

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004745
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 May 2016 08:45	12 May 2016 19:00
13 May 2016 08:00	13 May 2016 19:00

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

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

Summary of findings from this inspection

Background to the inspection

This inspection was the second inspection of this centre by the Health Information and Quality Authority (HIQA). The inspection was undertaken to monitor compliance with the regulations and standards and to inform a registration decision. The previous inspection was unannounced and was undertaken on 15 October 2014. A substantial level of regulatory non-compliance was evidenced at that time primarily due to the governance arrangements, staffing arrangements and deficits in staff training. The provider was issued with an immediate action plan to alter the night time staffing arrangements and to consolidate the existing governance structure. The

provider responded positively to both the immediate action plan and the standard action plan within the specified timeframes.

How we gathered our evidence

As part of this inspection the inspector met with the person in charge, the clinical nurse manager 1 (CNM1), the head of integrated services, staff on duty on both days of inspection and the residents. There were ten residents living in the centre all of whom welcomed the inspector to their home and engaged with the inspector over the two days of inspection. The inspector observed practice and reviewed records including health and safety records, fire safety records, accident and incident records, residents' personal plans, policies and procedures and staff related records. Prior to the inspection residents and relatives were invited to complete on a voluntary basis feedback on the centre and the supports and services provided. All were positive and complimentary of the staff, their kindness and competence. Where issues of concern were noted these pertained to requests for more social activities and social engagement, unhappiness at the disturbance caused by behaviours that challenged and observations that the staff ratio was not sufficient to meet the needs of the residents.

Description of the service

In this centre the provider provides residential integrated services to 10 residents. This means that residents live in the centre and are provided with a programme of engagement and occupation both in the centre and off-site such as in the day service. The ten residents individually and collectively presented with a broad range of diverse needs and between them spanned four decades in terms of their age profile.

The centre was purpose built to meet the needs of residents with high physical support needs. It was welcoming in presentation and suited to its stated purpose and function. While located in a rural location transport was available.

Overall findings

Having reviewed accident and incident records, risk assessments, behaviour management guidelines and on speaking with staff the inspector was concerned at the incidence of and the nature of behaviours that challenged in the centre and the risk and negative impact of these on both residents and staff. There was evidence of actions taken by the provider, however these had clearly not resolved the matter. Given the duration of the behaviours, their impact, and the fact that they were ongoing at the time of this inspection the provider was requested with immediate effect to review behaviours and their management and put arrangements in place that adequately supported residents to manage their behaviours and protect all residents and staff from all forms of harm and abuse. The provider submitted a detailed response within the specified timeframe of the actions that had and would be taken to address the identified failings.

Improvement was required in the standard of documentation maintained as it was difficult to extract current and accurate information. A review of risk assessments and controls to manage risks was required.

There was evidence to support that in the context of the number of residents, the range and complexity of their needs including advancing age and behaviours that challenged, that staffing arrangements were not always sufficient to meet those needs.

There was evidence of good practice. The actions that had emanated from the last inspection were largely addressed. With the exception of the impact of behaviours that challenged the inspector was satisfied that residents' rights, privacy and dignity were respected. There was commitment to improving resident's opportunities for meaningful occupation and social engagement. Residents had good access to medical review and multi-disciplinary supports as appropriate to their needs. Residents were supplied with any equipment necessary for their comfort and well-being.

Staff spoken with had sound knowledge of residents' needs and supports and were seen to be timely and respectful in their engagement with residents.

Residents sought out staff with ease, clearly liked to spend time with staff and there was no evident restriction on them doing so.

Of the full 18 Outcomes reviewed the provider was judged to be compliant with 11, in substantial compliance with two, in moderate non-compliance with four and in Major non-compliance with one, Outcome 8: Safeguarding and Safety

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The inspector saw that on an ongoing basis residents sought out and had ready access to staff. The interactions observed by the inspector between residents and staff were courteous, respectful and equitable. In addition to this observed ongoing communication structured weekly house meetings were convened. Minutes indicated that resident attendance was sufficient for these to be representative and meaningful. Minutes indicated that residents were consulted with and their preferences were ascertained on issues such as the menu and planned activities. Residents were also provided with information/discussion on issues such as making a complaint, keeping safe, feedback from the advocacy meetings or the upcoming inspection by HIQA.

