

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by L'Arche Ireland
Centre ID:	OSV-0003421
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	L'Arche Ireland
Provider Nominee:	Mairead Boland Brabazon
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 11 November 2015 08:30 To: 11 November 2015 19:00

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This inspection of a designated centre operated by L'Arche Ireland - Cork was carried out in response to an application to vary the conditions of registration and was the second inspection of the centre by the Health Information and Quality Authority (the Authority). The application to vary related to a request by the provider to increase the number of residents accommodated in one of the houses from six to seven. As part of the inspection, the inspector visited the centre and met with residents, staff members and management. The inspector observed practices and reviewed documentation such as personal plans, medical records and accident and incident records.

In total, 15 adult residents live in this designated centre which was operated from three large domestic houses in three residential areas of Cork city. Many of the residents attended a day service during the day, however, a small number of residents were also in employment.

The centre was well maintained and furnished to a good standard. Residents confirmed that they were happy in the centre and some enjoyed visiting their

families at weekends. This inspection was a follow-up to a registration inspection that was carried out in December 2014. On this inspection it was found that many of the actions identified following the last inspection were not completed satisfactorily. For example, at the last inspection a number of policies required by the regulations were not available in the centre. In the response to the action plan, the provider stated that these would be available by 31 March 2015, however, while work had been done in developing these policies, they were not available in the centre. Additionally, a number of the policies were not sufficiently comprehensive. For example the policy on monitoring and documenting residents' food/fluid intake did not adequately outline how this would be done.

At the last inspection it was identified that there were a significant number of medication errors particularly in one of the houses. While improvements were identified in this house on this inspection, the number of errors had increased significantly in another house. Measures had been put in place to address these errors however, it was too soon to ascertain if these measures were effective. Improvements were also required in relation to governance and management as there was not an adequate annual review of the quality and safety of care and a record of unannounced visits to the centre on or on behalf of the provider was not available. Other required improvements included:

- personal plans were not reviewed annually or more frequently as required
- the risk management policy did not comply with regulations
- the emergency plan was not sufficiently comprehensive
- the statement of purpose did not contain all the required information
- personnel records did not contain all the required information
- not all staff had attended required training

The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Residents records were contained in a number of folders addressing different aspects of residents' care. For example, there was a medical file containing all of the residents information in relation to their medical care, including details of reviews and assessments by their general practitioner (GP) and allied health/specialist services. There was a folder that contained information on the health/social history of each resident, daily routines and preferences, a missing person profile, personal emergency evacuation plan and health related care plans. There was also a folder for person centred plans containing annual reviews and goals that were set in consultation with the resident to be achieved in the forth coming year.

Each resident had a comprehensive assessment detailing information on residents' recreation and social interaction including their interaction with other residents, family involvement, hobbies and interests, and interests external to the centre. While each resident had a person centred plan(PCP) reflecting the needs and aspirations of each resident, a number of these were out-of-date and had not been reviewed annually as required by the regulations. Where reviews were in place, they were not always multidisciplinary. Additionally, some PCPs contained six-monthly reviews to assess the effectiveness of the plan, however, this was not done for all. There was evidence that, where up-to-date PCPs were in place, they were done in consultation with the resident and the resident was free to choose who was consulted when PCPs were being developed. However, PCPs were not always made available to residents in an accessible format.

Each resident was assessed for their capacity to have possession of a key to the house based on issues such as road safety sense and orientation to the local environment.

Residents to whom the inspector spoke with confirmed their participation in a range of activities both within the centre and in the wider community. Many of the residents attended a day centre which was operated by the provider and a range of activities were available such as art and crafts and there was also support to develop life-skills such as cooking. A small number of residents held either full-time or part-time employment.

Residents were supported when moving between services through a process of transition, incorporating visits to the centre for meals and trial periods of residing in the centre. This process was planned for the proposed new resident, however, it had not been finalised on the day of the inspection.

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):

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

Findings:

The centre comprised three large houses located in three separate residential areas in Cork City with good access to public transport. Two of the houses were approximately one kilometre apart and the third was approximately four kilometres away. The houses were homely, appeared clean throughout and were furnished to a good standard. All residents had their own private bedrooms and there was also bedroom accommodation for assistants that lived in each of the houses. Residents had access to front and back gardens in each of the houses.

