

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by L'Arche Ireland
Centre ID:	OSV-0001959
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	L'Arche Ireland
Provider Nominee:	Mairead Boland Brabazon
Lead inspector:	Ide Batan
Support inspector(s):	Noelene Dowling
Type of inspection	Announced
Number of residents on the date of inspection:	4
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 May 2015 10:00	05 May 2015 17:30
06 May 2015 08:30	06 May 2015 14:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second inspection of this centre by the Health Information and Quality Authority (the Authority). The inspection was carried out in response to an application from the provider to register the centre. As part of the inspection, the inspectors met with the residents and staff members. Inspectors reviewed documentation such as the centre's statement of purpose, person centred care plans, medical records, arrangements with regard to meal preparation, activities, staff training records, staff files, policies and procedures, fire safety records and the residents' accommodation.

As part of the application to register, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purposes of application to register were found to be incomplete. The outstanding documents are required to be submitted to the Authority.

The person in charge has also changed since the previous inspection by the Authority. The fitness of the person in charge was determined by interview during the inspection. The person in charge is supported in her role by the provider and community coordinators. There was no deputy person in charge to cover any absences of the person in charge on this inspection.

The centre can accommodate four residents. This residential service is located on the periphery of a small village and is operated from a large, detached house. The centre supports people with different levels of abilities and needs. The ethos of the designated centre as outlined in the centre's statement of purpose and function which is to provide 24 hour care and support to adults who have intellectual disabilities. Inspectors observed that some residents also presented with behaviours that challenge and have complex care needs. Day services are provided for all residents approximately seven kilometers from the house.

Two questionnaires from relatives were returned to the inspector and the inspectors spoke with residents during the inspection. The collective feedback from relatives was one of satisfaction with the service and care provided.

The findings of this inspection are influenced by the fact that the service are only in the process of familiarising themselves with the requirements of Regulation. The provider demonstrated an awareness of the requirements of legislation. Improvements were required in the consistent development and implementation of meaningful personal plans and reviews for residents, the development of cohesive strategies for risk management, challenging behaviours, and healthcare reviews by the multidisciplinary team.

The numbers and skill mix of staff was also found not to be sufficient, with particular emphasis on skill mix and training pertinent to the resident group. There was evidence of compliance, in some areas, of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

The inspectors reviewed resident's preferences, access to and participation in recreational activities. The inspectors spoke with residents and staff in addition to making observations regarding resident's activation levels on the inspection and also reviewing the resident's progress notes. The inspectors found that residents participated in activities that were meaningful, frequent and in line with resident's preferences.

Inspectors saw that residents had jobs within the community such as the centre's coffee shop, attending activation therapies such as baking, art, candle making and computer work. Residents also engaged in other activities in the community such as swimming, bowling and going out for meals.

Inspectors saw that residents' meeting takes place on a weekly basis. A review of the minutes indicated that residents, discuss issues such as outings, complaints food and activities. There was a human rights committee in operation. Inspectors viewed minutes from a recent meeting in November 2014. There was also a listening group in operation which included residents from residential services and this group was chaired by the person in charge.

There was no appropriate advocacy service available suitable to the needs of the residents. The provider was acting as informal guardian to one resident and had appointed a member of staff to act as advocate / for a resident with profound intellectual disability in the absence of any close next of kin. This arrangement was however not supported by any agreement that outlined the actual function of the advocate and the provider as guardian in terms of resident's finances or medical care and decisions. In the, long term interest of the resident this arrangement should be

formalised. The provider and person in charge concurred with this finding.

Overall, inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint. There was a local complaints policy which was available in an accessible format. The centre did maintain a complaints log to record complaints. However, there was no second nominated person to respond and maintain complaint records as required under regulation.

The manner in which residents were addressed by staff was seen to be appropriate and respectful. However, inspectors observed that care was provided in a way that respected privacy but was not consistent. The policy on intimate care was adequate. There was inconsistent evidence in personal plans viewed by inspectors that dignity and gender specific issues were sufficiently assessed and appropriate supports sought. Inspectors also observed inappropriate use of language in relation to residents' moods in minutes of house meetings.

There was a policy on residents' personal property and records of residents property was observed in their files. Residents could keep control of their own possessions. Inspectors saw that there was adequate space for clothes and personal possessions. The laundry facilities were appropriately set up to facilitate residents in doing their own laundry if they wished. In the house staff did the laundry and residents were encouraged to participate if they wished.

Residents were facilitated to exercise their religious rights as inspectors were told that some residents like to attend mass in the local village. Staff were unclear of the process in relation to residents being facilitated to vote.

The provider had a detailed policy in relation to the management of resident's finances. As assessment was carried out of the resident's capacity to manage money. This policy outlined the rules for the safeguarding of residents monies and for the use and withdrawal of same by staff. Residents had their own bank accounts. Fee payments were made directly to this and the remainder was itemised in the account. They did not have unsupervised access to their account but were accompanied by staff or family member when withdrawals took place.

In some instances staff had to complete the withdrawal slips on behalf of the residents. Statements were issued to the residents on a monthly basis. Staff withdrew specific amounts of money on a monthly basis to cover day to day and other expenditure. Resident had a day purse in which they carried up to ten euros for drinks of coffees. Expenditures were receipted and forwarded to the homes co-ordinator along with an accounting ledger for review on a monthly basis.

