

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by L'Arche Ireland
<b>Centre ID:</b>	OSV-0003419
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	L'Arche Ireland
<b>Provider Nominee:</b>	Joan Costello
<b>Lead inspector:</b>	Ide Batan
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	13
<b>Number of vacancies on the date of inspection:</b>	1

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
06 August 2014 10:30	06 August 2014 18:00
07 August 2014 09:00	07 August 2014 17:30

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 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This monitoring inspection was the first inspection carried out by the Authority. As part of the monitoring inspection, inspectors met with residents and staff. Inspectors reviewed documentation such as the centre's statement of purpose, person centred care plans, records of residents' finances, medical records, arrangements with regard to meal preparation, activities, staff training records, staff files, policies and procedures, fire safety records and the residents' accommodation.

This inspection was announced and took place over two days. The designated centre consisted of seven houses which accommodated 14 residents in total. There are also three day services amalgamated with this service, a cafe, workshop and a garden workshop. Residents told inspectors that that they enjoyed going into the local villages, to the city or to work in the different workshops.

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. However, inspectors observed that some residents also presented with behaviours that challenge and have complex medical care needs.

This inspection primarily focused on staffing, health and safety, risk management and the robustness of clinical supervision systems in place to ensure the quality and safety of care being delivered to residents. Overall, there was an absence of a sound, contemporary evidence base to care.

There was a notable deficit in core areas, fundamental to the quality and safety of care provided to residents such as medication management practices, fire safety, the process of care planning, delivery of evidenced based care, infection control, health and safety and risk management.

The findings of the inspection are set out under ten outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons(Children and Adults) with Disabilities) Regulations 2013.

The inspectors found that the service was significantly non compliant with the requirements of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, contraventions included :

- medication management practices
- health and safety and risk management
- staff training and development
- staff files were not adequate
- evidence based clinical risk assessments
- resident and family consultation in development of personal plans
- infection control
- statement of purpose
- premises
- governance

**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 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):**

This was the centre's first inspection by the Authority.

**Findings:**

A single aspect of this outcome was covered during this inspection. Inspectors observed that baby monitors were in a bedroom. According to staff it was used as a listening device for night time. However, inspectors saw that staff also used it during the day when the resident was asleep. Inspectors were informed that some were no longer needed and not in use even though documentation reviewed indicated that another monitor was in use for a resident who was at risk of wandering. Staff informed inspectors that this resident did not have a monitor in operation.

There was no evidence that residents had consented to the use of monitors and these devices infringed on the resident's right to privacy. The centre failed to demonstrate that residents' permission was sought in relation to receiving guests in their home.

Inspectors observed that the prayer room/quiet room in a house contained a fold up bed. However, inspectors were not satisfied with the explanation given by staff as to the reasons that the fold up bed was there as staff did not seem to know why it was there or whether guests had stayed overnight. The centre's policy indicated that no guests stayed overnight.

**Judgment:**

Non Compliant - Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Staff who spoke with inspectors did not have up-to-date knowledge and skills, appropriate to their role to enable them to manage and respond to behaviour that is challenging. Inspectors saw that in another instance 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.

Inspectors saw that some residents had difficulty in managing their own behaviour. However, there were no assessments carried out by a suitably qualified professional or by staff in order to draw up a plan to provide additional support to the residents.

Inspectors did not observe that the assessment and planning process used gave direction and coordination to care delivered to residents who had multiple care needs as outlined in detail under Outcome 11. In the sample of care plans reviewed there were inconsistencies in relation to residents' involvement in the development of their personal plans. In some personal plans there was evidence of resident involvement while in others viewed by inspectors there was no evidence available. It was also unclear if family members were involved in this process.

The inspectors reviewed a selection of personal plans which were personalised and detailed resident's specific requirements in relation to their social care and activities. There was evidence of residents' social needs including residents' interests, communication needs and daily living support assessments which reflected resident choices. There was a communication policy which outlined different modes of communication such as verbal, non verbal and pictorial communication. The personal plans included the resident's wishes in relation to where they wanted to live and with whom, short and long term goals and assessment of abilities, skills and needs. Annual reviews of personal plans took place.

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, it was not documented which reference workers were responsible for pursuing objectives in conjunction with individual residents in each

residents' personal plan and agreed time scales and set dates in relation to identified goals and objectives.

There was a discharge policy. To date only one resident has been discharged from the service as this resident wished to relocate to another area. There was a temporary absence policy which had been reviewed in July 2014. It covered weekend leave and holiday leave for residents.