Relatives surveyed by HIQA said that they were satisfied that their family members were treated with respect and had choice and control in their daily lives.

Staff said that residents were registered to vote and were supported by staff to exercise their vote at the local polling station.

The person in charge said that local clergy visited the centre on a monthly basis and/or staff supported some residents to attend the local church.

The provider operated an advocacy service for residents. There was evidence that this service had been discussed with residents and one resident confirmed that they were now the local advocacy representative. An advocacy meeting was held on the first day of this inspection and the resident was supported to attend the meeting. Minutes seen indicated that residents were forthcoming with their issues and concerns; action plans

and responsible persons were clearly identified.

Staff spoken with were familiar with the provider's revised policy and procedures on the management of complaints and the revised complaints records were in place. Records indicated that residents did feel comfortable raising a complaint with staff. Staff recorded the actions taken, if these were sufficient to resolve the matters complained of, or if further action was necessary such as escalation to the person in charge.

Policies and procedures were in place for the management and safeguarding of residents finances. Staff said that residents did require staff support in this area but as appropriate some residents had direct access to and control over some monies. Staff maintained financial records for each resident. The inspector saw records of each financial transaction, the purpose for which monies were used and supporting receipts. Staff completed, signed and counter signed daily balance reconciliations.

Judgment:
Compliant

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:

Staff had completed recent training on communication and the person in charge frequently referenced the importance of effective communication between staff and residents to the delivery of quality supports to residents.

All residents welcomed interaction and communication with the inspector. Residents were engaged and informed and spoke of what was important to them, family, friends, social engagement, new experiences and meaningful input into the organisation of the service such as through the advocacy network. Residents were seen to approach staff with ease and communicate needs and requests to staff, at times through the use of gestures. No barriers to effective communication were noted by the inspector.

Staff had completed training on communication with the speech and language therapist and further to this five residents had a communication passport in use that one resident shared with the inspector.

Residents were seen to have ready access to media in both the communal area and in their own bedrooms. Pertinent information such as the complaints procedure and the

photograph and contact details of the designated person were prominently displayed. Some information such as the menu and the staff rota was presented in a visual format.

However, while each resident had a communication support plan these did not always reference what was in place in practice such as the communication passports or further goals identified in other records seen such as acquiring computer skills. This is addressed as a failing in Outcome 5.

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:

Staff spoken with had a sound knowledge of each resident's family and support network. Relatives surveyed indicated that they had a good relationship with the centre and with staff. Staff were known to relatives on a first name basis and were described as welcoming and open with information.

Staff maintained a log of family contact and communications.

Residents spoken with spoke of the importance to them of family and friends, of ongoing home visits and freely shared and invited the inspector to see their personal information including family photographs. Equally where residents had experienced loss and bereavement they spoke of this and the impact that this had on them. Residents said that staff supported them to express their loss such as by visiting the family grave.

Residents also spoke of their friends and peers outside of the centre and how they were facilitated to maintain these friendships.

The person in charge said that there was increasing awareness in the centre of supporting family and social inclusion and this was reflected in the minutes of multi-disciplinary meetings seen. The inspector also saw that residents were supported to access local amenities such as shops and restaurants and to celebrate important life events with families and friends.

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:

There were policies and procedures including a multi-disciplinary forum that governed admission to and transfer and discharge from the designated centre.

There was evidence available to the inspector that placement reviews did take place. This is discussed again however in Outcome 8 in the context of safeguarding, behaviours that challenged and residents' individual and collective needs.

Residents were provided with an explicit contract for the provision of supports and services that detailed the services to be provided to the resident, the charge to be levied for these services and services that the resident may avail of but were not included in the basic fee.

Judgment:

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:

On speaking with staff and with residents, the feedback received from relatives and observation of care and practice on inspection, the inspector was satisfied that resident wellbeing and welfare was supported by a high standard of evidence based care and support. Staff spoken with were familiar with each resident and their required supports, care and supports were guided by multi-disciplinary review and recommendations, the staff training programme reflected residents evolving needs. However, this was not always evident or reflected in the documentation maintained.

Two files were maintained for each resident, the daily file and the person centred plan (MPMP). There was duplication and a lack of consistency noted between both files. Many records including core plans of support such as epilepsy plans were undated and it was difficult to retrieve the required current accurate information so as to substantiate both good practice and where failings had been identified.

