Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004782
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	13
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 January 2015 10:00	20 January 2015 18:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of the designated centre by the Authority. The centre provided full time residential care to twelve residents with a severe to profound intellectual and physical disability and respite care to two residents at a time. On the day of inspection there were thirteen residents in the centre and one vacant bed.

There was evidence of good practice and of the eight outcomes inspected the provider was judged to be compliant in two; meeting residents healthcare needs and requirements, and medication management. It was evident that staff spoken with had a sound knowledge of residents' needs and preferences and the supports required by each resident to maintain well-being and enjoy a good quality of life. However, a concerning deficit that posed a serious risk to the safety and wellbeing of residents was identified in the night-time staffing arrangements and this consequently impacted on the level of compliance evidenced in other outcomes such as measures to promote the health and safety of residents and staff, and governance and management. Overall the provider was judged to be in compliance with two outcomes, substantially compliant with one, in moderate non compliance with two and in major non-compliance with three.

Given the risk identified the provider was issued with an immediate action plan and following further discussion with the Authority, the required action of an additional

night-time staffing resource was implemented by the provider with immediate effect from the 21 January 2014.

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 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:
It was evident that staff spoken with had a sound knowledge of residents' needs and preferences and the supports required by each resident to maintain well-being and enjoy a good quality of life. Staff also spoke of the relationship that had developed between staff and residents who had grown old with the service; this was evident in the commitment and care shown by staff at end of life.

There was a process in place for the comprehensive assessment of the health, personal and social care needs of each resident from which a personal care plan was devised. The process provided for multidisciplinary and family input and annual review.

The inspector saw that staff had substantial and detailed narrative information on each resident and additional resources were available to them to undertake further assessments as required such as skills observation. There was evidence that priorities had been identified such as enhanced socialisation and enhanced community integration. However, it was not clear as to how priorities/objectives were to be pursued, who was responsible and within what timeframe. There was evidence that the available staffing resources had been identified as a constraint to achieving some identified objectives and it was not clear what impact this had if any on the effectiveness of the plan. The personal plans did not read as an integrated and holistic record that reflected all aspects of the residents life and their required supports be they social, health or psychosocial.

A personal plan was not in place for each resident within twenty eight days of admission to the centre.

There was documentary evidence that residents were supported when transitioning between services and that the suitability of their placement was monitored by the overarching admissions committee. There was a formal system in place for the exchange of relevant information with the receiving facility when a resident was temporarily absent from the centre. Staff spoken with confirmed that supports included an allocated staffing resource if required.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a health and safety statement in place and a policy on the identification and management of risk. Further evidence of risk identification and management systems included weekly environmental and hygiene surveys and property surveys. There was documentary evidence that deficits were identified and remedial action taken. There were completed centre specific risk assessments including the risks as required by regulation 26(1) (c). However it was not clear that all identified risks and particularly those that remained unresolved were collated and entered into the risk register.

While there was evidence of good risk management practice the inspector found that night time staffing levels were not sufficient and placed residents at serious risk. The risk had been identified by staff but there was no evidence of measures and actions taken by the provider to control the risk identified. This is discussed again in outcome 17.

There was a procedure in place for the identification, recording and management of accidents and incidents. The record was completed by the staff member on duty, reviewed by the person in charge and there was evidence that actions identified as necessary to reduce the risk such as occupational therapy review were implemented.

The inspector saw that fire escape routes were clearly indicated and unobstructed. Records were in place to confirm that the fire detection system was inspected and tested at the prescribed intervals most recently in October 2014 as was the emergency lighting. Fire fighting equipment was signed as serviced on an annual basis most recently in 2014. Staff training records indicated that four staff had no recent recorded attendance at fire safety training; training had been provided twice in 2014. The person

in charge monitored training attendance and was aware of this deficit but there was no planned date for providing the required training.

Records indicated that regular simulated fire evacuation drills were undertaken by staff with residents. The inspector also saw that each resident had a personal emergency evacuation plan (PEEP). There was an evacuation plan and the actions to be taken in the event of fire were prominently displayed. Given the structure of the building with all rooms and service areas leading to a central foyer there was little apparent internal compartmentation. The inspector was not satisfied that the available night-time staffing levels would be sufficient to safely evacuate all residents given their high needs and there was no evidence available to provide reassurance. For example all fire drills had been completed with a minimum of two staff present; some beds were suitable for bed evacuation but others had evacuation sheets in place that required the presence of two staff; in May 2014 staff had identified that a formal "secondary plan for help" was required.

