**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

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| **Centre name:** | A designated centre for people with disabilities operated by Brothers of Charity Services Limerick |
| **Centre ID:** | OSV-0004752 |
| **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:** | Margaret O'Regan |
| **Support inspector(s):** | Mary Costelloe |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 29 |
| **Number of vacancies on the date of inspection:** | 0 |

## About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

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

| From: | To: |
|---|---|
| 10 November 2015 09:20 | 10 November 2015 20:00 |
| 11 November 2015 09:00 | 11 November 2015 16:00 |
| 12 November 2015 07:00 | 12 November 2015 15:30 |

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

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

**Summary of findings from this inspection**

This congregated setting for people with intellectual disabilities is operated by the Brothers of Charity, Limerick. The campus consisted of 15 bungalow style houses. The 15 houses were grouped under three separate centres and each centre had a person in charge. The centre to which this report refers to, catered for 29 residents.

This was the second inspection of the centre carried out by the Health Information and Quality Authority (HIQA). It was announced and took place over three days. The inspectors met with residents, staff, the person in charge and senior management of

the Brothers of Charity, Limerick. The inspectors observed practices, examined the premises and looked at documentation such as residents' care plans, medical records, policies and procedures and risk assessments.

The centre comprised of four single storey houses with between six and eight residents in each house. This was a nurse-led facility and many of the residents were of high nursing needs dependency. A number of residents had behaviours that challenged. Both male and female residents were accommodated in this centre. The majority of residents had their own bedroom but some did share. The plan put in place in January 2015 to have single rooms for each resident had not materialised. Since the last inspection, when a vacancy arose in the three bedded room, another resident was admitted. Each house had a sitting room, kitchen, bathroom, office and storage space. Three of the houses had a sitting room where residents could meet visitors in private. While the houses were generally clean, the cleaning practices seen on the day were inappropriate. In particular the exterior was poorly kept. This is discussed under Outcome 7.

Bedrooms were recently painted and much effort was made to make them as homely as possible within the limitations of the design and layout of the centre. Sanitary facilities in two of the houses were grouped together in an institutional like arrangement. Sluice rooms were generally accessed via the shower room. While houses were made as comfortable as possible within the design limitations, the premises were in need of upgrading. For example windows needed to be replaced, new flooring was needed in a number of rooms and improvements were needed to the sanitary arrangements. One house was deemed to be a significant fire safety risk and the fire safety specialist advice received on the day of inspection, was for the residents to be relocated as a matter of urgency. In the interim staffing ratios were increased, updated training was provided and a system of 15 minute checks was put in place. These are discussed under Outcome 6 and 7. Subsequent to the inspection the Health Information and Quality Authority requested assurances from the provider in relation to fire safety in this centre. These assurances were provided.

Approximately 45% of families completed questionnaires with regard to the services provided in this centre. This was a higher than normal response to such questionnaires. Families sent these completed questionnaires to HIQA. Almost 18% of residents completed questionnaires and this was also a good response rate, given many residents would not be in a position to complete such questionnaires. The overwhelming response from residents and relatives was that staff were very respectful and attentive. However, responses also indicated that there were limited opportunities for residents to go on outings or be involved in the local community. Comments also clearly articulated the opinion that the buildings were outdated. Comments from relatives included, "The centre has acted as a home from home for my brother. The staff are very kind towards him and all residents that I have seen. He is treated with respect at all times and he is very happy to be there. Cutbacks have altered his living accommodation which took a while to adjust to". Another remarked, "It’s very dated and badly needs to be updated".

Staff were well informed about residents' needs and helped residents to make decisions and choices about their lives. Overall residents looked relaxed and

comfortable in the company of staff. Residents had detailed care plans and they were written in a respectful and meaningful way. However, the layout of these plans were such that they were not easy to follow. Staff expressed similar views with regards to the care plans. The inspectors were informed the layout of the plans was under review. Residents had easy-to-read versions of their care plan which described their likes and dislikes in picture format.

The healthcare needs of residents were met. This was confirmed by relatives who reported that the, "doctor is called if sick and family members contacted". Records of referrals to specialist services were seen as were medical notes and laboratory results. Generally, there was good access to general practitioners (GP), occupational therapists (OT), behavioural therapist, psychiatry, dental and other health professionals. However, residents' notes indicated some delay in psychology and social work assessment. One relative was of the opinion there was inadequate physiotherapy available. Records were maintained of accidents and incidents. However, the auditing of these was inadequate. This is discussed under Outcome 7.

Staff with whom the inspectors spoke had received mandatory training in the protection of vulnerable adults from abuse. Staff expressed no barriers to reporting any concerns they may have, in particular in relation to protecting vulnerable adults. Staff were satisfied that if they expressed such concerns they would be addressed by management personnel.

A complaints process was in place and the inspectors were satisfied that staff were receptive to receiving complaints and acting on them. However, staff were not clear on the new complaints procedure. This is discussed under Outcome 1

In so far as possible, residents were facilitated to engage with their preferred interests and hobbies. Since the previous inspection, much work had been done to improve the availability of meaningful activities for residents. For example, "the hub" was created in the unused canteen area and day services transferred to this area which was in the centre of the campus. Apart from day services activities, staff were attuned to the need for many residents to have "quieter" activities and one to one therapies. The inspectors saw residents receiving a foot massage which they clearly enjoyed. Residents were accommodated in walks around the grounds of the centre. Residents were accompanied to mass or attended mass independently. These preferred activities were identified in the residents' care plans. However, due to competing residents' needs there were limitations as to the time available for one to one therapy and outings. Both staff and relatives remarked on this with comments such as, "due to staffing levels, the number of outings and trips to the swimming pool are not as often as my brother would like or benefit from".

In summary, the inspectors found that a good standard of care was provided to residents in an environment that was outdated and showed signs of a lack of investment. Residents were shown respect, their health care needs were attended to and a lot of work was done to help residents manage as independently as possible. The level of activities provided had improved since the previous inspection. However, staffing levels continued to impact on the frequency and variety of activities/outings available to residents. The governance and management systems were such that

oversight of some areas of the provision of service was inadequate. A reorganising of the systems in place would help alleviate the burden that administration had become and place a greater emphasis on staff support and overall management of the centre. The provider was aware that significant resources were required to bring this centre and other centres on this campus up to an acceptable level of accommodation and a level which met with fire safety requirements. The provider nominee's primary way of securing resources was through the submission of business plans to the Health Services Executive (HSE). The HSE was the primary funder of this service.