For example each plan contained a detailed assessment that was person-centred and respectful in tone and language; those reviewed however were undated. Current reviews and updates were seen in the daily file and these reflected what was seen by the inspector in practice and reported by staff, they did not however concur with the content of the MPMP. The MPMP did not always reflect residents current needs particularly where there had been a significant change in those needs. For example it was unclear from either file of one resident whether bed-rails were still in place or not; they were not. A significant recent diagnosis for another resident was not reflected in the MPMP but was reflected in the daily file.

The review of the plan/supports was multidisciplinary (MDT) and this MDT input was ongoing as appropriate to residents changing needs.

There was a process for establishing and agreeing resident's personal goals and objectives. There was evidence of actions taken to progress these and the identification and escalation of barriers to their achievement. However, again at times the documentation process was disjointed and it was difficult to track progress. The importance of goals to residents was clearly evident with residents eagerly sharing their achievements and planned goals with the inspector.

In summary, while extensive information was available there was duplication, contradiction and a lack of consistency in the residents' records seen and no one clear record that outlined and guided the supports currently required to maximise the resident's wellbeing and personal development.

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:

Overall the inspector was satisfied that the premises was fit for its stated purpose and alterations had been made since the last inspection to enhance its suitability.

The premises was single storey and purpose built; the design and layout was suited to meeting the needs of residents including those with high physical needs and requiring universal accessibility. The premises was welcoming and homely in presentation, well maintained and in good decorative order. The premises was visibly clean, adequately lighted, heated and ventilated.

The premises was located on a spacious site and residents were seen to be supported by staff to access and enjoy the well maintained and pleasantly landscaped gardens.

The premises was in a rural location and transport was necessary to access amenities; transport was available.

Each resident was provided with their own single bedroom the size and layout of which was suitable to meeting their needs. The inspector saw that resident's bedrooms were personalised and reflected their personal interests and hobbies; sufficient personal storage was available.

With the exception of one bedroom, there was a fully accessible shared en suite sanitary facility located between each pair of bedrooms. The design and layout of these facilities was suited to meeting the high support needs of residents; facilities were adequately equipped with hand rails and grab-rails. In addition there was a further sanitary facility located in close proximity to the main dining area. The main stand alone bathroom was spacious and had been refurbished since the last inspection; a universally accessible shower had been installed so as to best meet resident's requirements.

Adequate communal space was provided. The kitchen and dining space was combined. This area was bright and spacious, homely in presentation and facilitated access for residents requiring assistive equipment for their mobility. The kitchen area was adequately equipped with suitable cooking facilities and equipment.

Residents were seen to be provided with such equipment as was required and as recommended by other healthcare services including physiotherapy and occupational therapy. Records were seen of the annual inspection and servicing of equipment.

Circulation areas were spacious and were seen to comfortably accommodate residents requiring mobility aids; two main access and egress points were universally accessible.

Adequate facilities were available for the management of residents' laundry.

A sluice room had been provided since the last inspection. However, its design and fittings did not meet the criteria for a sluice room as it only contained a stainless steel waste unit. Environmental hygiene equipment was stored in the room; there was no wash-hand basin and no bed-pan washer. This requires review and is addressed in Outcome 7 in the context of infection prevention and control.

There was still some evident difficulty with storage with equipment seen to be stored adjacent to one designated escape route. The door was not blocked but this practice is addressed again in Outcome 7.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

While failings were identified there was evidence of actions taken and improvements made in response to the previous inspection findings.

There were measures in place for promoting the health and safety of residents, staff and others. These included the provider's health and safety statement, local operational risk management procedures, procedures for the identification and assessment of risks and the management and investigation of accidents and incidents. Annual health and safety audits were completed.

The inspector reviewed the risk register. The register included centre specific risks, the risks as specified in Regulation 26, for example self-harm and unexplained absence, and risks as they pertained to individual residents. There was evidence that risks were reviewed on a regular basis by the person in charge. There was evidence that in line

with the provider's own procedures risks were escalated as appropriate to senior management. However, resident specific risk assessments particularly where there was a clearly identified risk required further review as they lacked specifics on the controls required and did not always provide reassurance that the controls were appropriate, sufficient and in place so as to manage the identified risk. For example the risk assessment on self-harm required further review to include the risk of serious and perhaps fatal self-harm. The risk assessment for a resident leaving the premises in an unplanned manner referenced controls that included the erection of main gates and staff supervision. The purpose and use of the gates was not however specified. Staff spoken with referenced staff one-to-one supervision for one resident but the parameters of this were unclear. Staff said that they were normally supervising while also completing a task such as cooking. The inspector saw that residents were not at all times supervised as appropriate to identified risk and this would concur with what staff had said.

