

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Desmond Community Residential Houses
Centre ID:	OSV-0005178
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 06 March 2018 09:30 To: 06 March 2018 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
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 the third inspection of this centre by The Health Information and Quality Authority (HIQA); the last inspection was undertaken in August 2017. This current inspection was undertaken to follow-up on the findings of that inspection and to evaluate the impact of the actions taken by the provider.

How we gathered our evidence:

Prior to the inspection inspectors reviewed the information held by HIQA in relation to this centre. This included the previous inspection findings and action plans and correspondence from the provider in the intervening period, and any notice received of any incidents that had occurred in the centre since the last inspection.

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

Inspectors conducted the inspection across the two houses that comprised this designated centre, spent time observing and discussing the supports and services

provided to residents. Inspectors reviewed and discussed with staff records including fire and health and safety related records and records pertaining to residents, their assessed needs and required supports.

The centre has capacity to accommodate nine residents; there were seven residents living in the centre; inspectors met and spent time with five of the residents. In both houses residents welcomed inspectors into their homes. Inspectors noted that residents particularly those who returned from the day service in the evening were happy to return to the house and were relaxed in their homes and with the staff present including the members of the management team. Residents were open and confident in their engagement with the inspectors, gracious in their welcome and extended a further invitation to call again.

From this engagement inspectors noted that residents could identify who the person in charge was and that they were supported by her when needed. Equally it was clear that residents had ready access to and an easy familiarity with the area manager. Residents knew the staff on duty and provided positive feedback to inspectors as to their views of both frontline staff and management.

Residents spoke of their day, their planned activities for the evening, invited inspectors to view personal items of interest and discussed planned breaks away and upcoming family events.

Of particular interest to inspectors were the views of residents on the recent changes made by the provider in response to the incompatible needs of some residents. Residents told the inspectors that things were good and better; that the house was quieter; that they liked their house and that they did not miss their previous home or peers. One resident did speak of a recent incident and the upset that this caused but also told inspectors of the support received from staff and the person in charge in response.

Description of the service:

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

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Overall the record did accurately describe the purpose of the designated centre; some amendment was required to reflect the recent changes made.

Overall Findings:

Improvement on the previous inspection findings was noted. Inspectors found that the actions taken by the provider in response to concerns for the safety of residents due to the risk posed by the incompatibility of needs had improved the quality and safety of residents lives. However, there was ongoing risk in one house; currently this was managed but the risk as assessed by the provider was still high.

Enhanced one-to-one staffing supports were in place to support residents and to

manage the risk posed by their assessed needs and the incompatibility of these needs. The provider articulated its commitment to maintain these staffing arrangements. However, the provider also stated that the funding requested from the funding body The Health Service Executive (HSE) for this safeguarding measure had not been provided in full despite the provider having made reasonable efforts to secure the funding.

Improvement was noted in risk management procedures. However, given the significance of risk assessment in the context of safeguarding residents, further improvement and oversight of risks and risk assessment was required as some inconsistency was noted.

Neither house was equipped with the required fire safety measures such as emergency lighting. The provider has submitted a plan to HIQA for the completion of the required fire safety works in one of the two houses. The provider has an alternative plan for the other house; that is to replace this house with an alternative property. The provider was requested to submit to HIQA evidence that there is a time-bound, fully-funded plan for this; this plan was submitted.

While there was action outstanding on the provision of staff training in this area, improvement was noted in medicines management practice.

Inspectors found that overall the maintenance and presentation of records had improved; however, there was ongoing inconsistency in relation to mapping the progress made on resident's personal goals and objectives.

There was a clear management structure and effective governance systems. Staff including the recently appointed person in charge had sound knowledge of residents needs and sought intervention for residents as necessary.

Inspectors reviewed 10 Outcomes; an improved level of regulatory compliance was evidenced. The provider was judged to be compliant with five Outcomes and in substantial compliance with four. The provider was judged to be in moderate non compliance with one outcome; Outcome 7: Health & Safety and Risk Management.

The evidence to support these judgements is discussed in the respective outcome; the regulations breached are specified in the Action Plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

To further inform the inspection findings inspectors reviewed two elements of this outcome.