These issues are discussed further in the report.

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

**Outcome 01: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
Overall, inspectors was satisfied that the rights, privacy and dignity of residents were promoted. Residents were encouraged to make choices and these choices were respected. For example, the inspector saw a resident being given the choice of when to have his meal and when to get up. Improvements were noted in the level of activities available. For example, a renovated area was used as a "hub" where day services were provided. Residents were consulted through weekly meetings and minutes were maintained of these. Two residents regularly attended advocacy meetings and the advocacy process had been strengthened since the previous inspection. Each resident had a named key worker. This person also advocated on behalf of the resident as did the person in charge. One relative stated "The key worker system is extremely positive". Another relative confirmed their family member had advocacy services. For example, in a questionnaire completed, a relative wrote "He has an external advocate assigned to him".

The inspectors saw staff encouraging residents to have free movement around their house, go out and about unaided and choose when and what to eat. One resident reported to the inspector "I can go to bed when I want. I can get up when I want. I can eat my meals when I want. I can phone my family when I want. I can have visitors when I want". All interactions observed were respectful and caring. Both relatives and residents stated they found staff "very kind" and "very respectful". Staff had an in-depth knowledge of residents' preferences and this knowledge was recorded in the written care plans that each resident had.

The inspectors saw that residents had control over their own possessions. For example, each resident had their own wardrobe and some had their own bedroom key. The way bedrooms were decorated showed each resident's individual tastes. The Brothers of Charity had a written policy on how residents' personal property was to be managed.

The complaints policy was displayed. There was evidence of a culture of accepting complaints and in so far as possible addressing the matters identified. The complaints policy was being reviewed at the time of inspection to ensure it was clear for staff to follow and that there was adequate oversight of the process. With the exception of one, all relatives and residents stated they had no issues with making a complaint. Relatives made comments such as "In over 30 years I have never had reason to complain". Residents and relatives stated they had no difficulty talking to any staff member in particular the manager. One respondent to the questionnaires felt the response time to their complaint was not timely.

A number of residents communicated in a non-verbal manner. The inspector saw that non-verbal residents were able to communicate if they were anxious, worried or in need of assistance. Residents' care plans showed a good level of attention given to ensuring residents' needs and preferences were documented, respected and acted upon. For example, a resident with impaired eye sight had the support of a national agency for the visually impaired and suggestions made by this agency around safety matters for the resident were acted upon.

Residents were facilitated to fulfil their religious rights. One resident stated what was important to him. "I am able to go to mass here". When Sunday mass was not available on site residents were accompanied by staff to the local church. Residents were facilitated to vote.

There were many good practices in terms of privacy and dignity; however, this was compromised in one of the houses. This house accommodated three residents in one bedroom. There had been a plan in place for occupancy to be reduced once a resident vacated the room but this had not occurred. The provider reported this was due to the pressure for this type of nurse led service. Occasionally, residents transferred from community houses as they did not usually have a nurse led service. Another resident was accommodated in a small room in which the door could not be closed. This is further discussed under Outcome 6. Screening curtains in the multioccupancy rooms did not adequately encircle the beds. Some toilet and shower doors did not have locks. One relative summarised the limitations of the facilities with the observation "Overall the service is a positive place to visit. However, in today's times it would not be what I would choose".

**Judgment:**
Non Compliant - Moderate

**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
There was a recently reviewed and redrafted policy on communicating with residents. Staff were aware of each resident's specific communication requirements. Visual cues and schedules were seen to be utilised to maximise resident consultation, choice and control over their routines. All staff were involved in communicating effectively with residents. One resident stated "if I had a concern I would talk to the maintenance man or the manager". Other residents stated "I can speak for myself" and "I am able to tell people what I want".

Residents were seen to have access to media, telephones, television, reading material and computers. One resident told the inspector "I like talking on my mobile phone".

Residents interacted and engaged freely with inspectors in the presence of staff, clearly had their own understanding of the role of the inspectorate and told inspectors that they were "free to say whatever they want". One resident informed the inspector "I feel grand and safe here".

**Judgment:**
Compliant

**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
It was evident from staff and residents spoken with, and records seen by inspectors that family, social, personal and community links for residents were integral to the operation of the centre. One relative wrote when referring to her family member "When I am not able to go to see him they (staff) bring him out to me for a visit which he enjoys."

Residents were facilitated to have ongoing access to their family and friends and had choice and flexibility as to how these visits were arranged. Arrangements were set out in

the support plan and discussed and agreed with both the resident and their family as appropriate. There was an open door visiting policy and some residents had daily telephone contact with their wider circle of family and friends. Residents were facilitated by staff or a private homecare provider to attend events of their choosing including the cinema, concerts, hotels and restaurants. One relative described staff facilitation as "truly wonderful". Another stated "When I get to see him he is always in good form and smiling".

Residents were given the option of inviting family to their person-centred planning meetings. Staff also included families in decisions concerning residents. This was done in a way that maximised the residents' choice and independence.

Residents were supported to maintain friendships with other service users of the same provider. For example, a resident who recently moved to the centre visited those he previously lived with and went for dinner with them. Families visits were enjoyed by residents and one resident stated, "I give them tea when they come"

Some residents attended an on-site day service which was known within the centre as "the hub".

**Judgment:**
Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Resident contracts had recently been introduced outlining the service provided and fees to be charged to residents. Inspectors found that the majority of residents had these contracts in place. The contract set out the terms and conditions of accommodation in the centre and also the responsibilities of the resident and the provider. Most contracts were signed by the resident, a representative of the provider and, where applicable, a family member. However, not all residents had a signed contract. The contracts set out the total fee to be charged to the resident and stated that additional items were at the expense of the resident such as some activities, clothing and toiletries.

The provider had a policy on admissions, discharges and transfers. Inspectors were satisfied that the policy was written in a person centred manner and covered

arrangements in place for the transition of a resident to a new centre. However, a recently admitted resident had difficulty in adjusting to his new environment as evidenced by the many challenging behaviours documented. While the resident's placement had been discussed with a view to organising accommodation more suited to the resident's needs and wishes, no timeframe was in place for this to happen. This is actioned under Outcome 5.

When asked, many relatives stated they had limited communication around the decision for their family member to move to the centre. However, these comments generally referred to admissions that happened 20 to 30 years previously. For example, relatives made comments such as "X was admitted as an emergency, very little information was given at the time (1995)"; "Very little, it was new at the time (1970's). It has proved to be a wonderful place for Y". A more recent admission/transfer in 2012 indicated a more planned and informed approach. For example, one relative stated " a family member informed me X was moving from one house on site to another. X had the opportunity to visit the other house prior to moving . X visited a couple of afternoons for a social visit".