**Judgment:**  
Non Compliant - Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The designated centre consisted of three houses and four self contained apartments. One of the houses, which accommodated two residents and a number of employees (also called assistants), and the four apartments, which could accommodate five residents, were located on a site shared with a day service, a computer workshop and offices. In general the residential accommodation here was suitable and met residents' needs in a comfortable and homely way. However, a commode which was in a bedroom was noted not to have non-slip material on the support legs and so did not provide for optimum stability while in use.

The second house, which accommodated four residents and a number of employees, was well maintained and met residents' needs. The third house was over two floors and provided accommodation for four residents and a number of employees. Overall, inspectors found that all of the buildings promoted resident's dignity, privacy and well being. In all of the houses there was adequate private and communal accommodation such as single bedrooms with ample space, spacious sitting rooms, adequate toilets, showers and bathrooms. Suitable storage facilities for residents personal belongings was available as observed by inspectors.

Inspectors found that one house to be unclean and poorly maintained. In the kitchen there were cobwebs on the light shades and mould was visible in a number of spots on the walls. The carpet on the stairs and landing had items of food on each step and was unclean. Paint was peeling from the ceiling and there was a rusting shelf in the shared

bathroom. The centre's health and safety policy outlined that all refuse was to be disposed of in a safe, secure and hygienic manner. However, a rubbish bin for recyclable materials was observed to be overflowing and a black rubbish bag had been left on the ground next to a pest control device. This area also contained a broken garden seat with support legs missing and four building control railings, approximately 15 feet high were stored here. Staff acknowledged that these were stored inappropriately and were for the building of a chicken coup. Inspectors identified significant hazards which required risk assessments and these are discussed in detail in Outcome 7 relating to risk management and infection control.

Inspectors did not observe any assistive equipment in use. There was no programme of ongoing maintenance available.

**Judgment:**  
Non Compliant - Major

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

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

**Theme:**  
Effective Services

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

This was the centre's first inspection by the Authority.

#### **Findings:**

There was an up to date risk management policy which outlined hazard identification and assessment of risks. However it did not include sufficient detail of the measures and actions in place to control the specified risks of unexpected absence of a resident, aggression and violence or accidental injury to residents, visitors or staff. 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. For example an action plan had been identified after a resident had been found wandering. However, staff who spoke with inspectors said that his action plan had never been implemented and staff were not clear as to the reasons the action plan had not been implemented.

There was a designated health and safety officer who worked part time two days per week. A number of staff had been trained in risk assessment. However, the assessments available were generic relating to issues like manual handling, falls and the use of sharp tools. The assessments did not relate to specific hazards in the centre.



In addition risk assessments were not available for:

- Laundry room flooring being worn and a potential trip hazard
- 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
- Injury by striking against the door frame on entering and exiting a storage room in the kitchen, which contained a fridge and freezer
- Smoking risk assessments for residents who smoked
- Pipe work for radiators not being covered and exposed chimney flues

There were personal risk assessments available for a number of residents. However, they were not available for all residents. In addition the assessments were not stored in the resident's healthcare records and did not inform a care plan for the resident. One risk assessment, which was undated, identified one resident as being positive for Methicillin Resistant Staphylococcus Aureus (MRSA). This assessment was located in the unit safety statement and not in the resident's healthcare file. There was no plan to be followed to reduce the risk of transmitting MRSA to other patients, staff, carers and visitors. There was also no information available as to how this infection was acquired or when it was first identified.

There was a policy in relation to control and prevention of infection. However, inspectors observed the practice of cloths being utilised for cleaning residents, who may be incontinent. These cloths, once used, were not being discarded but were transferred to the laundry for machine washing. Inspectors observed that there were no paper or disposable hand towels available and in a bathroom residents and staff were sharing hand towels. This practice could lead to potential cross infection. Staff had responsibility for cleaning the premises. However, a hand basin in one resident's room was visibly unclean and there were no arrangements in place for the resident to dry their hands. The centre policy outlined that staff had a responsibility to attend training on infection control. However, inspectors did not see any evidence of such training.

The emergency plan was unsigned and undated and while adequately addressing the centre's response to fire and evacuation arrangements it did not contain provision to deal with other emergencies like loss of power, loss of lighting or flooding. There were no personal emergency evacuation plans in place for any resident, some of whom had restricted mobility. There were a number of vehicles available for transporting residents. Inspectors saw evidence that these were all roadworthy, regularly serviced and insured.