Further to the last inspection a review of access to the staff call-bell system had been undertaken and the inspector saw that they were connected and accessible. Staff had advised residents at the weekly house meetings to use the call bell system as required.

There was an emergency plan in place that provided guidance for staff on the action to be taken in specific emergency scenarios.

Staff said that no residents were currently dependent on the use of the hoist for moving and transfers. Staff said that resident weight-bearing and independence was maximised and staff utilised equipment such as transfer-belts. Staff had received the required training, staff were seen to use the transfer belts and there was regular input in the centre from the physiotherapist. Residents' files contained manual handling plans.

Certificates were available of the inspection and testing of the fire detection system, the emergency lighting and fire fighting equipment at the prescribed intervals in January 2016, February 2016 and most recently in March 2016. Fire action notices including some presented in a visual format were prominently displayed. Final exits were clearly indicated and final fastenings were easily released thumb-turn devices.

Each resident had a personal emergency evacuation plan (PEEP) that detailed comprehension, ability and the assistance required. A copy of the PEEPS was available in a prominent location for ease of access for emergency personnel.

Simulated fire evacuation drills were undertaken. Given resident numbers and dependency levels the person in charge said and records seen stated that recommended evacuation times were not achieved and had taken up to 10 minutes. Staff had repeated the exercises and reviewed procedures so that the current evacuation time was reduced to four minutes. There was evidence that a person with the required fire safety expertise was requested to review the evacuation procedure in line with the safe compartments available within the building; this review was awaited.

On the day of inspection the inspector noted that equipment was stored in the lobby of one main fire escape route. While the door was not blocked this required review, risk assessment and strict control to ensure unobstructed evacuation of dependent persons.

Some facilities and practices required review to ensure compliance with infection prevention and control standards. These included the use of open top bins for discarded items including personal protective equipment, the storage of environmental hygiene products in the sluice room, and, while their use was minimal, the management and cleaning of commodes to avoid the risk to staff of manual sluicing and cleaning.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

There were measures in place to safeguard residents. These included organisational and national policies and procedures, training for staff and a designated person whose photo and contact details were prominently displayed. The minutes of the residents meetings also indicated that on a regular basis staff supported resident knowledge and awareness of self-protection by regular discussion and familiarisation with the procedures in place to support them.

The inspector saw that residents were comfortable with staff, approached them with ease and were eager to be in contact with staff. Residents expressed no concerns to the inspector and described staff as good and nice.

Staff spoken with confirmed their attendance at training. Staff articulated a good understanding of what did or might constitute abuse and their personal responsibility to safeguard residents. Staff said that in the event that they did report any concerns to the person in charge they had confidence that appropriate action would be taken.

There was evidence available to the inspector that any concerns or reports of alleged or suspected abuse were listened to and investigated by the provider. HIQA had received required notifications. There was evidence of learning from concerns received including enhanced vetting procedures and training for all persons providing services or supports in the centre.

The person in charge described and there was evidence of protective measures taken. However, further risk assessment and explicit safeguarding plans were required to ensure that adequate safeguards were in place on a daily basis to protect all parties from any alleged, suspected or reported abuse. This was partially addressed prior to the conclusion of the inspection.

Thirty percent of residents were reported by staff to present with behaviours that were a challenge and presented risk to themselves, other residents and staff. The inspector having reviewed records and spoken with staff was not reassured that the issue of behaviours that challenged had been sufficiently and satisfactorily addressed to ensure that residents had the supports that they required to manage their behaviours and that all residents and staff were at all times protected from harm and injury.

Given the duration of the issue, the unpredictable and ongoing nature of behaviours that challenged, the impact on the quality and safety of the service provided to all residents, the risk to residents and staff including injury, and the concerns articulated by staff, a judgement of major non-compliance was issued. The provider was requested to take immediate action to ensure that all residents and staff were protected from all forms of harm, injury and abuse. The provider submitted a detailed reply within the specified timeframe.