The first house comprised seven residents' bedrooms and five live-in assistants' bedrooms in a two-storey detached house. The seventh resident' bedroom had previously been a live-in assistant bedroom but had been converted to a residents' bedroom in anticipation of a new admission to the house. This bedroom had been redecorated in consultation with the proposed new resident in relation to the paint colour and furniture. The room was adequate in size, contained a double wardrobe, a new bed, bedside locker and a desk that was still in its packaging. Additional items such as a television and game console were planned for when the resident was admitted.

Sanitary facilities in this house comprised two bathrooms on the ground floor, each with a shower, toilet and wash-hand basin, and two bathrooms on the first floor, one of which contained a bath, toilet and wash-hand basin and the other contained a shower, toilet and wash-hand basin. This house contained a large sitting room, a small sitting room, a dining room with a large dining table with seating for 12 people, and a large kitchen

The second house comprised four residents' bedrooms and four live-in assistants' bedrooms. Sanitary facilities comprised a toilet with a wash-hand basin, and a separate shower on the ground floor and a bathroom containing a shower, toilet and wash-hand basin on the first floor. This house contained a living room, dining room and a kitchen.

The third house comprised five residents' bedrooms and four live-in assistants' bedrooms. Sanitary facilities comprised two bathrooms on the ground floor, each with a shower, toilet and wash-hand basin on the ground floor and two bathrooms on the first floor, one with a shower and the other with a bath and both had a toilet and wash-hand basin.

All three houses were comfortably furnished and decorated in accordance with residents' preferences. Residents had personalised their bedroom rooms with their own pictures and personal belongings. There was adequate storage space in each of the bedrooms for personal belongings and residents could lock their bedrooms, if they wished.

There was evidence of ongoing maintenance, including the preventive maintenance of equipment, such as gas boilers. As found on the last inspection a number of windows had unrestricted opening on both the ground and first floors and there was no risk assessment to identify if this posed a risk to the residents currently living in the centre or for the proposed new resident. The person in charge was asked to consult with fire safety personnel before deciding the best course of action to address windows with unrestricted opening. This action is addressed under Outcome 7, Health and Safety and Risk Management.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

Findings:

There was a health and safety policy that also contained a safety statement. There was a risk management policy and associated risk register that identified hazards and risks throughout the centre and the control measures in place to mitigate the risks identified. The policy addressed accidental injury to residents, visitors and staff, however, it did not address the unexpected absence of any resident, aggression and violence or self-harm, as required by the regulations. A new draft policy was presented to the inspector on the day of the inspection but this was not available in the centre prior to the inspection. Even though this policy addressed the risks specified in the regulations it did not include the measures and actions in place to control these specified risks.

Each resident had a range of risk assessments including risk of falling, electrical hazards, burns and access to chemicals. Some improvements, however, were required in relation to risk management. For example, it was not clear how the level of risk was estimated in the risk register and the level of risk was not estimated prior to and following the implementation of control measures. Additionally, the levels of risk identified in the risk register did not equate to those identified in the risk management policy. For example, the levels of risk used in the risk register were High, Medium and Low, whereas the risk management policy identified the possible level of risk as Extremely High, High, Moderate and Low. While some of the actions identified at the last inspection in relation to the risk register were addressed, such as the inclusion of access to chemicals by residents and the potential of falling due to the height of bannisters on the first floor landings, not all issues identified were addressed, such as unlocked front doors and unrestricted window opening.

Inspectors viewed the accident and incident logs and there was evidence of action in response to individual accidents/incidents to mitigate reoccurrence. There was also a three-monthly audit of accidents and incidents, however, where there was evidence of trends there was no associated action plan to address the issues identified. For example, as will be discussed further under Outcome 12, Medication Management, there were a significant number of medication errors, however, there was no evidence of an overall plan or strategy identified for learning from this trend or to mitigate reoccurrence of these types of errors.

Most, but not all, staff/assistants had received up-to-date training in manual handling.

There were adequate procedures in place for infection prevention and control including the use of separate mops for general and bathroom areas. Since the last inspection, hooks had been installed to ensure that mops were now stored correctly to minimise the chance of cross-contamination.

There was an emergency plan that addressed how to respond to a major emergency, such as fire and the safe placement of residents in the event of a prolonged evacuation. However, consistent with the findings of the last inspection, it did not address emergencies such as loss of electricity, flooding, loss of kitchen facilities or loss of water.