Inspectors were not satisfied that effective fire safety management systems were in place. While records indicated that 18 staff had attended fire safety awareness training in November 2013, in one residential house no staff member had been trained in fire prevention. When questioned by inspectors these staff did not know what to do in the event of a fire. In a house there was a fire escape leading from the upstairs bathroom to the garden. The exit to this fire escape was partially blocked internally by a cabinet. When stepping out onto the roof there was a slip hazard both from bird droppings from a nest in the eaves of the building and moss. Risk assessments were not available on the fire escape arrangements in relation to:

- a steel chimney outlet from a wood burner in the sitting room
- the height of the railings to prevent a resident falling from the roof

- unrestricted access to the fire escape from the garden.

Inspectors recommended that the provider contact the local fire authority in relation to the evacuation procedures from this house.

The health and safety policy outlined that fire drills were to be undertaken monthly. However in records seen by inspectors the last fire drill in one house had been in April 2014. A fire safety audit report had been undertaken in November 2013 by an external fire consultant. This recommended a daily inspection of means of escape, a weekly testing of the fire alarm and a weekly inspection of emergency lighting, all of which were being implemented. However, staff outlined that a number of recommendations from this audit were still to be implemented. There were procedures to be followed in the event of fire on display in prominent places. However these were general arrangements which did not relate to the specifics of each house where residents lived.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

This was the centre's first inspection by the Authority.

**Findings:**

While policies and procedures were in place for the prevention, detection and response to abuse. Staff with whom inspectors spoke were not knowledgeable in relation to abuse. Inspectors found that there was a lack of understanding of the particular vulnerability of people with disabilities to abuse.

There were records available which indicated that staff were trained in abuse detection and prevention as required by legislation. However, not all staff had been trained. It was difficult to ascertain if this training was accredited or not. However, 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 no evidence that residents were provided with emotional, behavioural or therapeutic support that promotes a positive approach to behaviour that challenges. Inspectors saw that there were no behavioural support plans were in place for residents as outlined under Outcome 5.

There were restrictive practices in place on this inspection. Inspectors saw that a resident was using bed rails. However, reasons for using restrictive procedures was not clearly assessed or recorded. The use of the restrictive measure was not monitored, supervised or reviewed. There was no evidence that other options had been tried for this resident. Staff were carrying out restrictive procedures without being trained to do.

Inspectors observed that residents had easy access to personal monies and where possible control over their own financial affairs in accordance with their wishes. Inspectors reviewed the local arrangements' to ensure residents' financial arrangements were safeguarded through appropriate practices and record keeping. Inspectors noted that all financial transactions when possible; were not signed by residents. In addition all transactions were not checked by two staff members. Written receipts were retained for all purchases made on residents' behalf.

**Judgment:**  
Non Compliant - Major

### **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):**

This was the centre's first inspection by the Authority.

#### **Findings:**

Overall, the evidence seen under this outcome shows that residents were not supported to achieve their health care needs. 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. Inspectors saw that a physiotherapy plan was in place for a resident. However, there was no evidence of staff following through on this plan. Inspectors saw that there was not timely access to some allied services. Residents had to wait long periods of time for appointments which does not maximise opportunities for continuity of treatment or promote best possible health. In one instance the inspector saw that a referral to a dental hospital for a resident had not been followed up by staff for over a year. In another case inspectors saw that the GP had referred a resident to an allied professional service. However, there was no

documentary evidence that this resident had seen the professional.

Residents' healthcare needs were not assessed. Inspectors saw that some residents had multi complex care needs. Social care needs were set out in personal care plan which was in an easy read format using symbols and diagrams. Inspectors saw that some personal plans were revised on a yearly basis. Inspectors observed that there was no link between the person-centred plan and the actual care being delivered.

Inspectors had concerns in relation to the significant lack of evidence based assessment tools being used for nutrition, skin integrity, behaviours or incontinence care. Inspectors were told that a resident had a pressure ulcer. However, there was no documentation available to review in relation to this which does not meet best practice guidelines in recording clinical practice and does not promote continuity of care for residents or promote the residents' well being.

The level of support which individual residents required varied as observed by inspectors. There were deficiencies in the management of some aspects of residents' health care. For example some had a diagnosis of epilepsy, documentation for management of seizures was not evidence based and was not supported by accredited training for all staff. There was no evidence that residents had consented to treatment and there was no evidence of any assessments in relation to mental capacity.

As outlined under Outcome 5 there was very limited multidisciplinary input for residents. The deputy person in charge said that residents had access to a GP of their choice. Many residents went out to the GP surgery. However, there were no formal medical records kept on site so inspectors could not see frequency of medical reviews. Resident's records were not maintained in a manner to ensure accuracy and ease of retrieval. This lack of systematic management of information causes a potential risk to ensuring residents receive adequate and appropriate care. It can also lead to confusion and potential for error.