The policy allowed for with drawl of up to two hundred at the discretion of staff and any amounts over this had to be sanctioned by a member of management. However, there were contradictory elements in the practice and the policy. Inspectors were informed that residents did not pay any amounts for staff if on outings, holidays or trips. The policy stated that if residents invite the staff out or requests staff assistance or attendance the resident will pay the cost of this and staff confirmed to inspectors that

this was the procedure. The ledgers and receipts viewed by inspectors did not detail this expenditure. Inspectors were concerned that this arrangements as it currently stands may inadvertently leave residents open to possible mismanagement of their finances. Inspectors were informed that all expenditure is sanctioned by the managers. However, there was no documentary evidence of such requests being made, how and by whom authorisation was given.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

In the personal plans reviewed by the inspectors, residents' communication needs were outlined in a communication plan. The communication plans detailed their preferred method and abilities of communication. Where applicable residents used picture aids to assist them with their communication. However, in one instance inspectors saw that the communication plan was not reviewed for a resident who required pictured picture enhanced communication. Staff told inspectors that this resident could display challenging behaviour if staff did not understand him. Therefore, it would be imperative that communication plans are kept updated.

As outlined under Outcome 1 inspectors observed the inappropriate use of language in some records. There was a policy on communication available. Inspectors found residents had good access to communication media, such as, television, radio, newspapers and magazines and brochures. The inspectors noted communication boards in the houses that highlighted appropriate and accessible information to residents such as a picture rota of staff on duty. Staff told the inspectors they knew residents well, this assisted them in understanding their needs for example through gestures. The inspector found this to be reflective of witnessed interactions with residents.

Judgment:

Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain personal relationships and links with the wider community. Staff told inspectors that residents' friends and families were welcome in the centre and were free to visit. Residents stated that they had made friends both within the service and outside through work and other social activities. Most residents went home at weekends and those who did not go home availed of one to one outings with staff. Inspectors saw in the personal plans that residents enjoyed one to one time with staff.

Residents were facilitated to meet family and friends in private. Inspectors observed that in the main house residents had their own room and there was adequate private space available also. Inspectors found that there was evidence that families were invited to attend annual personal care plan meetings. Inspectors saw that residents would go out to the local shop for groceries and one resident liked to go to the local pub for tea.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The organisation had a policy on admissions and discharge. The admissions policy did not take into account of the need to protect residents from abuse by their peers. The policy did not include transfers of residents. The statement of purpose did not outline the specific care and support needs that the centre is intended to meet.

Inspectors were not assured that if a resident was transferred to hospital all relevant information was made available to the service assuming responsibility for the resident. Staff told inspectors that they would stay with residents in the event of a hospital admission. Admissions were overseen by an admissions committee. The provider said that there had been no admissions for quite some time. Inspectors observed that each resident had a written agreement but details of charges for additional services were not covered in the contract. There have been no recent discharges from this service.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The inspector reviewed a sample of four resident's personal plans. The inspectors found that resident's needs were not sufficiently assessed and documented to ensure staff were providing safe and effective care in line with their assessed needs. From a sample of personal plans reviewed inspectors found that they were detailed in relation to social, family and activity based needs and preferences.

The person-centred plans contained, personal details and family contacts. They also contained an outline of:

- Important people in the resident's life
- communication requirements
- important things in the resident's life like work, weekends, fun things to do and family
- how the resident likes to spend time on activities
- improvements to the resident's life in the last 12 months.

Residents who could communicate with the inspector said that they had a good choice of meaningful activities from which they could choose to attend or work in each day. Some residents also outlined how they enjoyed just relaxing in their room, spending time alone, reading and sometimes watching television or listening to music. These preferences were seen to be facilitated.

However, personal plans did not have a multi disciplinary or comprehensive focus and had not been implemented to meet the changing needs of some residents. Accidents and incidents were documented and inspectors saw that there had been a previous incident of choking. There was no risk assessment completed in relation to the incident for this resident. Inspectors also observed that the risk for this resident in relation to choking was significant as he did not have any dentures.

The inspectors read medical files of all residents, which included appointments they had attended such as general practitioner appointments. Inspectors saw that since the previous inspection of August 2014 residents were only being referred now for dietary

and speech and language consultations. Inspectors saw that one resident attended mental health services. However, there were no outcomes recorded following the appointment to guide staff in the care of the resident. This required review to ensure residents assessed needs and healthcare needs were accurately captured and recorded.

The plans did not adequately address:

- education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support
- transport services

the resident's wishes in relation to where he/she want to live and with whom

- the resident's wishes or aspirations around friendships, belonging and inclusion in the community.

Inspectors saw that a resident had repeated falls. There was no evidence that falls assessments were maintained in relation to the areas of vulnerability identified and therefore there were no individual safeguards put in place even though staff had identified that the resident was at risk. Another resident had been identified as a risk of wandering onto the main road. On the second day of inspection inspectors saw this resident unaccompanied at the front door which was open. This presented a risk as the centre is located beside a busy main road.