The inspector reviewed the fire safety registers. Records indicated that fire safety equipment, the fire alarm and emergency lighting was serviced at suitable intervals. Most, but not all staff, had received up-to-date training in fire safety. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire.

Records indicated that fire drills were carried out frequently and response times were noted. Most fire drills were carried out by House Leaders, who were mainly present in the centre during the day and evenings. The person in charge was informed by the inspector that this process could be enhanced if fire drills were conducted by live-in assistants, possibly when residents were in their bedrooms.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The new person in charge was involved in the management of the centre on a daily basis. He informed the inspector that he monitored safeguarding practices through regularly speaking with residents and staff. Residents were forthcoming in interacting with the inspector and stated that they felt safe in the centre. Staff/assistants were seen to be interacting with residents in a friendly, dignified and respectful manner and it was obvious that residents were comfortable in the presence of staff/assistants.

There was a policy on dealing with behaviour that poses a risk to the safety of individuals. A new safeguarding policy was in draft format but had not yet been implemented. Most, but not all, staff had received training in safeguarding practices. Staff/assistants spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. Contact details of safeguarding officers, including their photographs were on display in the centre as were the contact details of an independent advocacy service.

A small number of residents presented with behaviour that challenged. Staff spoken with by the inspector were knowledgeable of triggers to the behaviour for various residents and how to de-escalate potential crisis situations. Most, but not all, staff had received up-to-date training in managing behaviour that challenges. There was evidence of the minimal use of chemical restraint for one resident, however, this was no longer in use.

There were procedures in place to safeguard residents finances through record keeping, such as maintaining a record of all transactions and the retention of receipts for all purchases made for and on behalf of residents. Some improvements were required, however, as it was not always possible to identify what monies were used for and there were not always two staff signatures for cash withdrawals, when the resident was unable to sign. As identified at the last inspection, improvements were also required in relation to the protocol surrounding the payment of expenses by residents for all activities, including overnight accommodation in hotels on holidays/weekends away.

Judgment:
Substantially Compliant

Outcome 09: Notification of Incidents

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

Theme:
Safe Services

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

No actions were required from the previous inspection.

Findings:

A sample of residents' records reviewed by the inspector indicated the minimal use of chemical restraint, however, this was not notified to the Authority as required by regulations.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents were facilitated with access to the services of a general practitioner (GP) of their choice and there was evidence of regular review. There was evidence of referral

and review to allied health professionals such as dietetics, speech and language therapy, dental and ophthalmology. As identified on the last inspection improvements were required in relation to the use of evidence-based tools for baseline and ongoing review of health related assessments such as, for example, falls risk assessment and nutritional assessment. This action is addressed under Outcome 5. There were detailed care plans in place identifying the care to be provided to residents with conditions such as diabetes and epilepsy.

Residents had access to refreshments and snacks with a selection of juices and fresh fruit readily available in each house. Residents likes and dislikes were recorded and residents were consulted in relation to the menu for the forthcoming week in each of the houses at house meetings that were held every Monday. There were adequate cooking facilities and all assistants and most staff had received training in food hygiene.

Some improvements, however, were required in relation to the management of nutrition. There was no policy on the monitoring and documentation of nutritional intake available in the centre on the day of inspection. A new draft policy was presented to the inspector, however, this policy predominately addressed mealtimes and presentation of food. It did not identify a process for monitoring residents nutritional status. Records of residents' weights were not maintained in the centre and the inspector was informed that these were kept in the day service by the nurse. As already stated under Outcome 5, there was no overall nutritional assessment on admission or at regular intervals thereafter. The inspector was informed that this was in the process of being developed.

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):

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

Findings:

There were written operational policies and procedures relating to ordering, prescribing, storing and the administration of medicines to residents. All but one member of staff had received training in medication administration. Most live-in assistants had received training in the management of epilepsy and the administration of medication to be administered in the event of prolonged seizure activity. A sample of prescription and administration records viewed by inspectors contained appropriate information to support the identification of each resident.