**Judgment:**
Substantially Compliant

**Outcome 05: Social Care Needs**
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

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

**Findings:**
There were systems in place to assess residents' abilities and needs. These systems informed the care plans and identified supports required by each resident. Needs were identified under three headings: my life, my world and my dreams. This information was usually collated by the keyworker.

It was evident that the resident participated in the planning process (and their family as appropriate). Generally the plan was supported as necessary by input from the multi-disciplinary team. However, there were occasions when it appeared there were delays in accessing multidisciplinary support in particular psychological support. For one resident

the living arrangements posed challenges for him. This was evident by what the resident stated and in his behaviour pattern.

The inspector was concerned that the manner in which the assessment and care planning was conducted was onerous on staff to the point that it was ineffective. There was an enormous amount of documentation but it was a challenge for both inspectors and staff to find pertinent information. For example, there was a difficulty in establishing the weight pattern of a resident who had been identified as losing weight; there was uncertainty whether or not a calendar of home visits (identified as a priority) was in place. The inspector concluded the system was a barrier to efficiency, accountability and effectiveness. Staff, in the main had cooperated with this system which was introduced approximately two years ago. Recently a group had undertaken a review of the care planning process and had reported their findings and recommendation to senior management. The outcome of this review was awaiting implementation

The feedback from residents and relatives was that the activities which were available were very well received. For example residents reported "I can go to work. I like golf and swimming". Another stated, "I am happy here. It is my home. I like art, reflexology in the hub (on-site day service)". However, it was also clear from residents, relatives and staff responses that activities were neither as varied nor as frequent as residents would like. For example one relative stated "Elements of his plans are met; however, there are a large amount of people living together which means staff have to balance needs". Another commented "Activities do occur; however, he has a lot of time where he is not active or leaving the grounds. He loves outings but these are limited given the current size of the unit". A resident stated, "I watch GAA matches on TV. I like to visit dad" and added "I'd like to see more of dad". Other residents made similar comments. For example, "I'd like more visits. I love Y (sister)"

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The premises consisted of four separate one storey buildings. These houses were built

in the 1970s on a spacious site and were part of a larger group of houses. The site enjoyed a feeling of open space, surrounded by mature trees in a village type setting. However, the premises showed signs of limited investment in upgrading them to modern day standards. For example, two houses had communal style bathing and toilet facilities. Relatives identified the premises as one of their main areas of concern. The premises impacted negatively on residents. One relative remarked, "The building is old and bathroom facilities are poor. The practices in this area do not always support privacy and dignity". Another comment was "The buildings are dated in relation to current standards". The impact of the building on residents was captured in the comment "More space would lead to a calmer atmosphere".

Most residents had their own bedroom; however, as discussed under Outcome 1, three residents shared a bedroom and two other residents also shared a room. The plan that was in place, for occupancy in the three bedded room to be reduced, had not materialised. The screening curtains between the beds in shared rooms did not always encircle the bed and they were short in length.

Some single occupancy bedrooms were small. For example, one small room had a bed placed in such a manner that the bedroom door could not be closed. The resident in this room had her wardrobe on the corridor. She appeared happy with her accommodation as it allowed her see what was going on. However, the reality of this was summed up by the relative who stated "My relative may be happy; however, this does not imply this is his choice and for him he has no other experiences to compare with". Another resident, when asked what change he would like, said "I would like a new double bed but it wouldn't fit in my room".

One house was deemed to be a significant fire safety risk and the fire safety specialist advice received on the day of inspection was for the residents to be relocated as a matter of urgency. In the interim staffing ratios were increased, updated training was provided and a system of 15 minute checks were put in place.

The houses were generally overcrowded. Six to eight people lived in each house. They shared bathrooms, toilets, living space and dining space. In some of the houses residents did not have a private area to meet with family or friends. Even more significantly, for many of these residents, what they needed most was a calm atmosphere and adequate personal space. Staff and management had made a genuine effort to provide a calm environment but this was severely hampered by the layout and design of the houses. For example, as already mentioned residents shared bathroom and toilet facilities and one resident was effectively sleeping on a corridor. In one of the houses it was a significant challenge to operate a hoist as the hallway was narrow. The use of a hoist had become necessary due to the changing needs of the aging resident cohort. Little or no planning or investment had taken place in anticipation of residents' changing needs.

Other matters noted on inspection of the premises was the inadequacy of the personal laundry facilities. In one of the houses the laundry was in a poorly decorated area, with a damaged ceiling and exposed wiring. One resident had a frosted window in her room which meant she couldn't see out. To access some of the sluice rooms staff had to pass through the shower room. There was no separate storage area for mops or buckets.

Flooring was damaged in some rooms and upholstery was stained. Wall and floor tiles were damaged in one house. Cleaning practices were very poor. Staff used the same mop for all parts of the house and between houses. Floors were washed with cold water and staff reported that sometimes they noted there was an unpleasant smell after the floors were washed. The cleaning trolley was visibly dirty. Cleaning staff had no apparent awareness of colour coding as part of good house cleaning practices. Dust was noted internally. Windows, especially external window ledges were dirty. Outside the main doorways, there was an accumulation of dust, cobwebs and leaves. There appeared to be very little oversight of the cleaning practices or cognisance taken of the overall appearance of the houses.

Hoists were due to be serviced in September 2015 but this had not taken place.

There was access to a kitchen with sufficient cooking facilities and equipment. The main meal of the day was delivered by a food catering company and residents reported satisfaction with this arrangement. Breakfast and evening meals were prepared in each house, in some instances with assistance from residents.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
As with previous outcomes, there were good practices in place and there were issues that required attention. The centre had policies and procedures relating to health and safety. A health and safety committee was in place. A risk register was in place.

The clinical waste bins were not securely stored. For example, one clinical waste bin was in an open bathroom. The outside clinical waste bin was locked on the day of inspection as is good practice. However, staff reported it is not normally locked. A key was not available on the day of inspection to open the bin if needed.