Inspectors saw that some residents had difficulty in managing their own behaviour. However, there was a behaviour support plan in place which was detailed. Inspectors observed that the intervention of a behaviour support specialist had only occurred recently and had taken a considerable length of time to access this specialist. There was no evidence of multidisciplinary involvement in the annual reviews.

The inspectors from a review of resident's personal plans were not assured that staff had sufficient knowledge on how to complete a personal plan and subsequent care plans. Inspectors were not assured that the reviews carried out assessed the effectiveness of the personal plans. The inspectors were not assured staff had the appropriate skill set to meet the needs for all residents as further outlined in Outcome 17.

Residents attended their day care facilities on weekdays and the inspector saw evidence of the activities in which they were involved. The centre had its own transport in which residents travelled to the city or on day trips. There was good communication between both the day and residential service as observed by inspectors.

There was a system of reference workers/key workers in operation whose primary responsibility was to assist the individual to maintain their full potential in relation to the activities of daily living. However, a reference worker had documented in a personal plan that an annual goal for the resident was to go out for trip. In a twelve month period this had not been addressed. Inspectors observed in personal plans that family contact and spending time with family in their homes was of great importance to most residents. Inspectors saw that residents/relatives were involved in their annual reviews.

Judgment:

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):

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

Findings:

The centre consisted of one two storey house which was located in a small rural village. The house could accommodate four residents.

There was a large kitchen dining area. The locked medication press was in the pantry adjacent to the kitchen. There was a well furnished living room and sun room. The kitchen led to a hallway with a bathroom with shower, toilet and wash hand basin. There was a one self contained apartment on the ground floor. There was one bedroom on this floor occupied by an employee (also called assistants). The resident specifically requested that inspectors did not enter his apartment. There was a quiet/prayer room on this floor.

On the first floor there were seven bedrooms three of which residents occupied and the other bedrooms three employees occupied. There was one vacant room. There were two bathrooms with toilets and baths. There was also an office on this floor. Suitable storage facilities for resident's personal belongings was available as observed by inspectors.

The inspectors found that the centre was homely and maintained. The design and layout of the centre was in line with the statement of purpose and met the needs of the residents whilst promoting safety, dignity, independence and wellbeing. The premises had suitable heating, lighting and ventilation and overall, the premises were free from significant hazards that could cause injury.

There were sufficient furnishings, fixtures and fittings and the centre was clean and suitably decorated. There was adequate private and communal accommodation and there was access to kitchens with sufficient cooking facilities and equipment. The centre had an adequate number of toilets, bathrooms and showers to meet the needs of the residents.

The house was set in very large grounds with very limited car parking facilities to the front as the house was situated on a main road. The gardens to the rear were spacious and contained suitable garden seating. There were walkways around the property and vegetable growing plots and tunnels. There was a garden workshop adjacent to the house and some residents worked there.

As the residents tended to be mostly independently mobile, specialist equipment for use by residents or people who worked in the centre was not required.

Judgment:

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 was a risk management policy in place which identified the hazard identification and incident reporting process and contained the measures and actions in place to control the following specified hazards as identified in the legislation:

- unexpected absence of a resident
- accidental injury
- aggression and violence
- self-harm.

However there were a number of areas of risk in the centre particularly in relation to the outdoor areas which were identified on the previous inspection and had not been rectified which included:

- Unrestricted access to a main road from a garden area, particularly as one resident had been identified as at risk of wandering
- unrestricted access to a boiler room in the garden area
- pipe work for radiators not being covered and exposed chimney flues.

From speaking with staff inspectors concluded that there were differences in how risk was identified and managed. Some staff members did not demonstrate an appropriate awareness of identifying hazards and managing risk. In some instances there was little knowledge of the content of the risk assessment or any planning in relation to this such as unlocked doors and access onto the main road.

Inspectors observed overall inconsistencies in the identification of and management of risk. For example, all residents had a generic risk register of being at risk from self harm and accidental injury. It was unclear from the risk register the actions/controls to mitigate these risks. Inspectors noticed that a number of keys were kept in the office upstairs and staff were not always sure which keys opened which doors or whether the laundry room fire exit door was locked at night and where the key was held. This factor and the subsequent risk had not been addressed in any risk management strategy.

The fire policies and procedures were centre-specific. There were notices for residents and staff on what to do in the case of a fire displayed. The inspector examined the fire safety records with details of all checks and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in June 2014. Inspectors noted that the emergency lighting had not been working since September 2014. The team leader said that this was due to an electrician working on the fire management system. A new fire alarm system had been commissioned. However, there was no evidence of the alarm being serviced since it had been installed in November 2014. In the sample healthcare files seen by the inspector each resident had a personal emergency evacuation plan which included procedures for evacuation. Records indicated that regular fire evacuation drills with residents had taken place the last one in April 2015.

Works was being carried out to upgrade the fire safety system in order to provide documentary evidence of compliance with the Fire Authority by a competent person. All staff had received fire training and those who spoke with inspectors were knowledgeable of the procedures to follow in the event of a fire.

There were guidelines in relation to control and prevention of infection and liquid soap and paper towels were provided. There were cleaning schedules in place and the team leader and staff informed the inspector that the cleaning of the centre was undertaken by all staff once their caring duties were completed. The inspectors noted that the centre was visibly clean. Inspectors were satisfied that the procedures that were in place were in line with the Authority's Standards on the prevention and control of healthcare associated infections.