There was evidence of supports and actions taken including regular referral and review by psychology, psychiatry and the behaviour specialist. There was evidence of regular multi-disciplinary reviews. Behaviour management guidelines were in place that outlined the behaviours, known and possible triggers and interventions to be used by staff up to and including physical restraint/ intervention by staff to limit and prevent escalation of behaviours that challenged. Accidents and incidents related to behaviours that challenged were recorded, investigated and monitored each quarter. Staff maintained records of exhibited behaviours, any identified triggers and how staff responded.

However, it was clear from records reviewed and staff spoken with that despite this, behaviours that challenged impacted negatively on residents and staff and were a trigger for behaviours between residents. One behaviour plan clearly stated that noise and disturbance was a trigger for behaviours for one resident yet there was unpredictability to, and a frequency of such occurrences and disturbance. Another resident had recently attempted to strike another resident who was displaying behaviour that challenged. Staff said that other residents removed themselves from the situation and at times requested to have their meals in their bedroom. Staff confirmed that as seen on accident and incident records they had to frequently remove other vulnerable residents from harm and risk. One resident in their completed questionnaire said that they did not like living in the house as they did not like the shouting and the aggression in the house.

Given the complex, collective needs of residents the inspector was not reassured that it was possible for staff to provide the supports that each resident required to manage their behaviours and as outlined in the behaviour management guidelines. Staff spoken with including the person in charge confirmed this. These required supports included observation, psychological support, immediate staff response, sufficient time, reassurance, routine, regular activity and chatting and extra support hours. There was

no evident evaluation of required supports and recommendations, with what could, given the collective needs of residents and the current staffing numbers and arrangements, be practicably and consistently provided and implemented in the centre.

There was a lack of consensus in the findings and recommendations of multidisciplinary reviews particularly in relation to the suitability of ongoing placement.

Core documents such as a completed needs assessment were undated. The status of a business plan in relation to the relocation and alternative placement of one resident was not clear.

A review of the risk assessments for behaviours that challenged particularly as they pertained to lone staff working required review, for example behaviours exhibited by residents while on the transport vehicle or during the delivery of personal care. Some staff said that they did not feel safe in these solitary situations and they perceived that they had little if any control at times given the nature and unpredictability of behaviours that challenged.

The extent of the behaviours and the risk they posed were clearly outlined by staff and in records seen and included instructions to staff not to adopt certain positions while delivering care and not to put either themselves or other residents in a situation where it was not possible to move away. There was a requirement to remove objects that could be used to cause harm. Language used to describe exhibited behaviours included threatening, abusive, physically aggressive, staff "cornered" and throwing of objects at staff. Reactive interventions recommended to staff included physical intervention by staff up to and including firm physical restrictive holds. Staff confirmed that they had been required to implement one such hold. Staff also said that they would not attempt such a hold as they did not think that it would be possible or safe to do so. Based on records seen including accident and incident records the inspector was not reassured as to the safety of the implementation of this recommendation.

Clarity was required on the use of devices that were potentially restrictive practices. Alarm devices were in use on three resident's bedroom doors. The rationale for their use was the safety of two of these residents due to risk to them as a consequence of behaviours exhibited by the third resident. There was no apparent review of the ongoing requirement of these devices to ensure that they had not become a routine part of the day-to-day operation of the centre, or of the impact of these devices on all residents. For example the restrictions they placed on privacy and freedom of movement as the devices alerted staff to all persons entering any of the three bedrooms including the inspector during the course of this inspection.

Judgment:
Non Compliant - Major

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 person in charge described good procedures for the management of accidents and incidents. Accidents and incidents were formally recorded by staff on duty, there was a communication folder used between staff and the person in charge so that she was informed of all incidents. The person in charge said that if medical review was required she was always contacted by staff. The person in charge took full responsibility for the submission of notifications to the Chief Inspector as prescribed.

The inspector reviewed a sample of accident and incident records and saw that each record was completed in detail by staff. There was evidence of review by the person in charge and actions taken in response including the provision of additional supports, physiotherapy, psychology and psychiatric referral and multi-disciplinary team meetings.

However, a review of accidents and incidents indicated that a physical restrictive practice implemented by staff in response to behaviours that challenged had not been reported as required.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The centre was described by the provider as part of its integrated services. The person in charge described this as a service where a programmes of activities and meaningful engagement were provided for residents both on site in the centre and off-site in

locations such as the day service. The person in charge said that factors such as each resident's age and needs informed the programme that was developed for them.