Records of medication errors indicated that improvements were required, as there were an unacceptable number of medication errors, which were predominantly in relation to staff/assistants forgetting to administer medications or giving medications twice. This had been identified at the last inspection, predominantly in one house. On this inspection the number of errors in that house had decreased due to the implementation of an alarm to remind staff that medication was due. However, there was a significant increase in the number of errors in another house, which again mainly consisted of staff/assistants forgetting to administer medications. These medicines were usually administered later in the day following consultation with the resident's GP/pharmacist. A measure had recently been put in place to remind staff to administer medications but it was too soon to ascertain if this measure mitigated future occurrence.

Residents prescriptions were reviewed regularly. There was a process in place to check medications following delivery to ensure the medications delivered corresponded with the prescription. Residents responsible for self-administration were appropriately assessed and reviewed on an ongoing basis.

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

Findings:
There was a written statement of purpose that set out the aims, objectives and ethos of the centre. The statement of purpose included most of the matters listed in Schedule 1 of the regulations, however, it did not adequately outline:

- the date on which it was last reviewed/revised
- the information set out in the registration certificate
- the management and staffing complements in full-time equivalents
- the role of the PIC in the organisational structure
- the arrangements for respecting privacy and dignity.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There was an effective management structure in place which supported the delivery of safe care and services. There was a national committee to oversee the organisation nationally and a local committee to oversee the organisation in the Cork area. There was a chief executive officer (CEO) who reported to the national committee and was also the provider nominee.

Prior to this inspection there had been two persons in charge (PIC) for this centre, however, one of the persons in charge had recently retired. A new person in charge had been appointed on 01 October 2015. The inspector interviewed the new person in charge and was satisfied that he was sufficiently knowledgeable of his obligations in relation to regulations and standards. He was familiar with the care needs of the residents and demonstrated a clear commitment to improving the service offered to these residents.

The person in charge reported to a community leader, who in turn reported to the CEO. The PIC met held formal minuted meetings with the community leader every month but also met with him on a weekly basis to discuss the day-to-day management of the centre.

There was a house coordinators meeting each week attended by the staff of each house that addressed issues in relation to the management of that house. There was also a community coordinators meeting, held once a week, attended by the management team that addressed issues in relation to the Cork area. There were house meetings each Monday attended by staff and residents to discuss plans for the forthcoming week and any other issues of concern to residents.

There were systems in place for monitoring the quality and safety of care, however, improvements were required. For example, records of medication management audits did not identify errors in medication administration and audits of accidents and incidents did not have an associated action plan to address opportunities for learning, which were also in relation to medication errors. Additionally, the audit process was not sufficiently comprehensive to adequately assess the quality and safety of care provided.

The inspector was not satisfied that there was a comprehensive annual review of the quality and safety of care. An annual review provided to the inspector following the inspection did not adequately assess the quality and safety of care provided as it was not supported by a comprehensive objective assessment/audit process. Additionally, while the inspector was informed that an unannounced visit to the centre had taken place in April 2015 to assess the quality and safety of care, a report of this visit was not available.

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):

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

Findings:

The centre was run with an ethos of "community" whereby residents and house assistants shared accommodation. Each assistant had a reference person for one of the residents and supports them with health, spiritual, money management and personal hygiene issues. House assistants were volunteers, many of whom were overseas visitors, who may have volunteered in L'Arche in other countries, and usually remained in the centre for one to two years. Each house had a house leader that were full-time employees and oversaw the assistants and the care provided to the residents.

Inspectors found that the numbers and skill mix of staff were appropriate to the assessed needs of the residents. Plans were in place for an additional care assistant to reside in the house to support the new resident settle in and also to ensure that he remained safe in the new environment.

There was evidence of strong recruitment practices where potential staff from abroad were interviewed by Skype, references were sought and verified, medical declarations were recorded, work and educational experience was documented and vetting was secured from their home country prior to recruitment. However, not all staff had a vetting disclosure in accordance with the National Vetting Bureau and full employment

history with a satisfactory explanation for any gaps in employment was not available for all employees. There was a process of induction for all staff and evidence of close supervision and mentoring.

Records were maintained of staff training indicating attendance at training such as infection control, person centred approach, protection of vulnerable adults, administration of medicine, challenging behaviour, manual handling, fire safety, epilepsy, diabetes, and food hygiene. However, not all staff had received up-to-date training in fire safety, safeguarding vulnerable adults and manual handling.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Inspectors found that there were systems in place to maintain complete and accurate records. Most of the required policies were in place, however, policies that were found to be absent at the last inspection in December 2014 were not present in the centre on the day of inspection. The inspector was informed that these had been updated but had not been distributed.