There was a policy on the reporting of accidents and incidents. Inspectors reviewed the incident log. The incident reporting system did not include details of how the service was acting to prevent an incident reoccurring. There was no evidence of an analysis of incidents or any shared learning following an incident. This was a finding on the previous inspection also. There was a health and safety which outlined the centre's response to fire and evacuation arrangements. It also dealt with other emergencies like loss of power, loss of lighting or flooding. However, staff whom inspectors spoke with were vague in relation to the relocation of residents in the event of an evacuation and find interim accommodation for residents.

Vehicles owned by the organisation to transport residents had evidence of road worthiness and insurance. All staff with the exception of one had completed manual handling training.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided

with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

There were policies and procedures in place for the prevention, detection and response to abuse. Staff with whom inspectors spoke were knowledgeable in relation to abuse and the reporting procedures in place. However, some staff were unclear as to who was the designated safeguarding officer.

There were records available which indicated that staff were trained in abuse detection and prevention as required by legislation. However, further training was required in relation to the role of the designated safeguarding officer in line with the HSE policy on safeguarding. Inspectors observed that staff were respectful and engaged positively with residents. Inspectors saw in a house that residents interacted and responded well to staff members. There was a policy relating to delivery of personal care to residents.

There was a policy on challenging behaviour and inspectors saw that staff had received training in the management of challenging behaviour. There was limited evidence that residents were provided with emotional, behavioural or therapeutic support that promotes a positive approach to behaviour that challenges as outlined under Outcome 5.

There was a policy on restraint dated February 2015 which was not centre specific. It was based on guidelines issued by the Authority. Inspectors saw that chemical restraint was used. Staff were unclear as to what constituted chemical restraint. There was no evidence of any other multidisciplinary input into the management of chemical restraint apart from the general practitioner (GP). There were no physical or environmental restraints in use at the time of this inspection. Arrangements in relation to residents' finances are outlined under Outcome 1.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The provider has not submitted any notifications to the Chief Inspector since 30 December 2014 as required by the Regulations.

The lack of robust arrangements being in place to analyse incidents or adverse events in an effort to mitigate risks to residents has already been addressed in Outcome 07.

Judgment:

Non Compliant - Major

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that resident's opportunities for new experiences, social participation, education, training and employment were facilitated and supported.

Staff outlined and inspectors saw that residents had regular roles within the house and the inspector noted that such roles formed part of residents' goals in their personal plans. The resident's roles and responsibilities included keeping the house tidy, setting tables for meals, participating in food preparation and clearing up after their meals. All residents attended day services at the main campus.

Residents outlined to the inspector how they could access appropriate and accessible indoor and outdoor recreational events for example bowling, cinema, and trips to the seaside, exercise classes and outings to different local amenities.

Care plans and daily records will documented the type and range of activities that residents were involved in. The inspector also saw that various training programmes and educational activities were available through the organisation. Some residents also worked in the garden centre and the centre's own coffee shop which was located near the day services.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Inspectors saw limited evidence of referrals to specialist services and allied health care services such as physiotherapy, occupational therapy, speech and language therapy based referrals. In all personal plans reviewed inspectors saw that referrals to some allied services such as dietetics and speech and language therapy had only just commenced. Inspectors were told that a resident required a modified diet. However, there was no evidence of any multidisciplinary input into the resident's care which would achieve the best possible outcome for this resident.

A pro-forma document is completed primarily by the staff and signed by the GP. In some instances the information was scant, for example, some residents refused to have blood tests done. Inspectors acknowledge that the resident's rights to refuse treatment were respected. However, there was no plan in place to encourage residents to have the tests done which would support them to achieve the best possible health. There was no evidence of any multidisciplinary input into each resident's annual review as required by the Regulations.

Residents were seen to have appropriate access to other allied health care services such as chiropody, optical and dental were accessed through the HSE and visits were organised as required. The inspector saw that residents were involved in the menu planning. Weekly meetings were held with the residents to plan out the meals for the week. The staff demonstrated an in-depth knowledge of the residents likes and dislikes.

Some of the residents were seen to have nutritional plans and swallow plans as required with some residents requiring a soft diet. The inspector observed that residents had access to fresh drinking water at all times. Residents' weights were recorded on a monthly basis. The food was seen to be nutritious and staff encouraged healthy eating. Residents to whom inspectors spoke stated that they enjoyed their meals and that the food was very good. They also liked to eat out and often had meals out at the weekends. Inspectors noted that easy to read formats and picture information charts were used to assist some residents in making a choice in relation to their meal options

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):

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

Findings:

The inspectors found that the medication management policies and procedures were satisfactory. The inspector reviewed the medication policy which was adequate and gave clear guidance to nursing staff on areas such as medication administration, refusal and withholding of medications, medications requiring strict controls, disposal of medications and medication errors.

The inspector saw that the residents own GP prescribes all residents medication and this is obtained from the residents' local pharmacist for each resident. Inspectors saw that some medication charts were transcribed in accordance with local policy and best practice. Medication was stored in a locked cupboard and counted and documented on admission by staff.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear and distinguished between PRN (as required), short-term and regular medication. There were no residents that required scheduled controlled drugs at the time of the inspection.