There were no appropriate referrals for dietetic reviews. Inspectors saw that two resident required a modified diet. There was no evidence that the malnutrition universal screening tool (MUST) which was an established weight monitoring/assessment tool formed part of the resident's assessment on admission to the centre.

Inspectors saw that residents' weights were not monitored. Inspectors could not ascertain if any actions were taken on foot of a resident being overweight or underweight. There were no menus displayed in the centre which offered choice. On the day of inspection inspectors observed that all residents received the same meal.

In a house staff told the inspectors that some residents liked to help preparing the meals. However, staff who spoke with the inspector were not knowledgeable regarding dietary requirements and providing varied foods for residents with special dietary needs.

**Judgment:**  
Non Compliant - Major

## **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):**

This was the centre's first inspection by the Authority.

### **Findings:**

Inspectors were not satisfied that residents were protected by safe medication management practices.

Medication was dispensed securely from pharmacy in packaging which held the medicine in individual pouches. The individual medication pouch was accessed by tearing along the perforation in the packaging. The medication was stored in a locked cabinet.

The medication policy, while outlining the responsibilities of managers and nursing staff, it did not outline the responsibilities of other staff, who mostly administered medication to residents. There was no evidence that staff had received any accredited training on the safe administration of medication. Inspectors observed staff in two of the houses not conforming to the safe administration practice outlined in the centre policy.

Inspectors observed that staff were not checking the prescription to ensure that the right medication was being administered at the right time to the right resident. Staff were taking the individual medication pouch from the packaging and administering the medication directly to the resident. Staff then recorded in the medication administration record that the medication had been given. In addition there were no medication resources readily available to staff as a reference in relation to the medication they were administering.

In relation to the management of residents with epilepsy there was a protocol in place for the administration of medicines in the event that a resident may have seizures. However, there was no risk assessment or care plan in the healthcare file in relation to the management of epilepsy as outlined under Outcome 5. Staff had not received any accredited training in relation to epilepsy, the management of epilepsy or the administration of this particular medication via different routes.

In the sample prescription sheets reviewed it was not clear that a record of each drug and medication was signed and dated by the GP.

There was no system in place for reviewing and monitoring safe medication practices. In one medication administration record sheet a note attached by staff outlined that an error had occurred. It was not clear to inspectors what the error was and nor was it clear whether the resident had received the medication. There was no evidence that the pharmacist had been contacted in relation to this issue.

There was no evidence available that medication management audits were being completed. These practices increase the risk of potential harm to residents and do not meet legislative requirements. There was no evidence that residents' medications were monitored and subject to review at regular intervals. There was no evidence that staff promoted the resident's understanding of his/her health needs relating to medication.

**Judgment:**  
Non Compliant - Major

**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):**  
This was the centre's first inspection by the Authority.

**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 accurate description of the organisational structure for the designated centre, emergency admission arrangements and criteria.

It did not detail the fire precautions and associated emergency procedures. It was not available in a format that was accessible to residents.

**Judgment:**  
Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

L'Arche is a company with charitable status. It is governed by a board of directors known as the central committee of L'Arche. In addition to the board of directors each local community is served by a local committee. The community leader is responsible for the overall operational management of all services within L'Arche. Management for the provision of residential services is delegated to house coordinators who supervise and support a team of house leaders who support house assistants who are directly responsible for care delivered to residents.

The person in charge was on leave at the time of inspection. The deputy person in charge was actively engaged in the operational management of the houses, and based on interactions with her during the 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.

There was no evidence that the quality of care and experience of residents was monitored and developed on an ongoing basis. There were not effective management systems in place to support and promote the delivery of safe and quality services as outlined throughout this report.

There was no evidence of continued professional development plans in place. There was no evidence of any tailored training programme to meet assessed needs of residents. Inspectors saw that an audit by an external company had taken place in April 2014. However, there had been little progress made completing the actions identified on this audit. No annual review of quality and safety of care has taken place to date as required by the Regulations.

There was evidence of house meetings taking place on a weekly basis which involved residents also. Inspectors did not see evidence of any other staff meetings nor any meetings between the nominated provider and person in charge.

There was no system in place to effectively manage risk as outlined in detail under Outcome 7. Risk assessments in relation to clinical and non clinical risk had not been completed in many areas as outlined throughout the report. Staff who spoke with the inspectors had not received any formal support or performance management in relation to their performance of their duties or personal development which is a requirement of the Regulations.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

This was the centre's first inspection by the Authority.