Based on a review of the policies the following improvements were required:

- the policy on monitoring and documenting nutritional intake did not address the assessment of residents' nutritional status
- the risk management policy did not address all of the items specified in Regulation 26
- the policy on residents' property and possessions did not adequately address the management of residents' property and possessions
- the complaints policy did not identify an independent appeals process or who was responsible for overseeing complaints
- the policy on the use of restrictive procedures and physical, chemical and

environmental restraint was not available in the centre

- the policy on access to education, training and development was not available in the centre

Inspectors found that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Judgment:

Non Compliant - Moderate

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by L'Arche Ireland
Centre ID:	OSV-0003421
Date of Inspection:	11 November 2015
Date of response:	26 November 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:

While each resident had a person centred plan(PCP) reflecting the needs and aspirations of each resident, a number of these were out-of-date and had not been reviewed annually as required by the regulations.

1. Action Required:

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

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

A PCP Co-ordinator will be appointed. The Residential Management Team will work with this person to agree a time frame for annual PCP reviews and 6-monthly reviews, and they will insure its implementation.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Where PCP reviews were in place, they were not always multidisciplinary.

2. Action Required:

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

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

A multi-disciplinary sub-folder will be created in each of the Residents' Care Plans, which will include an annual assessment form and evidence of follow up.

Proposed Timescale: 30/01/2016

Theme: Effective Services

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

Some PCPs contained six-monthly reviews to assess the effectiveness of the plan, however, this was not done for all.

3. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

Update the 6-monthly PCP review form to incorporate an assessment of the effectiveness of each plan and to explore whether or not there have been any changes in circumstances that might affect the plan.

Proposed Timescale: 16/12/2015

Theme: Effective Services

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

PCPs were not always made available to residents in an accessible format.

4. 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:

An easy-read version of each Resident's PCP will be made available to them to place on the wall in their room or to carry with them.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Improvements were required in relation to the use of evidence-based tools for baseline and ongoing review of health related assessments such as, for example, falls risk assessment and nutritional assessment.

5. Action Required:

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

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

Our community nurse is in the process of completing a nutritional assessment of each resident and, in conjunction with the House Leader of each house, is also doing a falls assessment. This will be updated on an annual basis or as any changes in need or circumstances dictate.

Proposed Timescale: 31/01/2016

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 was an emergency plan that addressed how to respond to a major emergency, such as fire and the safe placement of residents in the event of a prolonged evacuation. However, consistent with the findings of the last inspection, it did not address

emergencies such as loss of electricity, flooding, loss of kitchen facilities or loss of water.

6. 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 risk management policy will be updated and a house-specific procedure will be drawn up by each house to assess and manage on an ongoing basis their response to any emergency, to include loss of electricity, flooding, loss of kitchen facilities and loss of water.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

Some of the actions identified at the last inspection in relation to the risk register were addressed, such as the inclusion of access to chemicals by residents and the potential of falling due to the height of bannisters on the first floor landings, not all issues identified were addressed, such as unlocked front doors and unrestricted window opening.

7. 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:

A system of quarterly audits will be put in place that look at the Risk Register and ensure that all possible risks are being identified and that a suitable plan is in place to respond to each risk. Risks relating to the window in An Croí will be assessed.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

The risk management policy available in the centre on the day of inspection addressed accidental injury to residents, visitors and staff, however, it did not address the unexpected absence of any resident, aggression and violence or self-harm, as required by the regulations.

8. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

Update the risk management policy.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

A new draft policy was presented to the inspector on the day of the inspection and even though this policy addressed the risks specified in the regulations it did not include the measures and actions in place to control these specified risks.

9. Action Required:

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

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

The risk assessment tool will include measures and actions in place to control the risk identified and the policy will be updated to cover this.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Some improvements were required in relation to risk management. For example, it was not clear how the level of risk was estimated in the risk register and the level of risk was not estimated prior to and following the implementation of control measures. Additionally, the levels of risk identified in the risk register did not equate to those identified in the risk management policy. For example, the levels of risk used in the risk register were High, Medium and Low, whereas the risk management policy identified the possible level of risk as Extremely High, High, Moderate and Low.