However, inspectors saw that there were four incidents of medication errors. In one instance there was no evidence of any follow up action or systems put in place to prevent incident reoccurring. There was no system in place for reviewing and monitoring safe medication practices.

The inspectors saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the medication and a colour photograph of the medication which is essential in the event of the need to withhold a medication or in the case of a medication being dropped and requiring replacement.

The centre was a non nurse led service Non nursing staff had undergone training on safe medication administration. The inspector saw evidence of this training in the staff files. There was evidence that a pharmacist had completed a recent audit and the medication administration sheets had also been audited in February 2015. An improvement plan had been put in place following the audit.

Judgment:

Non Compliant - Moderate

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
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: The statement of purpose, the most recent of which was revised April 2014, for the most part complied with the Regulations. Some areas for improvement included an:</p> <ul style="list-style-type: none"> •accurate description of the organisational structure for the designated centre •specific care and support needs that the designated centre is intended to meet .
<p>Judgment: Substantially Compliant</p>

<p>Outcome 14: Governance and Management <i>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.</i></p>
<p>Theme: Leadership, Governance and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: L'Arche Ireland is a limited company and the chief executive officer (CEO) had been appointed on 1 November 2014. The Board of L'Arche Ireland provided oversight of the management of each community. This is achieved by each community having a local committee, the chairperson of which sits on the Board and who provide reports to the Board. At senior management level there is the post of CEO, a quality assurance officer who works part-time and the person in charge.</p> <p>The nominated provider who is also the CEO outlined the governance arrangements in place for L'Arche Kilkenny. The person in charge has changed since the previous inspection. There was an acting person in charge on this inspection who had over twenty years experience of shared living as part of the L'Arche Community. The nominated provider told inspectors that the position of person in charge was currently in the process of being recruited. The acting person in charge was based in the day services campus approximately seven kilometres from the designated centre.</p> <p>The person in charge was engaged in the operational management of the house. Based</p>

on interactions with the person in charge and interview during this inspection, she had some knowledge of 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. Inspectors saw that the residents knew her well and staff were clear on the reporting structures in place. Staff confirmed that the person in charge would visit the house during the week.

A system of audits had been put in place within the organisation by members of the senior management team, and the inspector saw evidence of some audits carried out in relation to this designated centre. An annual review to capture the quality and safety of this designated centre had been completed to date. However, this review did not present an overview on the quality and safety of care and support provided to residents as it included:

Ethos of L'Arche

House assistants coping with change

Retreats and spirituality

Inspectors were not assured that the service was governed in a manner that supported the creation and continuous improvement of a person centered service that collectively met the needs of all residents. There was no evidence to support that a systematic, constructive and proactive culture and system was in place for reviewing the quality and safety of care and services provided to residents.

Inspectors observed that there was a planned programme of support and supervision for staff members. Inspectors saw that the person in charge did receive supervision from the registered provider. There was evidence of regular meetings taking place between the provider and person in charge.

Documents were not provided with the application to register regarding compliance with fire and planning under Regulation 5 of the Health 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. These two documents are required before a recommendation for registration can be made.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The Chief Inspector had not been notified of the planned absence of the person in charge of the centre for more than 28 days by the provider. However, there was no deputy person in charge in place on this inspection. This was discussed with the provider at the feedback meeting.

Judgment:

Non Compliant - Major

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 provider and person in charge said that the centre was not resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose. Inspectors saw that staffing levels were low in the house particularly at weekends which was inadequate to meet the needs of residents.

The facilities and services in the centre reflected the statement of purpose. There were resources in place to support residents achieving their individual personal plans. For example, residents who required a staff member to accompany them to appointments or social occasions were fully accommodated. Transport was provided and all residents attended day services.

Judgment:

Non Compliant - Moderate

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):

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

implemented.

Findings:

The inspectors found that improvements were required regarding the workforce to comply with the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with Disabilities) Regulations 2013. There was insufficient provision of suitable qualified staff to meet the needs of the residents.

Inspectors were not satisfied that the skill mix of staff available during the inspection was appropriate to meet residents' needs. Inspectors formed this judgement through observation, review of documentation and speaking with staff. Some staff members who were predominantly known as volunteers by the community had very little experience of working with people with disabilities.

The support intensity scale was used to measure dependency levels of residents. However, staff were unclear how the level of dependencies were measured and staff were unclear of the nature of disability that residents presented with. Therefore, inspectors were not assured that the assessed needs of residents were met at all times.

The inspectors reviewed the roster, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night. There was no designated person in charge of coordinating any shift. In one instance an employee was rostered for 22 days consecutively.

The inspector observed staff and residents interactions and found that staff were respectful patient and attentive to residents needs. Inspectors were satisfied that staff received required mandatory training at appropriate intervals such as fire management and prevention, protection and response to abuse and managing and preventing aggression (MAPA). However, staff require further access to training and education to meet all the assessed needs of residents. As outlined throughout the report some residents had complex care needs and the training records viewed did not support the skills required to safely care for these residents.

Staff who spoke with inspectors had limited understanding of the Regulations and Standards or any other relevant guidance issues from statutory or professional bodies. Copies of the Standards were available in the house. There was a recruitment policy in place for employees and volunteers.

