was required in relation to the unannounced visits by the provider to ensure that they effectively captured the safety and quality of care and support in the designated centre. Management systems also required review.

The person in charge had been appointed to their role in December 2016. She was a registered nurse with experience and qualifications in the area of intellectual disability nursing. She displayed enthusiasm for her role and had the required management experience and qualifications for this position.

Support was given to the person in charge by a CNM3 who had previously served as a person in charge for this centre. The person in charge was based in an office separate to where residents were accommodated. The person in charge's presence in each house was limited due to time taken on administrative duties. This impacted on their ability to provide staff support, guidance and supervision. Inspectors were informed at a previous inspection that the recruitment of an administration manager to reduce the burden on the person in charge was at an advanced stage.

The person in charge was also supported by two CNM1s, one who provided supervision in one house while the second CNM1 supervised two houses. However, inspectors were informed that one CNM1 would be retiring in the weeks following inspection with a replacement not yet identified. There was no CNM1 in respect of the remaining two houses which made up this centre. This did not assure inspectors that robust management systems were in place.

At the onset of this inspection and at the end of the second day's inspection, inspectors met the Clinical Nurse Managers 2 (CNM2) who were responsible for the management of the campus at night. They described how they linked with the person in charge including the giving of handovers at the beginning and end of each shift. An inspector attended the hand over meeting between day and night managers. This was seen to be detailed, with information exchanged about what happened during the day and the night.

The person in charge attended night staff team meetings. One such meeting was seen to take place on the second day of inspection and was well attended by night staff who came on duty early for this meeting. A system of staff supervision was in the process of being rolled out at the time of this inspection.

Since the previous inspection a detailed annual review had been carried out which included;

- input from residents and their families
- progress on addressing the quality and safety matters raised on the last HIQA

inspection

- progress on addressing the matters raised in the six monthly unannounced provider inspections
- general quality initiatives which had benefited residents and the centre
- areas for improvement
- summary of HIQA notifications
- progress update on person centred plans
- overview of complaints
- overview of risk identified in the centre.

Unannounced visits had also been conducted by the provider at the required intervals. However, inspectors noted that the unannounced visit reports did not sufficiently capture issues related to the safety of residents within the centre. For example, the most recent unannounced visit carried out in January 2017 did not sufficiently address issues relating to fire safety and the premises, which impacted on the safety and quality of service provided.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

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

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 staffing arrangements negatively impacted on residents' ability to access appropriate activities.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

There was a high level of staff continuity. This was confirmed to the inspectors by staff. It was also clear from observation and the care plans examined, that continuity of staff was important to residents. During the inspection, the inspectors observed staff interacting and speaking with residents in a friendly, respectful and sensitive way. Staff members were knowledgeable of residents' individual needs. Residents reacted positively towards staff by appearing relaxed in their company, smiling and chatting with staff. Inspectors spoke with staff and they were aware of their roles and responsibilities. Staff stated they felt supported by the person in charge.

In surveys carried out, relatives were complimentary of staff and described them as looking after residents in a caring manner. In particular, the survey indicated staff were very supportive in times of crisis such as family sickness and bereavement. This mattered a lot to families. Staff were described as being "organised" and "well able" to interpret resident needs. Relatives expressed the view that more staff were required, while others considered staffing levels adequate.

All houses had staff on duty all night and some houses had the assistance of extra staff up to 22:30 hours.

The night manager provided support to night duty staff. Changes had recently been made to ensure the person in charge had oversight of night staff training requirements.

Inspectors found that residents were not always provided with the activities that were planned for them. In some areas this appeared to be due to demands on staff time to provide physical support and care; in other areas it appeared to be connected to how the day services were organised. However, the impact on residents was that activities were not provided for as planned. This is actioned under Outcome 5. The inspector was provided with details of the managers plan to address staffing matters and the provision of appropriate activities to residents.

Staff with whom the inspector spoke confirmed they had received mandatory training in fire prevention, adult protection and moving and handling. Other training was also provided such as food safety and managing behaviours that challenge. As discussed under Outcome 7, records indicated not all staff had fire safety training and two staff were overdue refresher courses in moving and handling.