Three of the ten residents attended off-site day services Monday to Friday. There, residents participated in programmes such as arts and crafts, life skills, exercise programmes, Olympic Games participation and socialisation. Residents spoken with confirmed this. Three further residents attended the day services two days a week and the remaining residents were reported to attend on a rotational basis.

There was evidence of good practice where the centre had recognised the benefit of, had liaised with and devised a programme where a resident with declining and increasing needs was facilitated to have ongoing but reduced access to an established programme of meaningful occupation.

In the centre itself the inspector saw that staff supported residents to engage in table-top activities and residents confirmed that they enjoyed their activities. There was a weekly music session and at weekends there was documentary evidence that residents were supported on an individual basis to access and enjoy local amenities and events. Staff confirmed that they facilitated both individual and collective programmes of activities including baking in the centre but that time was an issue for them given the multi-task nature of their role.

The person in charge said that it was recently acknowledged in the centre that a review of the programme delivered to each resident required review to ensure that their general welfare and development needs were being met. There was documentary evidence of the commencement of this process which was multi-disciplinary (MDT). There was explicit evidence of an acknowledgement that an increased level of meaningful engagement and activity was needed for residents. There was a plan to review the current supports that were available within the centre to see how these could be maximised to facilitate activities. There was a plan to review each residents needs on an individual basis. This acknowledgement of the need for improvement would concur with some relative feedback received. While acknowledging the quality of supports delivered in the centre there was a clear strong desire articulated for more social engagement and increased opportunity for meaningful engagement and activity for their family member. Based on the inspector's observations of the residents age, ability and current limited access to structured day services the inspector concluded that this was a reasonable request for this particular resident.

In conclusion there was evidence of a belief in and a commitment to ensuring that residents were supported to have access to new experiences, social inclusion and meaningful engagement. However, as discussed above and in the providers own MDT review there was also evidence that in line with each resident's age and level of ability increased access to structured development opportunities was required for their on-going well-being and personal development.

There was evidence that a review of each resident, their needs and their current programme had commenced and on that basis this Outcome is judged compliant.

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:

Residents did have specific healthcare needs and staff reported that these needs were increasing, some due to advancing age. There was evidence that supports were in place to meet these needs. Nursing assessment and input was available daily in the centre. A local general practitioner (GP) attended to the needs of each resident as required. Staff said that this worked well, that the GP either called to the centre or residents accompanied by staff went to the surgery. Staff said that with increasing familiarity and the reassurance offered to residents in the surgery the majority of residents now co-operated fully with medical review and intervention.

There was evidence of regular and timely medical review, regular blood-profiling and seasonal influenza vaccination.

As appropriate to their needs staff said and there was documentary evidence that residents had timely referral and good access to multi-disciplinary supports. These supports included physiotherapy, psychiatry, psychology, occupational therapy, speech and language therapy, behaviour therapist, social work, dietician, dental care, optical review and chiropody.

Staff spoken with were familiar with individual resident's healthcare needs and supports, specific healthcare plans were in place. Staff were seen to attend relevant training and/or had support from others with the required expertise such as in wound care so as to meet resident's needs in an evidence based manner. Staff were seen to implement interventions outlined in the healthcare plans.

Residents were seen to be supplied with equipment required for their care such as pressure relieving equipment.

Staff were seen to freshly prepare each main meal; residents were seen to be offered choice and to enjoy their meals at their own pace. Staff were aware of any specific dietary requirements that residents had.

End of life care was provided in the centre. The person in charge said that the principle of care was to support residents to have a comfortable and dignified death in their own

home with the support of services including hospice care. End of life care was last provided in December 2013.

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):

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

Findings:

There was evidence of policy and procedures that supported safe medication management practice. Failings identified at the time of the last inspection had been addressed.

Medicines were supplied to residents by a community pharmacy in either a compliance aid or in their original containers. Staff said that this arrangement worked for each resident.

The inspector saw that medicines were securely stored and each medicine was supplied and labelled for individual resident use.