Inspectors reviewed all staff files and noted for the most part were compliant Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, in one instance inspectors noted that the references for the employee and police clearance were in another language and had not been translated. Inspectors were informed that no volunteers are currently used in the service.

There was a programme of induction in place as observed by inspectors. The person in charge told inspectors that a community nurse had just commenced employment. The nurse would have a specific remit for training and supervision. Inspectors saw that all

staff received support and supervision.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The inspectors found that records were accurate, up-to-date, maintained securely and easily retrievable with some improvements required. Some of the records pertinent to residents did not have the required plans in place for all identified health care needs and in some instances documents did not identify all professionals who had attended meetings such as annual reviews in relation to residents

There was a directory of residents held in individual files which was in accordance with the Regulations. Improvements were identified in relation to the policies in place. A small number of written operational policies as required by Schedule 5 of the Regulations were not in place. These included staff education and training and creation of, access to maintenance of and destruction of records.

An up-to-date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements of the Regulations. The centre also had a policy in relation to visitors and there was a visitor's book available in the centre.

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:

Ide Batan
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 L'Arche Ireland
Centre ID:	OSV-0001959
Date of Inspection:	05 May 2015
Date of response:	30 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

There was not appropriate advocacy services in place.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

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

The registered provider will send a referral to the National Advocacy service. The Provider already has the involvement of the National Advocacy Service on the organisation's internal rights' committee.

Proposed Timescale: 09/07/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was inconsistent evidence in personal plans viewed by inspectors that dignity and gender specific issues were sufficiently assessed and appropriate supports sought.

Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

The PIC will review care plans and seek to ensure they are responsive to gender specific issues.

Guidance will be given to staff and the care plans will be reviewed quarterly.

Proposed Timescale: 30/09/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff were unclear of the process in relation to residents being facilitated to vote.

Action Required:

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

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

The referendum and election was discussed at the listening group on 20 May 2015, using accessible documents

Residents were facilitated to vote on 22 May as per our long-standing practice

All staff will be reminded of the organisation's process for facilitating residents to vote as per the established practice and this will be included in training. A policy on civic and social inclusion will be developed.

Proposed Timescale: 30/07/2015**Theme:** Individualised Supports and Care**The Person in Charge (PIC) is failing to comply with a regulatory requirement**

in the following respect:

The ledgers and receipts viewed by inspectors did not detail some expenditure. Inspectors were concerned that this arrangement as it currently stands may inadvertently leave residents open to possible mismanagement of their finances. Inspectors were informed that all expenditure is sanctioned by the managers. However, there was no documentary evidence of such requests being made, how and by whom authorisation was given.

Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

We will amend the contract to reflect practice. A finance request form, which is signed by the resident and house leader will be in place. The PIC will sign off on all expenses over €200 per month and where appropriate the family/representative will be consulted.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

There was no second nominated person to respond and maintain complaint records as required under regulation.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

A second complaints officer will be appointed.

Proposed Timescale: 30/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

In one instance inspectors saw that the communication plan was not reviewed for a resident who required pictorial enhanced communication.

Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

The Person in Charge will ensure that the communication book is kept up to date and will review at team meetings.-Completed

The PCP/ Care plans will be audited by the registered provider to ensure compliance with best practice.

Proposed Timescale: 10/07/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The admissions policy did not take into account of the need to protect residents from abuse by their peers.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

The policy will be changed to reflect the requirement of the regulation.

Proposed Timescale: 30/05/2015

Theme: Effective Services

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

Inspectors observed that each resident had a written agreement but details of charges for additional services were not covered in the contract.

Action Required:

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

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

The charges for additional expenses will be outlined in the contract of care.

Proposed Timescale: 19/06/2015

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:

There was no evidence of multidisciplinary involvement in the annual reviews.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The PIC will ensure that there is multidisciplinary involvement in the annual reviews

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

There was no evidence that falls assessments were maintained in relation to the areas of vulnerability identified and therefore there were no individual safeguards put in place even though staff had identified that the resident was at risk. Another resident had been identified as a risk of wandering onto the main road. On the second day of inspection inspectors saw this resident unaccompanied at the front door which was open. This presented a risk as the centre is located beside a busy main road.

Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A falls chart is maintained. All falls/ incidents will be discussed at the co-ordinating/management meetings to analyse and manage risk. The resident now has a personal alarm. The risk of wandering will be reassessed by an appropriate external healthcare professional. All decisions will balance the right of the resident for personal freedom and the level of risk involved

The provider will consult the local council with regard to traffic calming measures near the centre.

Proposed Timescale: 10/07/2015

Theme: Effective Services

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

The inspectors from a review of resident's personal plans were not assured that staff had sufficient knowledge on how to complete a personal plan and subsequent care plans. Inspectors were not assured that the reviews carried out assessed the effectiveness of the personal plans.

Action Required:

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

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

The registered provider will source a consultant to provide training and a review of the method in this area.

Auditing will commence using an assessment tool to review the effectiveness of the personal plans.

The care plan will address

- education

- development, where appropriate, a network of personal support

- transport services

the resident's wishes in relation to where he/she want to live and with whom

- the resident's wishes or aspirations around friendships, belonging and inclusion in the community and other relevant issues

Quarterly reviews will assess the effectiveness of the personal plans.