**Findings:**

Inspectors reviewed a sample of staff files and noted that all were not 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.

The inspectors were not satisfied that the numbers and skill mix of staff available during the inspection was appropriate to meet residents' needs. Inspectors formed this judgement through observation, review of documentation such as personal plans, training, staffing records and speaking with staff. Inspectors observed that there was a high turnover of staff. The house assistants who were predominantly known as volunteers by L'Arche had very little experience of working with people with disabilities.

A validated dependency tool had not been completed or used by the organisation to determine the skill mix of staff. 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.

There was no evidence of any nursing care input. Inspectors observed that there was a lack of evidence based care provided to residents such as skin integrity, nutrition, continence and mobility to meet the assessed needs of residents. Inspectors observed that there was a significant deficit in care practices and practices were not in line with national policy and best practice in relation to consent, restraint, medication management and infection control.

As there were no risk or dependency assessments available it was not possible to ascertain how staffing levels and skill mix were deployed. Inspectors formed the view that resident's needs could not be met as staff members lacked the required skills or experience to adequately support or care for residents. This was evidenced through dialogue with staff, review of training records and staff files.

There were actual and planned rosters which correlated with staff on duty during the inspection. The house coordinator told inspectors that supervision takes place. However inspectors did not see any formal documentation regarding supervision or staff appraisal. Inspectors saw and were told by staff that there was an induction programme for new house assistants which was tailored to the safeguarding and supporting



residents of L'Arche.

As outlined under Outcome 7 a training programme was in place but some staff have not received statutory training such as fire and abuse training. Staff who spoke with inspectors had no understanding of the Regulations and Standards or any other relevant guidance issues from statutory or professional bodies. There was a recruitment policy in place for employees and volunteers.

**Judgment:**  
Non Compliant - Major

## 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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by L'Arche Ireland
<b>Centre ID:</b>	OSV-0003419
<b>Date of Inspection:</b>	06 August 2014
<b>Date of response:</b>	17 September 2014

### 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 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 no evidence that residents had consented to the use of monitors and these devices infringed on the resident's right to privacy. The centre failed to demonstrate that residents' permission was sought in relation to receiving guests in their home.

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

**Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Protocol and Documents in place for resident or/and his/her family where consent has been obtained from resident and/or residents' representatives. No guests will stay overnight in the designated centre and will be accommodated outside of the designated centre. L'Arche Ireland has set up a rights review committee and any issues where there is considered to be an infringement of rights will be addressed by this committee. Frames of reference for this group will be determined at the first meeting on 15 October 2014.

**Proposed Timescale:** 15/10/2014

**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:**

In the sample of care plans reviewed there inconsistencies in relation to residents' involvement in the development of their personal plans. It was also unclear if family members were involved in this process.

**Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The format of care plans is being reviewed and amended template implemented. Relatives/representatives, in consultation with the resident will be invited to each review and planning meeting. Written records of this will be signed by participants and maintained.

**Proposed Timescale:** 15/03/2015

**Theme:** Effective Services

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

It was not documented which reference workers were responsible for pursuing objectives in conjunction with individual residents in each residents' personal plan and agreed time scales and set dates in relation to identified goals and objectives.

**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:**

We will ensure that recommendations arising out of all personal care plans will be documented, and any changes and actions will be documented. The format of the review template will be reviewed and amended so that time-scales and people responsible for actions will be stated.

**Proposed Timescale:** 15/03/2015

**Theme:** Effective Services

**The Registered Provider 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.

Inspectors saw that some residents had difficulty in managing their own behaviour. However, there were no assessments carried out by a suitably qualified professional or by staff in order to draw up a plan to provide additional support to the residents

**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:**

Individual risk assessments regarding mobility will be conducted by 15 December 2014. Incidents will be reviewed by the Person in Charge and appropriate plans put in place. Reporting format for all accidents and incidents has changed, with an addition to documentation for further follow up and learning opportunities. Learning from critical incidents protocol in place and there is now a plan of assessments regarding residents' ability to manage their own behaviour. All residents have been assessed and behavioural support plans will be in place by 30 November 2014. Suitably qualified staff have been identified to provide support and put appropriate plans in place.