A staff roster was in place.

Staff were aware of the policies and procedures related to the general welfare and protection of residents. Staff had a good awareness of the regulations and standards. A copy of the regulations and standards were available in the centre.

Staff were supervised appropriate to their role. Parts of the supervision system was new and in the process of being implemented. Regular staff meetings took place and day and night staff regularly met for meetings. The inspector noted that one such day and night staff meeting was taking place on the second day of inspection just prior to the night shift starting.

The nursing registration documentation viewed indicated nurses were up to date with their registration.

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):

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

Findings:

As referred to under Outcome 11, the recording of the same information in up to three different locations led to inconsistencies. It impacted on the reliability of the records.

Judgment:

Substantially 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:

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 report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0002831
Date of Inspection:	23 and 28 February 2017
Date of response:	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 05: Social Care Needs

Theme: Effective Services

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

Some residents' priorities had not been reviewed in over 12 months while some parts of residents' personal plans had not been reviewed since 2014.

1. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- Roll out of meetings with keyworkers have commenced in February 2017 with regard to reviewing residents priorities.
- IT System on PIC's PC is in place to highlight review dates of priorities.
- A complete review of residents personal plans (My profile my plan) has taken place and a trial in one residence in another designated centre is due to commence on Monday 13/03/2017. Following successful completion of same this will be rolled out across the service.
- In the interim PIC will advise all keyworkers to review all personal plans this will be communicated through staff meetings, memo and spot checks.

Proposed Timescale: 19/06/2017

Theme: Effective Services

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

Inadequate arrangements were in place to meet the assessed needs of each resident; in particular the assessed activity needs of residents.

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:

- Referral has been made to the admissions team and the resident is on a waiting list for an assessment of need, with a view to identifying accommodation and support needs.
- PIC to review current activities with resident and keyworker to identify meaningful activities which the resident enjoys participating in and ensure optimal activity levels for the resident.
- An additional staff member from the CE Scheme is due to commence work on Monday 13/03/2017, on a part-time basis to assist in facilitating activities.
- An observational skills assessment was completed; identifying activities that this resident may enjoy. PIC to update Psychologist on status of activities identified with a view to explore other opportunities for the resident.
- As part of priority setting for 2017, PIC will ensure that individualised activity plans are developed for all residents.
- Monitoring of activities will be completed monthly through analysis of individualised activity charts.
- Spot Checks will also be carried in all residences to ensure scheduled activities are supported and where activities are cancelled (i.e., due to weather conditions) suitable alternatives are arranged in order to ensure the resources that are allocated to the designated centre are maximised.

Proposed Timescale: 22/06/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Some parts of the centre were not kept in a good state of repair

3. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

- 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.
- The Brothers of Charity Services Ireland Limerick Region does not have a capital budget to upgrade bungalows where there is significant cost. Nor is there capital funding available from the HSE as the HSE has advised that capital funding is prioritised for decongregation.
- 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 system for prioritizing maintenance work will be developed once the Facilities Manager is recruitment. This recruitment process is at an advanced stage.
- The Cleaning Tender is at an advanced stage and specifications have been agreed. The tender process will be completed by September 2017.
- Cleaning checklists will be updated and implemented to flag the requirement for a deep clean. This will then be reviewed by the manager.

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 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.

4. 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 System needs to be upgraded.
- 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 (5 year plan) 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. The upgrade of the Fire Safety System is included in the Fire Safety Strategy following a review of the system by a Consultant.
- 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 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 the Provider Nominee)

Proposed Timescale: 27/04/2017

Theme: Effective Services

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

Emergency lighting was in place but records were not available to show this lighting was serviced and checked every three months.

5. 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:

- All emergency lighting has been serviced and checked 21/03/2017.
- PIC through consultation with maintenance manager have ensured that the allocated company completes same quarterly. This is highlighted through the companies computer system.
- Records for Emergency lighting are now stored in PIC's office and available to all personnel when required.
- PIC will continue to ensure that these records are maintained and kept up – to – date.