10. 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:

Risk management policy will be updated. Risk assessment forms will be updated to highlight how the risk level was estimated. The Risk Management policy will be updated

to reflect the levels of risk identified in the risk assessment tool.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

There was a three-monthly audit of accidents and incidents, however, where there was evidence of trends there was no associated action plan to address the issues identified. For example, there were a significant number of medication errors, however, there was no evidence of an overall plan or strategy identified to mitigate reoccurrence.

11. Action Required:

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

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

The Risk Management policy will be updated to include regular audits of the incident log with trends identified and learning from such trends taken on board .

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Most, but not all staff, had received up-to-date training in fire safety

12. 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:

Team will ensure that any training gaps are addressed. Current training addresses fire control techniques and first aid fire-fighting equipment. A new induction section in mandatory training matrix will be introduced to supplement this with areas that are currently covered in House Team Planning meetings, such as building layout and escape routes, location of fire alarm call points, emergency procedures, and arrangements for the evacuation of residents.

Proposed Timescale: 29/02/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some improvements were required in the management of residents' finances as it was not always possible to identify what monies were used for and there were not always two staff signatures for cash withdrawals, when the resident was unable to sign. As identified at the last inspection, improvements were also required in relation to the protocol surrounding the payment of expenses by residents for all activities, including overnight accommodation in hotels on holidays/weekends away.

13. Action Required:

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

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

Draw up a protocol to insure that Residents' finances are safe from abuse.

Proposed Timescale: 31/01/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

A sample of residents' records reviewed by the inspector indicated the minimal use of chemical restraint, however, this was not notified to the Authority as required by regulations.

14. Action Required:

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

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

We will ensure that this is done.

Proposed Timescale: 16/12/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Records of medication errors indicated that improvements were required, as there were an unacceptable number of medication errors, which were predominantly in relation to forgetting to administer medications or giving medications twice.

15. Action Required:

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

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

Practises will be reviewed and suitable systems will be put in place that includes regular alarms and reminders to insure that all medicines are administered as prescribed. Our Community Nurse will review practises relating to storage and administration of medicines in each house and report back to the PIC. We will update our procedures and practises according to findings. Specific times and locations will be identified in each house for the administration of medication.

Proposed Timescale: 31/01/2016

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 included most of the matters listed in Schedule 1 of the regulations, however, it did not adequately outline:

- the date on which it was last reviewed/revised
- the information set out in the registration certificate
- the management and staffing complements in full-time equivalents
- the role of the PIC in the organisational structure
- the arrangements for respecting privacy and dignity.

16. 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:

Statement of Purpose will be updated to contain the relevant information

Proposed Timescale: 16/12/2015

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 were systems in place for monitoring the quality and safety of care, however, improvements were required. For example, records of medication management audits did not identify errors in medication administration and audits of accidents and incidents did not have an associated action plan to address opportunities for learning, which were also in relation to medication errors. Additionally, the audit process was not sufficiently comprehensive to adequately assess the quality and safety of care provided.

17. 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:

System of quarterly audits by the PIC will be put in place which will include opportunities for learning. This will be overseen by the HIQA Committee.

Proposed Timescale: 29/02/2016

Theme: Leadership, Governance and Management

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

The inspector was not satisfied that there was a comprehensive annual review of the quality and safety of care. An annual review provided to the inspector following the inspection did not adequately assess the quality and safety of care provided as it was not supported by an objective assessment/audit process.

18. Action Required:

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

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

The Provider will adopt a new quality system to ensure that the Annual Review will monitor the quality and safety of care and support in the designated centre, and that such care and support is in accordance with standards.

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

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

Additionally, while the inspector was informed that an unannounced visit to the centre had taken place in April 2015 to assess the quality and safety of care, a report of this visit was not available.

19. 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 Provider will carry out unannounced inspections in the centre as per regulations. They will 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.

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not all staff had a vetting disclosure in accordance with the National Vetting Bureau and full employment history with a satisfactory explanation for any gaps in employment was not available for all employees.

20. 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:

Recruitment practises for House Assistants will include full exploration of any employment gaps. National Garda Vetting (to supplement Police Clearance already on file) will be processed once all foreign House Assistants have been in the country for 3 months.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

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

Not all staff had received up-to-date training in fire safety, safeguarding vulnerable adults and manual handling.

21. 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:

Management Team will ensure oversight of the training programme to include a training needs analysis for all staff and assistants.

Proposed Timescale: 31/01/2016