A fire safety assessment had taken place the day prior to inspection. It identified serious issues with regards to the fire safety arrangements in one of the units. To mitigate against this fire risk, and on the advice and guidance of a qualified person in fire safety, a minimum staff to resident ratio of 1:2 was put in place immediately. This was to

continue 24 hours a day as an interim arrangement until alternative accommodation for residents could be sourced. In addition all staff in this unit were provided with updated fire training. A system of 15 minute checking all fire hazards throughout the day was put in place. As stated at the outset of this report, the provider was requested to provide assurances to HIQA that the interim fire safety arrangements continued to remain in place over the Christmas period and until such time as alternative accommodation was organised for residents. Such assurances were provided.

Fire equipment was serviced annually and records were maintained of this. However, as identified in a fire safety specialist's report, a commissioning fire certificate for the fire alarm system was not available.

Records were maintained of accidents and incidents. However, the auditing of accidents and incidents could be improved. The person in charge discussed incidents with staff in each house but there was no analysis of why or how incidents occurred or what could be done to prevent a reoccurrence.

**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):**
No actions were required from the previous inspection.

**Findings:**
The inspectors found that systems were in place to protect residents from being harmed or suffering abuse. There was a non judgemental approach to managing behaviours that challenge. However, specific support plans were not always in place in instances where bedrails were required. Where plans were available they detailed the emotional, behavioural and therapeutic interventions to assist in achieving a good outcome. Psychological support was sought to assist with specific positive behaviour plans and families were also involved in these.

Policies were in place in relation to the protection of vulnerable adults. The inspectors spoke with staff who were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. The inspectors

interacted with residents and were satisfied that residents felt safe in the centre and had access to staff with whom they could communicate. There was a designated person to manage any incidents, allegations or suspicions of abuse.

Staff had specific training and considerable experience in the care of residents with an intellectual disability. Regular training updates were provided to staff in the management of behaviours that challenge including de-escalation and intervention techniques. Practices observed showed the staff had the skills to manage and support residents to manage their behaviour in a safe and dignified way. Restrictive practices were kept to a minimum. For example, residents with significant behaviours that challenge were accommodated in larger houses to facilitate them to move about freely with the minimum disruption to other residents.

A policy on restrictive practice was available and was in line with best practice. However it was not adhered to. Bedrails used were not always considered by staff as a form of restraint. Some residents did not have an assessment prior to the use of bedrails and when used there was no indication that night staff checked the bedrails regularly.

The inspector reviewed arrangements in place for managing residents' finances and found that residents, with the aid of their key worker, had access to their monies. A ledger was kept for each resident detailing income and expenditure. The balance in the account was checked on a regular basis by the resident's key worker. Receipts were kept for items purchased on behalf of the resident and these were sent to the person in charge. If a query arose about any expense incurred by a resident, the receipts could be checked.

**Judgment:**
Non Compliant - Moderate

**Outcome 09: Notification of Incidents**
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors found that the person in charge was familiar with the process for recording any incident that occurred in the centre and familiar with the procedure for maintaining and retaining suitable records as required under legislation. The inspectors was satisfied that a record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**
Compliant

**Outcome 10. General Welfare and Development**
*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that there was an assessment process further to which staff sought to facilitate and promote opportunities for residents to enjoy new experiences, learn new skills, enhance their independence, personal development and social integration. Much of this has already been discussed in Outcomes 1 and 5. Inspectors noted that since the last inspection, the management and availability of transport vehicles was better organised and were more readily available. This was an important development as many residents enjoyed having opportunities to go shopping, visiting family or eating out. On this inspection the major impediment to this happening was the time available to staff to actually facilitate such trips.

Since the previous inspection the onsite day services were relocated to a more central area of the campus. It was referred to by residents and staff as "the hub". It was a larger and brighter day service area than the previous location. The hub had been a canteen which had become redundant. Residents and staff reported this was an improvement. There was scope to expand this on-site service and provide a greater and more varied level of activities for residents who live on the campus.

**Judgment:**
Compliant

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspectors saw that a health assessment was carried out. There was evidence there was a good referral system in place for support health services. However, as discussed under Outcome 5, there was scope for more involvement of some disciplines such as behavioural support, social work support and psychological support. One relative commented on the limited availability of physiotherapy support.

The practices in place showed that good health was promoted; for example, healthy eating and exercise was encouraged, residents were offered vaccinations and regular health screening checks were provided. Relatives concurred with these findings and in their feedback stated "He (family member) has been supported to acute care when required". Others stated "X is a bad epileptic and he has a lot of medical support to help him" and "Doctor is called if sick and family members contacted".

The records showed that blood tests were carried out on a regular basis. Blood pressures were checked and residents were weighted regularly albeit that, as discussed in Outcome 5, it was a challenge at time to find the documentation showing where weights had been recorded.

The dietician and speech and language therapist were available to lend support and guidance in the planning of good nutritional care for residents. There was evidence of referral and access to the general practitioner (GP), psychiatrist and dentist. Where other specialist services were required such as consultation with medical specialists, these were facilitated. Discussions took place around end of life care and these were documented. Hospice care was available to support staff in caring for residents in their own house at the end of their life.

The breakfast and evening meal was prepared and cooked daily in the centre. Residents had their lunch delivered to them from a contract catering company. The inspectors saw that staff supervision and assistance was in place and that residents were facilitated to be as independent as possible.

**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):**

No actions were required from the previous inspection.

**Findings:**
The service was nurse led and all medication was administered by nurses. The practices observed were in line with professional guidelines. There was little use of PRN medications (medications that are taken only when needed). There was a clear process for disposal of out of date or unused medication. Medications were regularly reviewed by a psychiatrist, staff and the GP. Staff had received medication management training. Medication errors were not routinely audited but a record was maintained of any errors which did occur. These were rare events.

**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):**
No actions were required from the previous inspection.

**Findings:**
The statement of purpose consisted of a statement of the aims of the centre and a statement as to the facilities and services which were to be provided for residents. The statement of purpose was kept under review and last reviewed in November 2015. The inspector found that the statement of purpose was implemented in practice and reflected the ethos of providing "love and respect in every action".

The statement of purpose contained the information required by Schedule 1 of the regulations such as room sizes and details of the education, training and work opportunities for residents.

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

**Findings:**
There were clear lines of accountability. For example, staff reported to the person in charge, who in turn reported to the head of integrated services. The head of integrated services reported to the director of services. There were also management supports available from the human resources department, health and safety personnel and other heads of disciplines. However, the centre's management systems were not effective. For example, the person in charge spent the majority of her time completing administrative work. It was clear to inspectors the person in charge's capacity to provide support, guidance and supervision to staff, was impacted upon by virtue of the systems in place rather that any deficits in her skills. Her managerial and leadership skills were not fully utilised. The person in charge did not have the support of an organisational structure which assisted her in staff supervision and performance review of staff working under her direction. The governance structure was such that she did not have a supervisory role for night staff working in her centre, this included supervision of staff training. The inspectors was not satisfied that the person in charge was appropriately facilitated to carry out her functions to ensure the effective governance, operational management and administration of the centre.