There was documentary evidence that hoists used in manual handling were serviced in line with legislative requirements most recently in October 2014. Staff confirmed that work was ongoing to correct an identified failing in part of the system and a floor based hoist was seen to be available to staff in the interim.

There was an emergency plan in place that provided succinct guidance to staff on the actions to be taken in the event of emergencies such as loss of power, unplanned resident absence or an unexpected death.

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:
There was a suite of policies with a protective component in place including policies and procedures on the protection of vulnerable adults, the use of restrictive practices, the management of aggression, and the provision of intimate care.

Training records indicated that all staff had received training on the protection of vulnerable adults most recently in 2014. Given the high needs of the residents many had limited capacity for learning the knowledge, self-awareness, understanding and skills needed for self-care and protection. Staff spoken with including the person in charge told the inspector that there had been no incident of suspected, reported or alleged abusive behaviour in the centre. There was overall evidence available to the inspector that the provider was aware of its responsibilities and took appropriate action to safeguard residents as and when necessary.

The person in charge confirmed that there were no behaviours of a nature that challenged or posed a risk to the resident or others and the provider nominee confirmed that training resources in this area were prioritised to centres where such behaviours did present. Notwithstanding this, training records indicated that only three staff had up to date training in the management of behaviours that challenged including de-escalation and intervention techniques as required by regulation 7(2).

There were restrictive practices in use such as the use of lap-belts and bed-rails and the rationale for their use was resident safety; this would reasonably concur with the needs of the residents as seen by the inspector. A risk-balancing decision making tool was in use and there was also evidence of other protective measures such as low-low beds and bed-rail protectors. However, the sample of restraint related documentation seen by the inspector did not fully demonstrate that practice was at all times in line with local procedures, national policy and evidence based practice including ongoing monitoring and review.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents were supported to maintain health and wellbeing by staff, the local general practitioner practice (GP) and allied health professionals available within the wider organisation. Staff reported that notwithstanding the high needs of the residents, residents in general enjoyed good health. The GP visited the centre three times each week, was also available to staff at times outside of these visits and an out-of-hours service was also available; records seen by the inspector supported this. As appropriate

to their needs residents received supports from other health professionals including weekly physiotherapy, speech and language therapy, occupational therapy, psychology and annual dental review. Staff reported a low incidence of transfer to the acute services and endeavoured to meet the needs of residents in the centre. There was evidence of the administration of seasonal influenza vaccine and regular blood profiling.

Residents' main meals were prepared off-site; there was evidence of pictorial menus and that staff ascertained each resident's meal choice based on the daily menu. The provision of modified diets was supported by speech and language review and individual swallow care plans. Staff were seen to provide residents with the required assistance in a dignified and unhurried manner. Residents were weighed monthly and the sample of records seen indicated that a stable body weight was maintained.
The inspector saw that some residents were facilitated to have access to structured activities off-site while activities appropriate to the nature and extent of each resident's disability were provided on site.

The centre facilitated end-of-life care for residents. The inspector reviewed an end-of-life care plan and found that it was sufficiently detailed to guide and direct care and support the resident to achieve a comfortable and dignified death. The care recorded was evidence based and closely supported and guided by the GP and the palliative care service. The record also indicated that family wishes were incorporated into the plan of care. Staff spoken with clearly saw end-of-life care as part of the continuum of care.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Medication management practice was guided by written operational policies and procedures; these were currently under review and a draft had been circulated for consultation and feedback. Medication was dispensed and supplied by a local pharmacist, the system of supply had recently changed and staff confirmed that they had received training from the pharmacist on the new system. Training records indicated that staff had also attended training on specific aspects of medication management and the person in charge said that a programme of further training in conjunction with the pharmacist was planned.

The inspector saw that medications were securely stored and while no medications requiring stricter controls were currently in use facilities were in place for their storage and administration in line with the relevant requirements.

Each resident had a medication prescription and administration record; these were legible, clearly signed and dated by the relevant GP and no administration discrepancies were noted on a random sample of records reviewed.

Medical authorisation was in place for the administration of medication in an altered format, crushed.

The maximum dosage of PRN (medication that is not scheduled or required on a regular basis) medications was stated, a record and rationale for their administration was maintained and no routine, regular administration was noted.

Medications no longer prescribed were clearly signed and dated as discontinued. Itemised signed records, countersigned by the pharmacist were in place for the return of unused or out-of-date medications.