Inspectors saw evidence that residents were consulted with as to the running of the centre by weekly resident meetings in both houses. Inspectors reviewed a sample of minutes from these meetings and saw that issues such as health and safety, menus, advocacy, activities and complaints were discussed between residents and staff. A resident told the inspectors that they loved attending the house meetings.

It was noted however that since January 2018 meetings in one house had mostly been attended only by one of the three residents living in the house. This was highlighted to the person in charge who confirmed that she was aware of this and outlined the plans to change the days of the meetings so as to maximise and encourage resident participation.

Complaints logs were maintained in both houses and both logs were reviewed by inspectors. Records maintained indicated the nature of the complaint, any action taken and whether the complainant was satisfied with the outcome. One resident informed inspectors about a complaint that they had made and spoke positively about the actions that had been taken by the person in charge in response to this.

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):

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

Findings:

Based on the sample reviewed by inspectors improvement was noted in the presentation of residents' personal support plans. The plans now clearly reflected the sequential process of assessment, planning and review. A reference guide was now included if any aspect of the plan was held separately, for example in the medicines management folder or in the folder that accompanied the resident to the day service so as to facilitate continuity of care and supports.

Where monitoring tools were in use by staff, for example tools for monitoring behaviours of concern, the rationale and purpose of these were clear.

It was evident that residents were consulted with and participated in their plan. For example inspectors saw that some residents signed as evidence of their participation; a resident shared and discussed their plan with inspectors and confirmed specific requests were agreed and facilitated by the provider.

Residents spoken with articulated satisfaction with how their personal goals and objectives were supported by staff. Some examples included community inclusion and integration, family contact, learning new skills such as music, and opportunities to meet peers and maintain friendships. For example a resident spoke of how she missed a peer currently not living in the centre due to deteriorating health, but how the provider supported this resident to attend the day service and to visit the designated centre on a regular basis.

Staff maintained records of how residents' personal goals and objectives were identified, agreed and progressed; residents and their representatives participated in this process. However, there was inconsistency noted in the standard to which staff recorded the actions taken and the progress made to support residents achieve their personal goals. Again it was not clear where a barrier to progression had arisen, if this had been escalated by staff in line with the process that was available for doing this.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

There continued to be inadequate fire safety measures in both houses. The maintenance of a risk register within the centre had improved since the previous inspection but inspectors observed that further improvement was still required.

A fire safety review of both houses that comprised this designated centre had been carried out by an external party in 2016. This review had made various recommendations including upgrading the fire detection systems and providing emergency lighting. An updated plan had been submitted by the provider in February 2018 indicating that some of the fire safety issues would be addressed in one of the houses during May 2018. Given that a registration decision in relation to this designated centre is outstanding the provider was requested as a matter of priority to formalise and submit to HIQA, confirmation of a time bound, fully funded plan for the other house.

During this inspection, inspectors reviewed the arrangements in place to promote fire safety; records seen by inspectors demonstrated that these were consistently implemented. These arrangements included weekly staff checks, regular fire drills, the display of evacuation plans, recently reviewed personal evacuation plans and maintenance checks of the measures that were in place, for example fire fighting equipment, carried out by external contractors. Training records reviewed also indicated that all staff had received fire safety training within the previous two years in line with the provider's policy in this area.

The previous inspection had found that while a risk register was in place, some risks were overdue a review while the documentation around some risks assessments required review to ensure ease of retrieval. On this inspection it was found that the person in charge had an updated risk register in place with the various risk assessments reviewed at the specified dates. However, given the significance which the provider had given to such risk assessments, for example the assessment of risk had informed a recent transfer of residents within the designated centre and between this designated centre and another, it was found that further improvement and oversight of risks and risk assessment was required.

For example, it was noted that the risk assessments within the risk register did not accurately reflect those contained in residents' personal folders where older risk assessments were in place; one resident's personal folder also contained two risk assessments relating to the same identified risk. It was also observed that some of the risk assessments in place at the time of inspection did not reflect the current actual level of risk as indicated by the person in charge. In addition some risks, which the provider had assessed as being high, did not identify additional measures to reduce the high level of risk identified.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

At the time of the last HIQA inspection, the provider had identified and inspectors also found that the designated centre was not suited to meeting the assessed needs of each resident; this had a profound negative physical and psychological impact on all residents and on their quality of life. Residents' needs were not compatible and consequently had a significant negative impact on them and their quality of life. While the provider sought to resolve the issue the situation escalated in late 2017; the provider advised HIQA of this and of the risk based decisions it had made and the actions it proposed to take.