Other indicators of deficiencies in governance and management were present. There was poor oversight of cleaning practices. This is discussed under Outcome 6. There was a breakdown in the manner in which contracts for servicing of equipment was maintained. There was limited awareness of the correct protocols associated with the storage of clinical waste. There was a lack of progress with addressing issues that had been identified in previous reports both for this centre and other centres on site. Each failure on its own had limited impact but combined they were a reflection of the overall inadequate coordination of the governance and management of the centre.

The exterior of the buildings were generally shabby. A number of years ago the main office building was moved to a new location. Subsequently the vacated premises, in the centre of the campus fell into further disrepair. Staff and residents reported that moving this office block and its staff, had an impact on the vitality of the campus. The office facilities that remained on site were generally in good repair.

There were also on site two large dilapidated buildings which were previously used as workshops. The loss of these workshops in terms of providing development and employment opportunities to residents has never fully been replaced.

Part of the disused canteen had, since the previous inspection, been converted to an

activities area. Staff and residents indicated this was a positive development.

Internally all of the houses in this centre had some issues with regards to how their design and layout met the needs of residents. These issues have already been referenced throughout this report. For example, bathrooms and toilets were grouped in one block compromising the homeliness of the house, a narrow corridor in one house impacted on the ease of moving a hoist (which was required by one resident), a fire specialist report indicated one house was unsafe and alternative accommodation should be sought. Overall, there was a lack of modernisation to bring the houses into an acceptable standard of comfort and cosiness. This is further discussed under Outcome 6.

The identified failings on this inspection were the accumulation of many years of underinvestment. There was no one reason for this underinvestment. It was partly due to cut backs, partly due to the classification of the campus as a congregated setting and a national policy to move away from congregated settings, and also due to what one staff member described as "missed opportunities". This view was supported by what inspectors were told by the provider, staff and families. It was also formed from the observations and records viewed by inspectors. The provider had not taken adequate strategic planning for:
a) the changing and increased needs of residents
b) the proper maintenance and upgrading of what were originally very comfortable houses
c) the evaluation of the impact of moving office facilities, the closure of the canteen and the closure of the workshops
d) the need to secure adequate funding to provide an appropriate service.

Staff mitigated against the impact of the poor premises, by providing good and respectful care to residents. For many residents this had been there home for up to 30 years. Relatives commented on the good care residents received. They commented on the attractive grounds and how progressive this centre was when their relative first came to live there decades ago. Relatives and residents spoke how the site facilitated residents to walk around with a freedom they might not have in another setting. Residents, relatives and staff spoke of the "village type" atmosphere on the campus. Positive aspects of the premises and facilities was the presence of a well maintained attractive church on site which several residents visited on a daily basis. There was a well equipped pool and gym which many residents used as did members of the public. On site were football pitches available to residents and local groups. Relatives were strong in their view that “The leadership needs to be promoting and driving change among their staff, have a plan to move, reduce number, and increase activity”. Another comment was “There is never enough staff or money allocated to these centres because of cutbacks”.

Funding of the service came from a third party, i.e. the Health Services Executive (HSE). The provider explained to the inspectors that the level of funding to the Brothers of Charity Limerick had been reduced over the past number of years at a time when the needs of residents were increasing and the building were becoming increasingly outdated and not fit for purpose. There was no strategic plan in place with regards to the short and medium term arrangements to provide appropriate accommodation and services to this resident population. This lack of planning was causing uncertainty for

residents, relatives and staff.

**Judgment:**
Non Compliant - Major

**Outcome 15: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The provider was aware of the need to notify HIQA of any occasion where the person in charge was or planned to be absent for 28 days or more. Suitable deputising arrangements were in place for the management of the centre in the absence of the person in charge. A clinical nurse manager 1 covered for such eventualities.

**Judgment:**
Compliant

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were not satisfied that this centre was sufficiently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. For example, as discussed under Outcome 5 there were limited social work, psychology support and physiotherapy support available to residents. One resident was awaiting a more appropriate placement. As discussed under Outcomes 6 and 14 there were significant deficiencies with the upkeep and modernisation of the premises including the fire safety arrangements in place for the centre.

**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 person in charge stated that most of the staff, including herself, had been employed in the centre for a long time. This meant there was a high level of staff continuity. This was confirmed to the inspectors by staff. It was also clear from observation and the care plans examined, that continuity of staff was important to residents. During the inspection, the inspectors observed the person in charge and staff interacting and speaking with residents in a friendly, respectful and sensitive way. Based on inspectors' observations, staff members were knowledgeable of residents' individual needs and this was reflected in the personalised person-centred plans seen by the inspectors. Residents spoke positively about staff, saying they looked after them well. The inspectors spoke to staff on duty and all appeared competent. They were aware of their roles and responsibilities. Staff stated they felt supported by the person in charge.

All houses had staff on duty all night and some houses had the assistance of extra staff up to 22:30 hours. In one house, to mitigate against the inadequacy of the fire safety arrangements and on the advice from qualified fire safety personnel, extra staff were on duty 24 hours a day to assist in the event of a fire and detect the outbreak of a fire. This was an interim measure until such time as appropriate accommodation was provided for residents.

Staff from the different houses assisted each other during the night if the need arose. The night manager also provided support to night duty staff. The reporting arrangements were such that the night staff did not report to the person in charge. The person in charge did not have oversight of night staff training requirements and it was unclear who took oversight of this. The person in charge was not in a position to fulfil her responsibilities with regards to supervision of staff given that some staff did not report to her.

The day time staffing levels varied with some houses having adequate staff and others having limited staff resources to provide for the increasing complex care needs of residents. The mix of residents in some houses led to competing demands and all demands could not be fulfilled. Staff reported challenges in finding time for attending to the residents, serving meals and carrying out cleaning duties. Contract cleaning was in place for a limited time each week but was not effective. This is discussed under Outcome 7.

As discussed in Outcome 14, the person in charge and staff confirmed that no formal staff appraisals took place. This is actioned under Outcome 14.