Staff reported that there were no identified medication errors.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The statement of purpose was reviewed prior to the inspection; review and amendment of the document was required as follows;
• two statements were in place for each house but only one was required as they had an identical purpose and function and were registered as one designated centre by the provider
• room sizes were not included
• the staffing whole time equivalent was not included
• notwithstanding the needs accommodated no reference was made to access to education, training and employment
• greater detail was required in relation to the range of needs to be met and the

services provided to meet those needs such as staffing levels and skill-mix.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a clearly defined management structure in place and systems for review and monitoring; however given the deficit and risk identified in night-time staffing numbers it was not clear how the structure and systems supported, promoted, monitored and ensured the delivery of safe, quality care and services to residents.

The night-time staffing deficit indicated that the centre was not adequately resourced to ensure the safe and effective delivery of care and support to residents.

The fact that staff had resorted to signing a statement of concern/disclaimer in relation to night time staffing arrangements did not support that effective arrangements were in place for staff to raise concerns and exercise their personal and professional responsibility for the quality and safety of services that they were delivering to residents.

There was a clearly defined management system in place and staff were clear on the structure and reporting relationships. The person in charge reported to the head of integrated services and in the absence of the person in charge the centre was managed by a clinical nurse manager one (CNM1). The person in charge worked full-time but was also person in charge of another designated centre and divided her working week between both centres. The person in charge was suitably qualified and experienced, she was an actively registered nurse in intellectual disability and had also completed a BA in Health Services Management in 2010; the person in charge had established management experience. There was documentary evidence that the person in charge continued to engage in ongoing professional development.

The person in charge was also person in charge of another designated centre and based on previous inspection findings the inspector concluded that this arrangement did not allow for the person in charge to be sufficiently supported and engaged in the

governance, operational management and administration of each service to ensure that the service provided was safe, appropriate to and adequate to meet residents needs, was consistent and effectively monitored. These inspection findings would consolidate those findings. Both the provider nominee and person in charge confirmed to the inspector that a business plan had been submitted and the action identified as necessary by the provider to ensure an effective governance structure was the appointment of a CNM1 to each of the two designated centres, reporting into the person in charge. At the time of this inspection the plan had not been sanctioned and implemented.

The registered provider had put a system in place for the unannounced six monthly visits to the centre; the visit was undertaken in June 2014 and a report was available for inspection. While comprehensive and acknowledging deficits the serious risk posed by night-time staffing levels had not been identified.

Records were maintained of regular local staff meetings and weekly and monthly management meetings inclusive of the person in charge and her line manager. In general the records seen did support the provider's commitment to recognising deficits, learning and continuous improvement.

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:
The night time staffing arrangements were not sufficient to meet the assessed needs of the residents and placed residents at unnecessary and serious risk. There were two staff nurses on duty at night time from 20:00hrs to 07:30 hours one in each house. Staff spoken with and documents reviewed confirmed that on a regular and consistent basis staff were required to leave their defined area of responsibility to provide assistance to the staff member in the other house to meet residents' needs and care requirements. The houses while in close proximity were separate and segregated buildings. Based on the records seen this occurred at least twice some nights and resulted in vulnerable residents with high needs being left without a staff presence, unsupervised and without ready access to staff assistance for periods of up to twenty minutes at a time. Staff also

confirmed that as a safeguarding measure they at times took more independent and ambulant residents with them to the other house as a safeguarding and risk reducing measure. Staff required to work in this way had assessed the situation as unsafe and given their concerns were signing a "statement of concern/disclaimer" on each occasion that they left their own area of responsibility; this was known to the provider.

The inspector reviewed the recent accident and incident records and saw that two residents had sustained falls and consequent injuries, one resident had succeeded in releasing a bed rail. While the records indicated that these incidents occurred while a staff was present there was a clear risk that this may not always be the case. The centre provided care to residents with a severe to profound intellectual and physical disability with very little if any capacity for self-protection and safeguarding. In addition there was a high incidence of dysphagia and risk of aspiration with at least one resident seen to have bedside equipment for the management of excess secretions. Given the serious risk to resident wellbeing and safety identified by the Authority the provider was issued with an immediate action plan to address with immediate effect the night time staffing deficit.