Proposed Timescale: 30/09/2015

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:

Staff whom inspectors spoke with were vague in relation to the relocation of residents in the event of an evacuation/emergency and finding interim accommodation for residents.

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:

The emergency plan will be discussed at the co-ordinating meeting and at the house team meetings and be included in training.

Proposed Timescale: 09/06/2015

Theme: Effective Services

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

The incident reporting system did not include details of how the service was acting to prevent an incident reoccurring. There was no evidence of an analysis of incidents or any shared learning following an incident.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The risk management policy and procedures will include an analysis of incidents and method of shared learning following an incident. This will be audited by the registered provider.

Proposed Timescale: 30/10/2015

Theme: Effective Services

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

There were differences in how risk was identified and managed. Some staff members did not demonstrate an appropriate awareness of identifying hazards and managing risk. In some instances there was little knowledge of the content of the risk assessment or any planning in relation to this such as unlocked doors and access onto the main road.

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

In service training will take place to clarify and train people in risk management. The risk management will include the measures and actions in place to control the risks identified.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

There were a number of areas of risk in the centre particularly in relation to the outdoor areas which were identified on the previous inspection and had not been rectified which included:

- Unrestricted access to a main road from a garden area, particularly as one resident had been identified as at risk of wandering
- unrestricted access to a boiler room in the garden area
- pipe work for radiators not being covered and exposed chimney flues.

Action Required:

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

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

Further risk assessments to be carried out by an appropriate external health care professional, There will be a referral to the rights committee to ensure that the residents personal freedom is not unnecessarily infringed, in light of the level of risk involved.

The risk management policy will include hazard identification and assessment of risk.

<p>The boiler room is locked</p> <p>The pipe work for radiators will be covered.</p> <p>The chimney flue is not in use since Sept 2014, we will get costings for the removal of the chimney flue.</p>
<p>Proposed Timescale: 30/07/2015</p> <p>Theme: Effective Services</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</p> <p>There was no evidence of the alarm being serviced since it had been installed in November 2014.</p> <p>Action Required:</p> <p>Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.</p> <p>Please state the actions you have taken or are planning to take:</p> <p>The alarm has been commissioned.</p>
<p>Proposed Timescale: 29/05/2015</p> <p>Theme: Effective Services</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</p> <p>Inspectors noted that the emergency lighting had not been working since September 2014.</p> <p>Action Required:</p> <p>Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.</p> <p>Please state the actions you have taken or are planning to take:</p> <p>The registered provider will continue to ensure that the emergency lighting is working.</p>
<p>Proposed Timescale: 09/05/2015</p>

Outcome 08: Safeguarding and Safety

<p>Theme: Safe Services</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</p> <p>There was a policy on restraint dated February 2015 which was not centre specific. It was based on guidelines issued by the Authority. Inspectors saw that chemical restraint was used. Staff were unclear as to what constituted chemical restraint. There was no evidence of any other multidisciplinary input into the management of chemical restraint apart from the general practitioner (GP).</p> <p>Action Required:</p>
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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:

The policy will be reviewed to be centre specific. Training on the restraint policy will be included in managing challenging behaviour training. The resident will be referred to a relevant healthcare professional to clarify the issues around medication for the individuals concerned.

Proposed Timescale: 30/10/2015

Theme: Safe Services

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

Some staff were unclear as to who was the designated safeguarding officer.

Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

All staff have been reminded and this will be discussed at the team meeting. The picture of the designated officer will be put in the prominent of the house.

Proposed Timescale: 26/05/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The provider has not submitted any notifications to the Chief Inspector since 30 December 2014 as required by the Regulations.

Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

The quarterly returns have been submitted. All notifications required by HIQA will be submitted and where necessary, retrospectively

Proposed Timescale: 14/05/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The provider has not submitted any notifications to the Chief Inspector since 30 December 2014.

Action Required:

Under Regulation 31 (4) you are required to: Where no incidents which require to be notified have taken place, notify the chief inspector of this fact on a six- monthly basis.

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

The nil returns have been submitted. All notifications required by HIQA will be submitted and where necessary, retrospectively.

Proposed Timescale: 25/05/2015

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:

Inspectors saw limited evidence of referrals to specialist services and allied health care services such as physiotherapy, occupational therapy, speech and language therapy based referrals. In all personal plans reviewed inspectors saw that referrals to some allied services such as dietetics and speech and language therapy had only just commenced.

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:

We are negotiating with other services provider to get enhanced access to multi-disciplinary services.

Proposed Timescale: 10/07/2015

Theme: Health and Development

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

Inspectors acknowledge that the resident's rights to refuse treatment were respected. However, there was no plan in place to encourage residents to have some tests done which would support them to achieve the best possible health.

Action Required:

Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

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

The community will put a plan in place to assist residents make medical decisions in their best interests, taking into account the person's capacity to understand and consent. This will be assisted by an independent advocate where necessary. The plan will be reviewed by the rights committee
The community will explore all options available to make medical procedures as comfortable as possible.