In response to the risk posed to resident physical and psychological well-being the provider transferred four residents between three houses (and two designated centres) in the locality. All of the residents would have been known to each other from the day service and from socialising with each other at weekends. The transfers took place in January 2018.

Inspectors spent time in each house, met with five of the seven residents living in the centre including the three residents who had transferred into and between these two particular houses. Based on the feedback received from residents, from staff, from inspectors observations of the dynamic in one house in particular and from records seen

inspectors concluded that the action taken by the provider had had a positive impact on the safety and quality of residents lives.

There were risk assessments, behaviour support plans, access to psychiatry, psychology and behaviour support; the latter had undertaken on-site observational work in addition to reviewing the behaviour charts completed by staff so as to inform both proactive and reactive strategies. There was evidence of regular multidisciplinary review and discussion. The primary mitigating factor to prevent peer-to-peer incidents was the allocation of the one-to-one staffing support from 06:30hrs to 21:00hrs; the provider stressed that this would be maintained. Staff were aware of and attuned to the recent nature of the changes and monitored and reported any incidents of concern.

However, the risk of negative peer-to-peer interactions was still rated by the provider as of high risk in one house. Narrative records seen indicated regular instances of behaviour directed at both residents and staff. Staff reported that there had been one significant peer-to-peer incident in this house since the transitions in January 2018. A resident spoken with described the incident of verbally abusive behaviour including name calling from a peer and the upset it had caused to her. The resident also spoke of the support received from staff and management.

Medicines were prescribed on a PRN (as required) basis as an adjunct to the management of behaviours. Staff maintained a record of each time these were administered, the reason why and the effect. The incidence of administration based on the records seen was not of concern to inspectors. However, inspectors did note that the audit of medicines did not include the audit of PRN usage. There was a prescription that gave clear direction on dosage and maximum dosage however there were no explicit PRN protocols in use in the designated centre to guide good practice. Inspectors noted that these had also been two requirements of an internal provider review.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors were again satisfied that the provider had arrangements in place for providing appropriate healthcare for each resident having regard to their assessed and changing needs.

Records seen demonstrated that staff sought advice and review as necessary from the respective General Practitioner (GP), the multidisciplinary team (MDT) and other health professionals as appropriate to the assessed needs. Residents had regular access to psychiatry, psychology, neurology, social work, speech and language, dental care, chiropody and optical care; records of referrals and reviews were maintained by staff.

Staff were seen to monitor residents' body weights monthly and sought to support residents to make healthy lifestyle choices.

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

Inspectors reviewed the plans that were in place to guide staff in responding to an emergency situation including the administration of any prescribed emergency medicine. The plans had been reviewed and amended based on the findings of the last inspection. The plan now outlined clear guidance to staff on the administration of the emergency medicine, recovery times, repeat administration, and when and why the assistance of emergency services may be required.

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):

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

Findings:

Improvement was noted in medicines management systems including the introduction of regular audits to enhance oversight of practice. The management of PRN (as required) has been referenced in Outcome 8.

Inspectors noted that medicines were supplied by a community-based pharmacist in a compliance aid or in the original container. Medicines were seen to be supplied for individual resident use, labelled and stored securely.

Inspectors reviewed a sample of medicines prescriptions and saw that they were legible, signed and dated. The instructions of the compliance aid were seen to concur with the prescription.

There was evidence of improved practice as staff now completed a record of each medicine administered to the resident as opposed to the administration of the “blister-pack” as had been practice in the centre.

Staff maintained a record of medicines supplied and a record of any unused or unwanted medicines that were returned to the pharmacy; these records were signed as verified by the pharmacy.

Three audits of medicines management procedures had been completed since the last HIQA inspection; the pharmacist had completed the audit of November 2017; overall satisfactory findings issued.

These audit reports and accident and incident records seen indicated improved practice and a reduced incidence of medicines related incident with one incident noted in late 2017.

The provider confirmed its commitment to provide all staff that had medicines management duties with enhanced training. While some unanticipated delay had been encountered it was planned to commence training in April 2018.