Staff spoken with confirmed that staffing levels were maintained in response to deficits arising from absence such as sick leave and annual leave and this was reflected in the staff roster. However, staff also confirmed that there was no structured allocation of staffing resources in response to periods of increased demand such as the delivery of end of life care; the allocated resource remained at one. Staff spoken with said that on a voluntary basis they provided a staffing presence both to assist the staff member on duty and provide support and comfort for the resident at end of life. While staff spoken with clearly did this willingly this arrangement did not reflect the provider's legal responsibility to ensure that at all times the numbers of staff were sufficient to meet the assessed needs of the residents.

A planned and actual staff rota was maintained; it did not however identify the duty roster worked by each person. The inspector saw that they were on duty but the roster did not indicate the shift to be worked by them.

A sample of staff files (four) was made available for the purposes of inspection and they were found to contain all of the documents required by Schedule 2 of the regulations.

Evidence of their current registration with their regulatory body was in place for each nurse employed including staff employed on a relief basis.

A record of completed staff training was maintained and from the record the inspector saw that attendance at mandatory training was good; a deficit was identified in fire safety training and in the management of behaviours that challenged and this is addressed in the respective outcome. Further training completed by staff included medication management training including specific aspects of medication management relevant to the residents needs, first aid, basic life support, person centred planning, the management of dysphagia and briefing on the regulations and the standards. There was evidence to support the scope of training reflected the evolving needs of the residents such as the training on dysphagia; one staff member had also completed post graduate education in palliative care and another staff member was currently undertaking a

similar programme.
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:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004782
Date of Inspection:	20 January 2015
Date of response:	06 February 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A personal plan was not in place for each resident within twenty eight days of admission to the centre.

Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the

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

resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
•The scheduled planning meeting of the person centred plan was held on 26/01/15, where goals were identified with resident, family and multi d members for the coming year.
•Review of the Needs Assessment documentation prior to admission is currently under review by the Admissions, Discharge and Transfer committee of the Brothers of Charity Services Limerick. This review will include the development of an assessment of health care needs.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not clear as to how priorities/objectives were to be pursued, who was responsible and within what timeframe. There was evidence that the available staffing resources had been identified as a constraint to achieving some identified objectives and it was not clear what impact this had if any on the effectiveness of the plan. The personal plans did not read as an integrated and holistic record that reflected all aspects of the residents life and their required supports be they social, health or psychosocial.

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:
•A review of the documentation will take place to stream line the personal plan and any associated health care plans to ensure a clearer integrated and holistic record which reflects all aspects of the residents life is accessible by 31/03/15.
•A review of My Profile/My Plan which contains all documentation relating to the person will be reviewed and feedback from the inspector will be taken into account.
•The Person Centre Planning process will continue to be reviewed and updated by the Quality Forum.

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:

Night time staffing levels were not sufficient and placed residents at serious risk. The risk had been identified by staff but there was no evidence of measures and actions taken by the provider to control the risk identified.

All identified risks and particularly those that remained unresolved were not collated and entered into the risk register.

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:
• Person in charge has completed risk register for identified night time risks and will continue on an ongoing basis to assess the centre with regards to risks
• One additional waking staff at care assistant level has been rostered from the 21/01/15 immediate action
• Night staff in future will comprise of one staff nurse in each house and one floating staff at care assistant level.
• Business has been submitted to HSE in relation to above on 27/01/15 – no response has been received to date despite ongoing correspondence for approval.

Proposed Timescale: Ongoing

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was not satisfied that the available night-time staffing levels would be sufficient to safely evacuate all residents given their high needs and there was no evidence available to provide reassurance.

Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
• One additional waking staff at care assistant level has been rostered from the 21/01/15(immediate action)
• Night staff in future will comprise of one staff nurse in each house and one floating staff at care assistant level.
• Business has been submitted to HSE in relation to above on 27/01/15 – no response has been received to date despite ongoing correspondence for approval.
• Fire drills are carried out bimonthly. Based on change in staffing a fire drill will be carried out to access the risks by 12/02/15

Proposed Timescale: 12/02/2015 and ongoing

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff training records indicated that four staff had no recent recorded attendance at fire safety 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:
• Fire safety training is scheduled for the 4/03/15 for outstanding staff.

Proposed Timescale: 04/03/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training records indicated that only three staff had up to date training in the management of behaviours that challenged including de-escalation and intervention techniques as required by regulation 7(2).

Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
• Discussions with behaviour support team to identify level of training required for positive behaviour support as risk rating is low as this area was not determined to require this level of training.
• A programme will be developed by the Behaviour Support Team
• Two hour training will be provided to all staff by the behavioural support team by 31/05/15

Proposed Timescale: 31/05/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The sample of restraint related documentation seen by the inspector did not fully demonstrate that practice was at all times in line with local procedures, national policy and evidence based practice including ongoing monitoring and review.