Staff with whom the inspector spoke confirmed they had received mandatory training in fire prevention, adult protection and moving and handling. Other training was also provided such as food safety and managing behaviours that challenge. Fire safety training updates were taking place on the days of inspection as a result of fire inadequacies identified by a fire safety specialist. Training records were maintained but it was difficult to determine from the records which staff had training.

A staff roster was in place. However, it was inadequate. It was not possible to identify who the senior nurse on duty in each house was. One resident was receiving one to one care but it was unclear from the roster who this person was. Staff who were working throught a government supported programme were not shown on the roster.

**Judgment:**
Non Compliant - Moderate

**Outcome 18: Records and documentation**
*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Much of the documentation was well maintained. However, the restraint policy was not implemented in full. There was a lack of familiarity amongst staff around the new complaints policy. The roster was such that it was not clear what staff were providing

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|---|
| one to one care on the day of inspection. Staff on work placement were not included on the roster and the roster did not indicate who was the senior nurse in charge of each house. |
| **Judgment:**<br>Substantially Compliant |

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

Margaret O'Regan
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-0004752 |
| **Date of Inspection:** | 10, 11 and 12 November 2015 |
| **Date of response:** | 21 January 2016 |

## Requirements

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

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

## Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents' privacy and dignity was compromised due to the limited personal space available to them.

**1. Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
• There are 5 people sharing bedrooms in this designated centre.
• A detailed plan has been submitted to the HSE to address the situation.

**Proposed Timescale:** 30/04/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints policy was under review at the time of inspection to ensure it was effective, provided clear guidelines for staff, and included an appeals process.

**2. Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
• A new Complaints procedure together with Easy Read and Plain English companions were agreed at the Policy Review Group meeting on 13/01/16 and circulated to management on 19th January 2016;
• This procedure replaces the Complaints Policy.
• A training session will be provided to all Managers on 27/01/16.
• The revised policy will be rolled out to all areas following this training together with new log books to record issues and complaints.

**Proposed Timescale:** 31/03/2016

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Each resident did not have a written agreement with regards to the terms on which that resident resides in the centre.

**3. Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
• A significant number of Residents in the designated centre do not have the capacity to sign their own individual service agreements.
• All relevant families were contacted and forwarded a copy of the service agreement in October 2016. 17 signed contracts were returned.
• Of the 10 outstanding contracts a referral to Social Work Department has been completed for follow up of outstanding agreements.
• Legal advice has been sought by the Provider Nominee in relation to cases where the person does not have the capacity to sign or the person has no family member that is able or willing to sign. Legal advice is to seek guidance from the HSE. This guidance has now been sought.

**Proposed Timescale:** 30/04/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Limited arrangements were in place to meet some of the assessed needs of each resident; in particular psychological or social work support. For one resident the living arrangements posed challenges for him. This was evident by what the resident stated and in his behaviour pattern.

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

**Please state the actions you have taken or are planning to take:**
• The appointment of two new Social Workers within the organisation took place on the 11th January 2016.
• A psychologist was appointed in November 2015 to replace a vacancy in this department;
• A Business Case is been prepared for additional Occupational Therapy, Physiotherapy and Speech and Language Therapy posts to address the shortfall experienced in these services and to support the increasing needs of the residents who are aging and/or have a decrease in mobility;
• Engagement with the HSE is also taking place in order to ensure that residents living in the community can access Primary Care Teams. This will increase capacity internally.
• One Clinical Nurse Specialist in Behaviour Support has been redeployed to PIC post. Following a lengthy recruitment campaign, applicants for PIC will be interviewed by week ending 06/02/15. Pending a successful candidate the CNS will return to her role in Behaviour Support;
• MDT meetings are scheduled for the designated centre every 6 weeks and residents discussed as the need arises;
• Each resident has a Person Centred Plan which gathers information from the residents' circle of support to support their life choices and keyworkers support the

priorities identified.
• The personal file of each resident, My Profile, My Plan is reviewed bi-annually.
• One resident who was admitted as an emergency due to his increasing medical needs and is unhappy with his placement is relocating to a more suitable accommodation on site week beginning 19/01/16 as reflected in plan submitted to the HSE for funding

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The centre did not have capacity to meet all the assessed needs of residents. For example, activities were provided but their frequency inadequate. There was limited psychology, social work, physiotherapy and behaviour support available.

**5. Action Required:**
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
• The appointment of two new Social Workers within the organisation took place on the 11th January 2016.
• A psychologist was appointed in November 2015 to replace a vacancy in this department;
• A Business Case is been prepared for additional Occupational Therapy, Physiotherapy and Speech and Language Therapy posts to address the shortfall experienced in the services and to support the increasing needs of the residents who are aging and/or have a decrease in mobility;
• Engagement with the HSE is also taking place in order to ensure that residents living in the community can access Primary Care Teams. This will increase capacity internally.
• One Clinical Nurse Specialist in Behaviour Support has been redeployed to PIC post. Following a lengthy recruitment campaign applicants for PIC will be interviewed by week ending 06/02/15. Pending a successful candidate the CNS will return to her role in Behaviour Support;
• MDT meetings are scheduled for the designated centre every 6 weeks and residents discussed as the need arises.
• Each resident has a Person Centred Plan which gathers information from the residents' circle of support to support their life choices and keyworkers support the priorities identified.
• The personal file of each resident, My Profile, My Plan is reviewed bi-annually.
• A review by management of the activities taking place in "The Hub" will take in Q1 with the view to building on what is currently offered to residents.
• Planning of activities for each individual will be discussed and agreed at staff meetings with reference to priorities identified in their Person Centred Plans. This planning is to include in-house activities and promoting community integration within the resources allocated to the centre. Personal Assistants will be requested where appropriate in line with policy.

**Proposed Timescale:** 30/04/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises provided were not designed or laid out to meet the aims and objectives of the service and the number and needs of residents. For example, one bedroom was too small to close the door, three residents shared a bedroom, flooring was damaged. In addition one house was deemed unsafe from a fire safety perspective.