Proposed Timescale: 30/09/2015

Outcome 12. Medication Management

Theme: Health and Development

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

Inspectors saw that there were four incidents of medication errors. In one instance there was no evidence of any follow up action or systems put in place to prevent incident reoccurring. There was no system in place for reviewing and monitoring safe medication practices.

Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The community nurse will review all medication accidents and implement any practice changes required.

Proposed Timescale: 19/06/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

Some areas for improvement in the statement of purpose included an:

- accurate description of the organisational structure for the designated centre
- specific care and support needs that the designated centre is intended to meet .

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:

The statement of purpose will be reviewed and a description of the organisational

structure for the designated centre and care and support needs that the designated centre is intended to meet will be included.

Proposed Timescale: 30/06/2015

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:

Documents were not provided with the application to register regarding compliance with fire and planning under Regulation 5 of the Health 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

Work will be completed and a fire cert obtained for the centre

Proposed Timescale: 29/02/2016

Theme: Leadership, Governance and Management

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

Inspectors were not assured that the service was governed in a manner that supported the creation and continuous improvement of a person centered service that collectively met the needs of all residents. There was no evidence to support that a systematic, constructive and proactive culture and system was in place for reviewing the quality and safety of care and services provided to residents.

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:

The community will develop a more robust and structured training programme for all staff, covering key areas of best practice standards, internal policies and quality of care.

The community will put in place more robust methods of evaluating key areas such as quality of care provision, risk management, complaints, behaviour management. More

robust systems will be put in place to evaluate incidents and complaints, within an appropriate time frame, and give feedback to the relevant houses and day services. An unannounced visit will occur within the next two weeks. These changes will be included in community policies and procedures.

Proposed Timescale: 30/10/2015

Theme: Leadership, Governance and Management

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

The annual review did not present an overview on the quality and safety of care and support provided to residents.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The provider will use an evaluation tool to ensure that the annual review will present an overview on the quality and safety of care and support provided to residents.

Proposed Timescale: 28/02/2016

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

There was no deputy person in charge to deputise for the person in charge.

Action Required:

Under Regulation 33 (2) (b) you are required to: Give notice in writing to the Chief Inspector of the arrangements that have been, or are proposed to be, made for appointing another person in charge to manage the designated centre during that absence, including the proposed date by which the appointment is to be made.

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

A deputy person in charge has been appointed and will be registered with HIQA as deputy person in charge

Proposed Timescale: 11/06/2015

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 provider and person in charge said that the centre was not resourced to ensure the

effective delivery of care and support in accordance with the centre's statement of purpose. Inspectors saw that staffing levels were low in the house particularly at weekends which was inadequate to meet the needs of residents.

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 registered provider is in active discussions with the funder on this issue. The roster will demonstrate that there are adequate staff on duty.

Proposed Timescale: 30/07/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Inspectors were not satisfied that the skill mix of staff available during the inspection was appropriate to meet residents' needs. Inspectors formed this judgement through observation, review of documentation and speaking with staff. Some staff members who were predominantly known as volunteers by the community had very little experience of working with people with disabilities.

Action Required:

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

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

The provider is in actively sourcing increased funding. The provider will recruit staff to ensure the skill mix of staff is appropriate to the number and assessed needs of the residents.

Proposed Timescale: 30/10/2015

Theme: Responsive Workforce

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

Improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night.

Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

A new template will be used to ensure the roster is reflective of the shifts and type of shifts worked by employees.

Proposed Timescale: 30/06/2015**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

In one instance inspectors noted that the references for the employee and police clearance were in another language and had not been translated.

Action Required:

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

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

Official translation has been sourced and translations will be available in the future.

Proposed Timescale: 04/06/2015**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff require further access to training and education to meet all the assessed needs of residents. As outlined throughout the report some residents had complex care needs and the training records viewed did not support the skills required to safely care for these residents. Staff were unclear of the nature of disability that residents presented with.

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:

As part of the community's ongoing strategic plan, it is aimed that staff with appropriate levels of professional qualifications and experience will be in place to carry out, or supervise, the provision of complex care.

The community will develop a more robust and structured training programme for all staff, covering key areas of best practice standards, internal policies and quality of care.

Proposed Timescale: 30/06/2016**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff who spoke with inspectors had limited understanding of the Regulations and

Standards or any other relevant guidance issued from statutory or professional bodies

Action Required:

Under Regulation 16 (2) (c) you are required to: Make available to staff copies of relevant guidance issued from time to time by statutory and professional bodies.

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

The community will develop a more robust and structured training programme for all staff, covering key areas of best practice standards, internal policies and quality of care. The community will develop links with organisations that can offer training and guidance on standards and best practise.

Proposed Timescale: 31/10/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

A small number of written operational policies as required by Schedule 5 of the Regulations were not in place. These included staff education and training and creation of, access to maintenance of and destruction of records.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

The policies required will be put in place with reference to the changes outlined in the above policies.

Proposed Timescale: 30/07/2015

Theme: Use of Information

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

Some of the records pertinent to residents did not have the required plans in place for all identified health care needs and in some instances documents did not identify all professionals who had attended meetings such as annual reviews in relation to residents.

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:

Records will reflect all professionals involved in the residents care and attending annual reviews. The recommendation of all professionals will be integrated into the residents care plans and communicated with relevant staff.
Proposed Timescale: 30/09/2015