**Proposed Timescale:** 15/12/2014

## Outcome 06: Safe and suitable premises

**Theme:** Effective Services

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

A rubbish bin for recyclable materials was observed to be overflowing and a black rubbish bag had been left on the ground next to a pest control device. This area also contained a broken garden seat with support legs missing and four building control railings, approximately 15 feet high were stored here. Staff acknowledged that these were stored inappropriately and were for the building of a chicken coup.

**Action Required:**

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

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

Bins have been removed and suitably repositioned and extra bins have been installed to ensure sufficient capacity to avoid over-flow.

The broken garden seat and building railings have been removed.

**Proposed Timescale:** 18/09/2014

**Theme:** Effective Services

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

Inspectors found these premises to be unclean and poorly maintained. In the kitchen there were cobwebs on the light shades and mould was visible in a number of spots on the walls. The carpet on the stairs and landing had items of food on each step and was unclean. Paint was peeling from the ceiling and there was a rusting shelf in the shared bathroom.

**Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

There is a daily cleaning schedule in operation and the Houses Coordinator will carry out unannounced spot checks. A re-clean of house has been undertaken. Referenced lampshades will be replaced by September 30 2014. Stair carpet will be removed and replaced with new flooring on stairs and upstairs by 15 March 2015. Rusting shelf has been removed. Bathroom will be repainted by 15 December 2014

**Proposed Timescale:** 15/03/2015

**Theme:** Effective Services

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

A commode which was in a bedroom was noted not to have non-slip material on the support legs and so did not provide for optimum stability while in use.

**Action Required:**

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

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

Risk assessment carried out and the occupational therapist has replaced commode.

**Proposed Timescale:** 18/09/2014

#### **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:**

There were not effective arrangements in place to identify and manage risk.

**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:**

We will review the risk management policy to ensure that it will include hazard identification and assessment of risks throughout the designated centre.

**Proposed Timescale:** 15/10/2014

**Theme:** Effective Services

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

Inspectors reviewed the incident log and found five notifications. However, the reports 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. For example an action plan had been identified after a resident had been found wandering. However, staff who spoke with inspectors said that his action plan had never been implemented or if it had been implemented it had not been

communicated to them.

**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 accident/incident form has been changed to include analysis and learning will be shared at the weekly management meeting. All accidents/incidents will be reported to the Registered Provider, for further action, advice and organisational learning and guidance

**Proposed Timescale:** 18/09/2014

**Theme:** Effective Services

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

The current system in place to manage risk were not effective.

**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 system is being reviewed at risk management meeting. Systems and policy being put in place regarding emergencies.

**Proposed Timescale:** 15/12/2014

**Theme:** Effective Services

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

The policy did not include sufficient detail of the measures and action in place to control the specified risks of unexpected absence of a resident.

**Action Required:**

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The policy has been reviewed and now includes protocols and actions to control the unexplained absence of a resident.

**Proposed Timescale: 18/09/2014**

**Theme: Effective Services**

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

The risk management policy did not include measures in place to control violence and aggression.

**Action Required:**

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

The risk management policy has been reviewed and now includes measures that are in place to control violence and aggression

**Proposed Timescale: 18/09/2014**

**Theme: Effective Services**

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

There was no care plan to be followed to reduce the risk of transmitting MRSA to other patients, staff, carers and visitors. There was also no information available as to how this infection was acquired or when it was first identified. Inspectors observed the practice of cloths being utilised for cleaning residents, who may be incontinent. These cloths, once used, were not being discarded but were transferred to the laundry for machine washing. Inspectors observed that there were no paper or disposable hand towels available and in a bathroom residents and staff were sharing hand towels.

**Action Required:**

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

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

There is a care plan in place which sets out procedures that are consistent with the standards for the prevention and control of healthcare associated infections. Disposable wash-cloths together with disposable hand towels are now in place and use of hand towels (cloth) now discontinued.

**Proposed Timescale: 18/09/2014**



**Theme:** Effective Services

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

There were not effective fire safety management systems in place.

**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:**

An external consultant and a fire officer have conducted a review of fire safety management, the findings of which have been acted on.

Outstanding documentation in fire registers now complete

**Proposed Timescale:** 18/09/2014

**Theme:** Effective Services

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

In one house there was a fire escape leading from the upstairs bathroom to the garden. The exit to this fire escape was partially blocked internally by a cabinet.

**Action Required:**

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

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

The obstacle has been removed.

**Proposed Timescale:** 18/09/2014

**Theme:** Effective Services

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

There was no evidence that all staff had received suitable fire training.

**Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

All staff will be trained and the appropriate records of attendance and completion will be maintained

**Proposed Timescale:** 24/09/2014

**Theme:** Effective Services

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

There was no evidence that fire drills were taking place at suitable intervals.

**Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

Fire Drills will be conducted at three monthly intervals and records will be maintained to include the name of those present at the fire drill and necessary action following fire drill.

**Proposed Timescale:** 18/09/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Failing to ensure that where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in line with national policy and evidence based practice.

**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:**

When a restrictive practice is implemented there will be full consultation, a detailed plan for use and regular review. All restrictive practices will be reviewed at Rights Committee meeting. (Risk assessment, Care Plan, family and Rights Committee)  
HIQA will be notified in writing of any restrictive practice immediately.

**Proposed Timescale:** 15/12/2014

**Theme:** Safe Services

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

There was no evidence that all staff had received training in the prevention, detection and response to abuse.

**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:**

Training has been arranged for 25 September 2014 for all new staff. Further training for all staff scheduled on 8 October 2014.

Training will be documented.

**Proposed Timescale:** 08/10/2014

## **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:**

Failing to ensure that residents have appropriate and timely access to allied health professionals.

**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:**

All residents have been assessed. A new system of recording appointments, follow up and outstanding appointments (a running record) has been implemented. This will be included and reviewed at weekly management meetings. Any outstanding referrals have been followed up and re-requested. New referrals have been requested as a result of assessments, where appropriate.

**Proposed Timescale:** 18/09/2014

**Theme:** Health and Development

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

Residents' healthcare needs were not assessed. Inspectors saw that some residents had multi complex care needs. Inspectors observed that there was no link between the person-centred plan and the actual care being delivered. Inspectors had concerns in relation to the significant lack of evidence based assessment tools being used for nutrition, skin integrity, behaviours or incontinence care.

**Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

Residents with multiple complex needs have an appropriate care planning system in place and staff are being trained on this system.

This system has been designed in consultation with the local GP, Public Health Nurse, Other health professionals and specialist clinics

**Proposed Timescale:** 15/11/2014

**Theme:** Health and Development

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

There was no evidence that residents were offered choice at meal times.

**Action Required:**

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

Residents are offered choice at breakfast and lunch. Dinner options are discussed at the weekly house meetings and individual preferences noted and agreed. Nutritional Assessment to be completed are currently being undertaken (HSE Guidelines).

**Proposed Timescale:** 30/11/2014

**Theme:** Health and Development

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

There was no evidence to suggest that meals were consistent with each resident's individual dietary needs and preferences.

**Action Required:**

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

Each residents' personal food preferences and dietary requirements are recorded in residents' personal care plans. All staff will be inducted on each resident's preference, requirements and choice-making. This will be documented

**Proposed Timescale:** 30/09/2014

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

There was no evidence to suggest that a pharmacist was readily available to residents.

**Action Required:**

Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

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

The pharmacist is available Monday to Friday and has visited the centre on 10 September 2014.

**Proposed Timescale:** 10/09/2014

**Theme:** Health and Development

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

Failing to ensure that appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines were in accordance with best practice and regulatory requirements.

**Action Required:**

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**  
Training in medication practices will be provided by the pharmacist on 24 September 2014. This training will be recorded and the person In charge will carry out regular audits

**Proposed Timescale:** 30/09/2014

**Theme:** Health and Development

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

There were no risk assessments to suggest that residents were encouraged to take responsibility for his or her own medications.

**Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

All residents will have an assessment of their capacity and the findings of the assessment will be acted upon. These will be reviewed annually or as need dictates.

**Proposed Timescale:** 15/12/2014

### **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:**

Failing to ensure that the statement of purpose contained all the matters as set out in Schedule 1 of the Regulations.

**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 and Function has been updated to comply with Schedule 1. An accessible version of the Statement of Purpose and Function will be produced by April 2015.

**Proposed Timescale:** 15/04/2015

**Theme:** Leadership, Governance and Management

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

Failing to ensure that the statement of purpose was made available to residents or their representatives.

**Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

A copy of the Statement of Purpose and Function will be distributed to residents and residents' representative. A record of documents issued will be maintained. For residents who require accessible format: 15 April 2015

**Proposed Timescale:** 15/04/2015

#### **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:**

Failing to ensure that the service provided to residents was safe, consistent and effectively monitored. There was a significant lack of risk assessments and awareness in relation to fire safety, abuse, medication management, clinical risk management and recruitment procedures. There was no consistent review of quality and safety of care which would monitor effectiveness of services provided to residents.