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):

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

Findings:

A revised statement of purpose had been submitted to HIQA in January 2018; the record contained most of the information required such as the services and facilities provided and the criteria for admission. However, further amendments were required to ensure that the record was an accurate reflection of the service particularly given the changes that had occurred since January 2018. The required amendments included the new management structure, the provision of respite, and the total staffing complement differentiating the management and staffing complement.

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):

No actions were required from the previous inspection.

Findings:

Management systems were in place to ensure that the centre was effectively governed and that action was taken to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. However, as discussed below in Outcome 16; Resources, the provider advised that some actions taken were influenced by the resources available to it.

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

The person in charge was recently recruited. The person in charge was employed fulltime, was suitably qualified and had the required management experience. The person in charge had completed studies in applied social studies and management. This was the only designated centre that the person in charge was responsible for. On speaking with her the person in charge had a sound understanding of her regulatory role, of the residents and their required supports and of the general operation and administration of the designated centre. The person in charge confirmed that she had received a comprehensive induction from the previous person in charge.

The provider operated two designated centres in the locality and the person in charge confirmed that the area manager and both persons in charge continued to work in a collaborative and supportive manner. For example the persons in charge worked opposite each other and worked alternate weekends; the area manager and both persons in charge operated an on-call system for staff.

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

The provider representative held monthly meetings to which managers including the

persons in charge were invited and could request items for discussion to be added to the agenda. The person in charge had attended one such meeting since her appointment and described the meeting as informative and constructive.

There was evidence from records seen that staff did raise any concerns that they had in regard to the supports and services provided to residents; for example during recent discussions in relation to the proposed transfer of residents between houses.

Arrangements were in place for the completion of the annual review of the quality and safety of the care and supports provided and the six monthly unannounced visits as required by Regulation 23; reports were available to inspectors. Inspectors reviewed the reports of two unannounced visits undertaken in the designated centre on behalf of the provider since the last August 2017 HIQA inspection. Action plans did issue; the actions taken in the centre to address the failings identified by the reviewers were recorded. Overall and on balance inspectors found that these actions had been completed as recorded.

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The action plan submitted by the provider in response to the August 2017 inspection of this centre stated that additional staffing would be put in place to support resident needs. These additional staffing resources were in place from 06:30 hrs to 21:00hrs daily. However, the provider stated that it did not have the required resources for this and that the funding requested from the funding body The Health Service Executive had not been provided in full despite the provider having made reasonable efforts to secure the funding.

The provider confirmed to inspectors that on the basis of risk it had diverted resources from a day service to maintain the additional staffing required in the designated centre. The provider confirmed that this diversion of funding had had a negative impact on the day service and the variety of activities that residents participated in. This was reflected in the minutes of residents' advocacy meetings seen by inspectors.

Judgment:

Substantially Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

Failings related to staffing levels and the maintenance of the staff rota were found to have been addressed.

The previous inspection had found that staffing numbers in one house were not appropriate to meet the needs of all residents. In response to this failing the provider had undertaken to put in place additional staffing at specific times. During this inspection inspectors found that this additional staffing had been put in place and was maintained. Staff spoken with confirmed this staffing arrangement and its adequacy. This staffing arrangement is a core risk management control and inspectors did, given the findings outlined above in Outcome 16, query the sustainability of this additional staffing. A representative of the provider stressed at verbal feedback of the inspection findings that this additional staffing would remain in place.

It had also been found on the previous inspection that neither a planned nor an actual staff rota was properly maintained showing all the staff members that were on duty in the centre. Staff rotas were reviewed and this issue was found to have been addressed. The rotas seen by inspectors also indicated that while a particular shift was worked by relief staff, generally a continuity of staffing was provided for. However, at verbal feedback, given residents' specific requirements, it was reiterated to the provider that this was an area that required ongoing review and a permanent solution if possible to ensure that best possible outcome for all residents.

The interactions observed between residents and staff were kind and caring. Residents presented as comfortable in the presence of staff and the management team; good natured conversation between all parties was overheard. Residents who spoke to inspectors spoke positively regarding staff members and the support provided by them.

Training records of staff working in the centre, staff files and arrangements for staff supervision had been reviewed previously by inspectors and so were not reviewed during this inspection.