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:
• Review of bed rails commenced with relevant members of multi d team on 26.01.15 and will be completed by 28/02/15

Proposed Timescale: 28/02/2015

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:
The statement of purpose contained most but not all of the required information.

There were two statements in place.

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:
One statement of purpose and function will be completed for the designated centre to include all information specified in regulations.

Proposed Timescale: 30/03/2015

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:
There was a clearly defined management structure in place and systems for review and monitoring; however given the deficit and risk identified in night-time staffing numbers it was not clear how the structure and systems supported, promoted, monitored and ensured the delivery of safe, quality care and services to residents.

A business plan had been submitted and the action identified as necessary by the provider to ensure an effective governance structure was the appointment of a CNM1 to each of the two designated centres, reporting into the person in charge. At the time of this inspection the plan had not been sanctioned and implemented.

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:
• Awaiting response from HSE to business plan submitted for additional CNM1 post in centre. Business case was discussed as part of a service arrangement meeting on the 29th Jan. The local HSE have advised that they have not yet received approval for this submission.
• Transfer of CNM1 to area as an interim awaiting response from business case submission 18/10/15 to increase to 2 CNM1 posts for centre.
• Acting CNM1 will be in place in second centre by 28/02/15.

Proposed Timescale: On-going

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fact that staff had resorted to signing a statement of concern/disclaimer in relation to night time staffing arrangements did not support that effective arrangements were in place for staff to raise concerns and exercise their personal and professional responsibility for the quality and safety of services that they were delivering to residents.

Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
• Grievance procedure in place for staff
• Complaints procedure in place for residents
• Monthly staff meetings in place where the agenda will now include more emphasis on quality and safety of services.
• All staff has access to manager to raise individual concerns.

Proposed Timescale: On-going

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had put a system in place for the unannounced six monthly visits to the centre; the visit was undertaken in June 2014 and a report was available for inspection. While comprehensive and acknowledging deficits the serious risk posed by night-time staffing levels had not been identified.

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 organisation currently has a schedule in place to ensure that an unannounced visit is carried out by the provider or provider nominee to each designated centre at least every six months.
• The focus of these unannounced visits is on 2 to 3 of HIQA's 18 outcomes and assesses the safety and quality of care in relation to these outcomes in the designated centre.
• A report is issued following each visit to the PIC.
• A report is issued on a quarterly basis for organisational learning following 3 months of unannounced inspections.
• In addition to these unannounced visits the Person in Charge of each designated centre will carry out an annual review of the safety and quality of care in the designated centre. This review will be carried out in each designated centre between January and April 2015 and will focus on 15 of HIQA's 18 outcomes.

Proposed Timescale: On-going

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The night time staffing arrangements were not sufficient to meet the assessed needs of the residents and placed residents at unnecessary and serious risk. On a regular and consistent basis staff were required to leave their defined area of responsibility to provide assistance to the staff member in the other house to meet residents' needs and care requirements. This occurred twice some nights and resulted in vulnerable residents with high needs including risk of aspiration being left without a staff presence and unsupervised for periods of up to twenty minutes at a time.Staff required to work in this way had assessed the situation as unsafe and were signing a "statement of concern/disclaimer" on each occasion that they left their own area of responsibility; this was known to the provider.

There was no structured allocation of staffing resources in response to periods of increased demand such as the delivery of end of life care; the allocated resource remained at one staff member.

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:

• Prior to relocating residents from their previous accommodation to the present centre negotiations were held under the auspices of the Labour Relations Commission between staff, unions and management on 01.05.02. The recommendation at the time was that nursing staff relocate under present management plan and staffing levels remained upto the time of inspection. The statement of concern/disclaimer was introduced at that time.

• One additional waking staff at care assistant level has been rostered from the 21/01/15 following the issuing of an immediate action by HIQA inspector.

• Night staff in future will comprise of one staff nurse in each house and one floating staff at care assistant level.

• Due to the nature of the centre and the service users living in the centre long term, un-rostered staff and families support the service user in the delivery of end of life care on a voluntary basis which is greatly valued by the organisation. In future additional staff will be rostered at this time.

• The practice will continue whereby additional staff will be roistered when there is increased demand for supports e.g. admissions to hospital.

• Business case has been submitted to the HSE for funding. No approval received to date.

Proposed Timescale: 21/01/2015