**Action Required:**

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

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

Internal Quality Control has been appointed. Internal Audit system based on Health Act (2007) Statutory Instruments will be completed by 15 October 2014. Health and Safety Officer and designated Fire Safety person in place immediately. Monitoring of Medication ongoing in conjunction with pharmacy and Person In Charge is in place. Weekly review of residents needs at coordinating meeting and at house team meetings and documented actions required. Weekly meeting with residents to ascertain their needs is in place. Internal assessments of behaviours that challenge and risk assessments, behavioural reviews: to be completed by 15 December 2014.

**Proposed Timescale:** 15/12/2014

**Theme:** Leadership, Governance and Management

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

There were no unannounced visits carried out by a person nominated by the registered provider and there were no reports available.

**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:**

Unannounced visits will be carried out every six months at the designated centre, by a person nominated by the registered provider.

**Proposed Timescale:** 01/11/2014

**Theme:** Leadership, Governance and Management

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

There were no arrangements in place to support, develop and performance manage all staff.

**Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

There is a planned programme of support and supervision meetings, meetings are recorded and goals/objectives are followed up, as per support and supervision policy and procedure.

**Proposed Timescale:** 18/09/2014



## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

There was no evidence of any nursing care input. Inspectors observed that there was a lack of evidence based care provided to residents such as skin integrity, nutrition, continence and mobility to meet the assessed needs of residents.

**Action Required:**

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

The Statement of Purpose and Function has been amended to reflect that we meet the assessed and changing needs of residents in their homes in L'Arche, with external medical and allied health services. Appropriate supports (as outlined in personal care planning) have been put in place, and are on-going, to meet the needs of the residents in consultation with the public health nurses, occupational therapists, physiotherapy, dietician, and chiropody care. The outcomes of the intensity support scale will be reviewed with a staffing planning group.

A Registered General Nurse will be appointed on a part-time basis for an initial one year contract to ensure continuity of care of residents. The role will be reviewed subject to it meeting the needs of the residents and in terms of financial viability, and subject to recommendations of the staffing planning group.

**Proposed Timescale:** 15/12/2014

**Theme:** Responsive Workforce

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

Failing to ensure that the qualifications and skill mix of staff was appropriate to the assessed needs of residents.

**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:**

A Support Intensity Scale has been undertaken, completed on 10 September 2014. Following this, a staffing planning group (comprised of person In charge, HSE representatives, registered provider nominated person, member from the board of directors will review the outcomes of support intensity scale, review and recommend a staffing structure that demonstrably meets the number and assessed needs of the

resident. A strategic plan has commenced and will be used to inform decision-making. Consultation with the Health Service Executive local area office in relation to funding is on-going.

**Proposed Timescale:** 15/12/2014

**Theme:** Responsive Workforce

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

There was evidence that all of the information and documents specified in Schedule 2 were not available for all staff.

**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:**

- Outstanding documents, as outlined in Schedule 2 have been submitted to personnel files and checked by Person in Charge.

**Proposed Timescale:** 18/09/2014

**Theme:** Responsive Workforce

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

Inspectors formed the view that resident's needs could not be met as staff members lacked the required skills or experience to adequately support or care for residents. This was evidenced through dialogue with staff, review of training records and staff files.

**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:**

There is a programme of training to ensure that all staff have the skills to meet the needs of the residents. A full programme of induction for new staff, containing the following

Medication Training: 24 September 2014

training in Adult Protections: 24 September 2014

fire Safety training: 17 November 2014

health and Safety Training: 24 September 2014

**Further Training:**

MAPA (Managing and Preventing Aggression) training: 30 September 2014

manual Handling: 09 October 2014

epilepsy: 23 October 2014

fire Manual Training: To be arranged by 15 November 2014

first Aid Training: 15 January 2015

risk assessment/ to be arranged: to be arranged by 15 December 2014

regulations under Health Act 2007 and standards: 25 September 2014 and 08 October 2014

behavioural Management Training: To be arranged by 15 October 2014

and on-going and refresher training as required or as identified in supervision.

**Proposed Timescale: 15/01/2015**

**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 no understanding of the Regulations and Standards.

**Action Required:**

Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

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

Training on Regulations and Guidelines will be carried out on 25th September 8th October 2014.

**Proposed Timescale: 08/10/2014**

**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 were not aware of any other relevant guidance issues 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:**

- A list of relevant guidance issues from the Health Service Executive and Health, Information and Quality Authority and all other relevant bodies will be completed and a record maintained of distribution to staff.
- The Person in Charge will ensure that future emerging guidance documents are

disseminated at weekly management meetings and documented as being discussed and implications for practice agreed.

**Proposed Timescale:** 15/10/2014