Proposed Timescale: 22/03/2017 and Ongoing

Proposed Timescale: 27/04/2017

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.

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:

- Training dates have been allocated to the three staff members whom had not received fire safety training in the designated centre.
- Training department will continue to send accounts of all training records to PIC.
- Importance of attending scheduled training will be re-iterated to all staff through local staff meetings.

Proposed Timescale: 21/03/2017 and Ongoing

Proposed Timescale: 27/04/2017

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.

7. Action Required:

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

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

- A working group to further clarify appendix 10 of the policy has been set up, this commences on 15th March. The work of the group is set to be completed by May 2017.
- Applications for funding for Aids and appliances are being submitted to the HSE for consideration

Proposed Timescale: 19/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was a delay in accessing speech and language therapy assessments.

8. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

- Currently the organisation has 1 Speech and Language Therapist (SLT) funded by the HSE as set out in our Service Arrangement. There are insufficient resources in relation to demand for SLT input for communication and dysphagia. A business case has been submitted to the HSE for additional resources to support those with more complex needs.
- Given the needs of the caseload as a whole and in order to plan for the most effective use of limited resources, there is access to SLT as part of the multidisciplinary team for the 27 individuals living in this area. This is to facilitate onward referral to another professional e.g. dietitian or by providing resources to support the observational skills assessment as part of the PCP process. Staff training is available by contacting the Training Department.
- The SLT provides sessional input to the area every 2 months. The PIC and SLT can plan for the most effective use of SLT provision. Reviews will be scheduled as required with new referrals seen as prioritised. Urgent referral will be seen outside these times. In addition joint working with the dietitian occurs outside of these times.

The SLT has made contact with the staff to support further development of communication tools. Currently in place:

- Observational skills assessment and recommendations (2014) with InterAAction folder to support recommendations.
- Communication Profile in MPMP
- Communication Passport (2015)
- Communication Dictionary (2017) in a draft format.

Proposed Timescale: 22/03/2017

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 ability of the person in charge to be involved in the management systems of the centre was negatively impacted by administrative duties while at the time of inspection there was a vacant CNM1 post.

9. Action Required:

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

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

- Post for office administrator advertised on 24/01/2017
- Interviews scheduled for 22/02/2017
- Successful candidate has been notified
- 2 applications have been received in response to an internal advertisement for CNM1 recruitment; One candidate has been successful and will be appointed to this designated centre.
- The management structure is being reviewed in conjunction with HR.

Proposed Timescale: 24/04/2017

Theme: Leadership, Governance and Management

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

Unannounced visits did not sufficiently capture issues related to safety and quality of care and support provided in the centre such as fire and premises issues.

10. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- In future each inspection report will reflect not only the findings from the visit which focuses on aspects of quality of care and support which can be addressed within resources but also the corporate level issues, such as fire and premises, which impact on safety and quality of care that have been documented and escalated to the HSE as part of the annual Service Arrangement process.
- There is an expectation that recommendations made and learning from the 6 month unannounced inspection process in the designated centre are generalised to other areas of the designated centre.

Proposed Timescale: 22/03/2017

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.

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

According to the records seen, two staff required refresher training in moving and handling.

12. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- Training dates have been allocated to the two staff members whom had not received refresher training in moving and handling in the designated centre.
- Training department will continue to send accounts of all training records to PIC.
- Importance of attending scheduled training will be re-iterated to all staff through local staff meetings.

Proposed Timescale: 18/05/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

The health care plans for some residents were not easily retrievable. The recording of the same information in up to three different locations led to inconsistencies. It impacted on the reliability of the records.

13. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- A complete review of residents personal plans (My profile my plan) has taken place and a trial in one residence in another designated centre is due to commence on Monday 13/03/2017. Following successful completion of same this will be rolled out across the service.
- In the interim PIC will advise all keyworkers to review all personal plans this will be communicated through staff meetings, memo and spot checks.

Proposed Timescale: 31/07/2017