**6. Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
• The Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.
• Several submissions, over a number of years, have been made to the HSE in respect of additional funding for the de congregation of the centre. No funding has been allocated to date in respect of de congregation.
• Several submissions have been made to the HSE in respect of capital funding to maintain the premises to an acceptable standard. The most recent submission was made in 2015 for €890,000 based on an engineers report. This included upgrades to windows, floors, painting, electrics and plumbing. No funding has been allocated for this submission.
• The Services does not have a sufficient budget to meet the maintenance costs arising in this centre. This will continue to be raised with the HSE as part of the Service Arrangement engagement process.
• In the majority of cases vacant beds are not filled within the centre when they arise following a death of a resident or a transfer. This has resulted in the number of residents in a number of bungalows reducing over time. This is being done with the support of the HSE and the process is overseen by the Admissions, Discharge and Transfer committee chaired by the Provider Nominee.
• Plans are in place, involving management and multidisciplinary teams, to close one house and relocate residents as a result of the findings of a Fire Safety Engineer on this particular bungalow within the centre. This plan will address the two shared bedroom situations referred to above.
• A detailed plan has been submitted to the HSE requesting funding to support this plan.
• An updated plan on the de congregation of Bawnmore Centre is current being developed by management of the centre for submission to the HSE.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Premises were not maintained in a good state of repair.

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

**Please state the actions you have taken or are planning to take:**
• A Maintenance referral system is in place where day to day maintenance requests are flagged by the designed centre PIC.
• The Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.
• Several submissions, over a number of years, have been made to the HSE in respect of additional funding for the de congregation of the centre. No funding has been allocated to date in respect of de congregation.
• Several submissions have been made to the HSE in respect of capital funding to maintain the premises to an acceptable standard. The most recent submission was made in 2015 for €890,000 based on an engineers report. This included upgrades to windows, floors, painting, electrics and plumbing. No funding has been allocated for this submission.
• The Services does not have a sufficient budget to meet the maintenance costs arising in this centre which was built in the 1970's. This will continue to be raised with the HSE as part of the Service Arrangement engagement process.
• An updated plan on the de congregation of Bawnmore Centre is current being developed by management of the centre for submission to the HSE.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Premises were not appropriately cleaned.

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

**Please state the actions you have taken or are planning to take:**
• A review of the system of in house cleaning is being prioritized in order to improve cleaning standards.

• Immediate review of the operation of the existing cleaning checklist that involves the carrying out of spot checks by management on a weekly basis.
• Discussions had been taking place with the cleaning contractor during 2015 on the poor standard of cleaning being provided to the services during 2015.
• A letter of complaint was sent to the cleaning contractor, following the inspection, on 01/12/15 outlining the services dissatisfaction with the cleaning service provided. All issues raised by the inspector were included in this correspondence.
• A meeting has been arranged with the contractor on the 29/01/16 in order to address our concerns in relation to the quality of service. An outcome of this meeting will be to agree a specification for the cleaning service being provided.
• A full tender process for cleaning services will take place by June 2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Hoists were not serviced at appropriate times

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

**Please state the actions you have taken or are planning to take:**
• At time of inspection, the Medical Equipment Contract was being tendered and a successful candidate has now been selected;
• The contractor has now been appointed since 1st December 2015.
• All hoists/equipment in the designated centre have been serviced.
• Hoists/equipment will be serviced 6 monthly as per regulation.

**Proposed Timescale:** 21/01/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Accessibility in part of the premises was hampered by the design of the house. For example, challenges in moving a hoist around a narrow corridor.

**10. Action Required:**
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**
• The Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.
• Several submissions, over a number of years, have been made to the HSE in respect of additional funding for the de congregation of the centre. No funding has been allocated to date in respect of de congregation.
• In the majority of cases vacant beds are not filled within the centre when they arise following a death of a resident or a transfer. This has resulted in the number of residents in a number of bungalows reducing over time. This is being done with the support of the HSE and the process is overseen by the Admissions, Discharge and Transfer committee chaired by the Provider Nominee.
• A detailed plan has been submitted to the HSE to relocate residents in one bungalow following the recommendations of a Fire Safety Engineer.
• An updated plan on the de congregation of Bawnmore Centre is current being developed by management of the centre for submission to the HSE.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Rooms were not a suitable size and layout for the needs of residents.

**11. Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**
• The Brothers of Charity Services Limerick accepts that the standard of accommodation for residents of this centre is not to an acceptable standard. This situation is further compounded by the aging population in the centre and their changing needs.
• Several submissions, over a number of years, have been made to the HSE in respect of additional funding for the de congregation of the centre. No funding has been allocated to date in respect of de congregation.
• In the majority of cases vacant beds are not filled within the centre when they arise following a death of a resident or a transfer. This has resulted in the number of residents in a number of bungalows reducing over time. This is being done with the support of the HSE and the process is overseen by the Admissions, Discharge and Transfer committee chaired by the Provider Nominee.
• An updated plan on the de congregation of Bawnmore Centre is current being developed by management of the centre for submission to the HSE.

**Proposed Timescale:** 31/12/2016

**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:**
The procedures in place did not adequately ensure that the standards for the prevention and control of healthcare associated infections were complied with.

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

**Please state the actions you have taken or are planning to take:**
• Immediate review of the operation of the existing cleaning checklist that involves the carrying out of spot checks by management of cleaning standards in bungalows on a weekly basis.
• A review of the system of in house cleaning is being prioritized in order to improve cleaning standards.
• Discussions had been taking place with the cleaning contractor during 2015 on the poor standard of cleaning being provided to the services during 2015.
• A letter of complaint was sent to the cleaning contractor, following the inspection, on 01/12/15 outlining the services dissatisfaction with the cleaning service provided. All issues raised by the inspector were included in this correspondence.
• A meeting has been arranged with the contractor on the 29/01/16 in order to address our concerns in relation to the quality of service. An outcome of this meeting will be to agree a specification for the cleaning service being provided.
• A full tender process for cleaning services will take place by June 2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire escape doors in one of the units were narrow and were not an adequate means of escape for several of the residents living in that house.

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

**Please state the actions you have taken or are planning to take:**
• A plan has been developed, involving management and multidisciplinary teams, to close one house and relocate residents. This plan was developed as a result of the

findings of a Fire Safety Engineer following his review of the building prior to the HIQA inspection. This building will close following the full implementation of this plan.
• As an interim measure additional staff have been put in place to support the residents in the event of a fire as recommended by the Fire Safety Engineer.
• The detailed plan has been submitted to the HSE requesting funding.
• The Fire Safety Engineer has been commissioned to prepare a report in order to set out a plan to ensure compliance of the services with fire regulations. This plan will issue shortly.

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Emergency lighting was in place but it was not illuminated in one house.

**14. Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
• All emergency lighting is now functioning in the designated centre.
• Servicing of emergency lighting is carried out quarterly as per regulation.