Judgment: Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0005178
Date of Inspection:	06 March 2018
Date of response:	16 April 2018

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:

Inconsistency was noted in the standard to which staff recorded the actions taken and the progress made to support residents achieve their personal goals. Again it was not clear where a barrier to progression had arisen, if this had been escalated by staff in line with the process that was available for doing this.

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

1. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Action:

- Inconsistency was noted and addressed with Keyworker.
- This issue has been resolved and action complete.
- PCP goals are being realised and reviewed quarterly.

Proposed Timescale: 16/04/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Given the significance which the provider had given to such risk assessments, for example the assessment of risk had informed a recent reallocation of residents within the designated centre and between this designated centre and another, it was found that further improvement in relation to oversight of risks and their assessment was required.

2. Action Required:

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

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

Action:

- Risk assessments in Residents personal folders have been updated to accurately reflect the risk in place for that resident.
- Two risks present for one resident have been amalgamated into one risk which will be monitored and reviewed at MDT.
- Risk assessments in place for all residents which were rated as high have been reviewed at MDT and are scored appropriately in line with control measures in place.
- Risks which are scored high have been reviewed with MDT and control measures identified to reduce the risk.

Proposed Timescale: 16/04/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

There continued to be inadequate fire safety measures in both houses.

3. 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:

- L1 fire detection system has been scheduled for installation and will be certified by Fire safety engineer in line with the schedule submitted to HIQA. All works for both houses in the designated centre will be completed by 31st May 2018.
- Emergency lighting has been scheduled for installation and will be certified by Fire safety engineer in line with the schedule submitted by HIQA. All works for both houses will be completed by 31st May 2018.
- Additional fire safety works will be reviewed with a fire safety engineer in the context of the recent update to Building regulations and a decision will be made as to what additional works are required. These works will be planned for completion by 31st March 2019.
- A replacement house has been purchased in to replace one house in the designated centre.
- A specification for this house has been agreed and the tender process for upgrade works will commence in April 2018.
- On completion of upgrade works this house will be fully compliant with Fire Safety regulations (2A). Works will be overseen and certified by Fire Safety Engineer.
- In the interim fire safety checks and fire safety controls will continue to be followed during the intervening period.

Proposed Timescale: 31/03/2019

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The audit of medicines did not include the audit of PRN usage: there were no explicit PRN protocols in use in the designated centre to guide good practice. Inspectors noted that these had also been two requirements of an internal provider review.

4. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

- PRN Protocol template agreed at MDT.
- Roll out of PRN protocol for all individuals will be complete for designated centre by the 30/4/18.

- PRN report to HOCS monthly.
- Referral to head of community services for review of the Community medication procedure and medication audit template to include PRN audit.

Proposed Timescale: 29/06/2018

Theme: Safe Services

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

The risk of negative peer-to-peer interactions was still rated by the provider as of high risk in one house.

5. 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:

- Monthly monitoring of impact of residents behaviour that challenge on peers.
- Quarterly review of risk at MDT.
- Ongoing support and intervention from MDT and behaviour support in supporting residents with behaviour that challenge.
- 1:1 support for one resident in place.
- Safeguarding plan in place.
- PIC informing Senior management team of situation at regular intervals.
- Staff advised to record and monitor any negative interactions between residents.

Proposed Timescale: 16/04/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

Amendments were required including the management structure, the provision of respite, and the total staffing complement differentiating the management and staffing complement.

6. 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:

- Amendments to Statement of purpose to reflect provision of respite, staffing compliment to include Person in charge and newly appointed person in charge

submitted to Hiqa on the 4/4/18

Proposed Timescale: 16/04/2018

Outcome 16: Use of Resources

Theme: Use of Resources

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

Resources had been diverted from a day service to maintain the additional staffing required in the designated centre. The provider confirmed that this diversion of funding had had a negative impact on the day service and the variety of activities that residents participated in.

7. 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:

- Senior Management continue to make decisions based on prioritization of safety risks.
- Funding deficits are advised to HSE as part of Service Arrangement engagement.
- Regional advocacy have highlighted reduction in staffing in Day Services to HSE as part of their engagement in 2017.
- Minimizing impact on day attenders is managed as far as possible by Day Services staff and management.

Proposed Timescale: 16/04/2018