**Proposed Timescale:** 21/01/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements in place for detecting, containing and extinguishing fires were inadequate. In one house the fire alarm system did not have a commissioning certificate.

**15. Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
• The Fire Safety Engineer has been commissioned to prepare a report in order to set out a plan for the Services to ensure its compliance with fire regulations. This plan will issue shortly.
• A review of the condition of the Fire Alarm system was commissioned in 2015 and a report was issued on 8th December. The findings of this report will be referenced in the above plan.
• Costing for the implementation of the above plan will be submitted the HSE for

funding.
• Fire Drills will continue to take place a minimum of 4 times per year;
• Monthly Safety Checklists are completed in each house;
• Fire Alarm System is serviced quarterly;
• The system for testing fire equipment will be included in recommendations of the fire safety engineers report.

**Proposed Timescale:** 31/12/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Physical restrictive practices used were not always applied in accordance with the centre's policy and evidence based practice.

**16. 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:**
• The organisational Policy on Restrictive Practices includes the use of bedrails as a restraint for 'intentional restriction of a person's voluntary movement or behaviour' (Health Act 2007, Regulations 2013). In line with this, risk assessments for all residents in this designated centre who require the use of bedrails and who are non-ambulant/hoist dependent have been completed and the use of bedrails in all cases are not considered a restrictive practice in line with the definition above;
• Where bedrails are being utilised a two hourly review of the practice has commenced and is being documented;
• The Policy on Restrictive Practices has been identified for review through the Policy Review Group.

**Proposed Timescale:** 30/04/2016

**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:**
The person in charge spent the majority of her time on administrative duties and little time providing on site supervision, guidance, support and mentoring to staff. The person in charge did not have the support of an organisational structure which assisted her in staff supervision and performance review of staff working under her direction.

The governance structure was such that she did not have a supervisory role for night staff working in her centre this included supervision of staff training. The inspector was not satisfied that the person in charge was appropriately facilitated to carry out her functions to ensure the effective governance, operational management and administration of the centre.

**17. Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
• There is a supernumerary manager on duty at night who manages the 3 designated centres in the Centre.
• This night manager will now report on staff training and supervision to the PIC of each designated centre. The PIC will ensure that staff training is updated in line with regulation;
• A reporting book is in place between night/day managers where any issues are identified. The PIC reviews this book each morning.
• Day and night managers attend a monthly meeting with their Senior Manager;
• Supervision at night is provided at frontline by the night manager. This includes nightly visits houses on site.
• In future the PIC will attend quarterly Night Staff meetings.
• The requirement for increased administrative support has been escalated as a risk to the Provider Nominee and is under consideration.

**Proposed Timescale:** 30/04/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ineffective arrangements were in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

**Please state the actions you have taken or are planning to take:**
• A draft policy has been sourced by the Head of HR and a group has been identified to agree this policy and set out a plan for its implementation.
• The Head of HR post will be vacated shortly and a recruitment process has commenced to fill this role. This will result in a delay in the roll out of this supervision

process but it will be a priority for the newly appointed Head of HR.

**Proposed Timescale:** 30/06/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Six monthly unannounced inspections were carried out by the provider; however, a written annual review of the quality and safety of care and support in the centre was not available.

**19. 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:**
• An Annual Review of the quality and safety of care and support in the centre was completed in April 2015. A copy has been forwarded to the inspector.
• A copy of the Annual Review will be filed in each bungalow of the designated centre.

**Proposed Timescale:** 21/01/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The chief inspector requests a copy of the annual review of the quality and safety of care and support in the centre.

**20. Action Required:**
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

**Please state the actions you have taken or are planning to take:**
• An Annual review of the quality and safety of care and support in the centre was completed in April 2015. A copy has been forwarded to the chief inspector.
• A copy of the Annual Review will be filed in each bungalow of the designated centre.

**Proposed Timescale:** 21/01/2016

**Theme:** Leadership, Governance and Management

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

**the following respect:**
The effectiveness of the service provided was compromised by the management systems in place.

**21. 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:**
• The requirement for increased administrative support has been escalated as a risk to the Provider Nominee and is under consideration.
• The PIC is supported to manage the centre by 4 x CNM1's (non supernumerary) by day and CNM2 managers at night time.

**Proposed Timescale:** 30/04/2016

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**22. Action Required:**
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
• The appointment of two new Social Workers within the organisation took place on the 11th January 2016.
• A psychologist was appointed in November 2015 to replace a vacancy in this department;
• A Business Case is been prepared for additional Occupational Therapy, Physiotherapy and Speech and Language Therapy posts to address the shortfall experienced in these services and to support the increasing needs of the residents who are aging;
• One Clinical Nurse Specialist in Behaviour Support has been redeployed to PIC post. Following a lengthy recruitment campaign applicants for PIC will be interviewed by week ending 06/02/15. Pending a successful candidate the CNS will return to her role in Behaviour Support;
• MDT meetings are scheduled for the designated centre every 6 weeks and residents discussed as the need arises.
• An updated plan on the de congregation of Bawnmore Centre is current being developed by management of the centre for submission to the HSE.

**Proposed Timescale:** 31/12/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The reporting arrangements were such that the night staff did not report to the person in charge. The person in charge did not have oversight of night staff training requirements. The person in charge was not in a position to fulfil her responsibilities with regards to supervision of staff.

**23. Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
• There is a supernumerary manager on duty at night who manages the 3 designated centres in the Centre.
• This night manager will now report on staff training and supervision to the PIC of each designated centre. The PIC will ensure that staff training is updated in line with regulation;
• A reporting book is in place between night/day managers where any issues are identified. The PIC reviews this book each morning.
• Day and night managers attend a monthly meeting with their Senior Manager;
• Supervision at night is provided at frontline by the night manager. This includes nightly visits houses on site.
• In future the PIC will attend quarterly Night Staff meetings.
• The requirement for increased administrative support has been escalated as a risk to the Provider Nominee and is under consideration.

**Proposed Timescale:** 30/04/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The staff roster, as referred to in schedule 4, was incomplete.

**24. Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:**
• A computerised system of day time rostering has been introduced, developed and implemented over the past 24 months. The PIC and those deputising will now be included on this system for the designated centre;
• A meeting has been arranged for 21st January 2016 with the Government Scheme supervisor to develop a roster that will be issued to each residence on a monthly basis. This will be displayed in the designated centre along with the staff roster.
• The night roster has been reformatted to show staffing in place at night in each of the designated centres.

**Proposed Timescale:** 29/02/2016