The skill-mix of the centre included both nursing and care staff and both staff groups had medication management duties. Staff completed generic medication management training as needed and had done so in 2014, 2015 and 2016. Training specific to the administration of emergency medications was also provided as needed to all staff and volunteers. Three residents had a prescription for this medication and training records seen and all staff spoken with confirmed that they had completed the required training.

Each resident was seen to have a current legible, signed and dated prescription record. Staff said that this record accompanied the resident to all reviews and this ensured that any changes to the prescription were made there and then. The administration record maintained by staff was seen to correspond to the prescription record. A separate administration record that included the rationale for the administration of p.r.n (as required medicines) was maintained.

Staff said that there was a very low incidence of medication related errors.

Itemised signed and countersigned records were maintained of the return of unused and unwanted medicines to the pharmacy.

Medical authorisation was in place for medicines requiring administration in an altered format (crushed).

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):

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

Findings:

The statement of purpose submitted with the application for registration of the centre did not contain all of the required information. It was reviewed and amended. However, given these inspection findings, the range and complexity of residents needs and the staffing supports available, precise detail was required and requested on the acceptance or not of emergency admissions to the centre.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

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

Findings:

There was a clear management structure in place comprised of the clinical nurse manager 1 (CNM1), the person in charge and the head of integrated services. There was clarity of roles, responsibilities and reporting relationships.

The person in charge had responsibility for two designated centres. The person in charge worked fulltime and said that she divided her working week between the two centres. The person in charge was supported by a Clinical Nurse Manager 1 (CNM1) in each centre.

The person in charge was suitably qualified for the stated purpose and function of the centre. The person in charge was a registered nurse in intellectual disability, also held postgraduate qualifications in health services management and there was further evidence of ongoing professional development including basic life support, the provision of palliative care and the management of epilepsy. Documents reviewed supported that she was actively engaged in the administration and operational management of the centre.

There was an out-of-hours on call management system, for example staff had access to the night supervisor on duty in the main campus. The person in charge said that she was also available to staff and staff described the person in charge as accessible, approachable and fair.

The person in charge said that she had ready access to the support of her line manager, the head of integrated services and they also met formally on a weekly basis.

There was evidence of systems for reviewing the quality and safety of care and services provided to residents. These included the management team meetings referenced above, staff meetings, weekly meetings with staff specific to matters in the designated centre and multi- disciplinary input, meetings and reviews. In addition there was an established pattern in the centre of the completion at the prescribed intervals of the reviews required by Regulation 23. The most recent review was undertaken in the days just prior to this inspection and the report was not yet available. The inspector reviewed the report from November 2015. The primary finding from this review was the inconsistent nature of the evidence available to demonstrate that required actions had been implemented. These inspection findings would concur with that view.

In summary there was a governance structure comprised of suitable persons, strong evidence that the quality and safety of care, services and supports provided to residents was monitored on an ongoing basis. However, this monitoring and the actions taken had not ensured that care, services and supports were appropriate and at all times safe for residents and staff, there was a reactionary element to some actions taken such as emergency reviews and referrals. This is addressed as a failing in Outcome 8 Safeguarding and safety.

Judgment:

Compliant

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:

Arrangements were in place for the management of the centre in the absence of the person in charge. The provider had appointed a clinical nurse manager 1 (CNM1) in each of the two centres that the person in charge had responsibility for. The CNM1 was the nominated person participating in the management of the centre (PPIM). The CNM1 described working arrangements that supported the management of each centre in the absence of the person in charge; weekend cover was provided by the CNM1's. The CNM1 had a sound knowledge of resident's needs and the operational management of the centre.

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:

The centre was well maintained. Residents were seen to be provided with the equipment necessary for their comfort and well-being. Residents had good access to their required multi-disciplinary supports. Transport was available and the person in charge had commenced a multi-disciplinary review of the social dimension of the supports provided to residents. While there was some evidence that staffing resources may not at all times be sufficient this is addressed and will be responded to by the provider in Outcome 17.

Judgment:

Compliant

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):

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

Findings:

There was evidence that staffing numbers and skill-mix were reviewed in response to previous inspection findings. For example there was now a nursing presence in the centre daily and night time staffing included a "waking" night staff member in addition to the sleepover staff member. A resource had been sourced to provide transportation for residents in the morning. However, there was evidence that staffing numbers and arrangements were not sufficient at all times to meet residents' needs.

Staff said that residents and their care were at all times prioritised by them over and above other delegated tasks. Staff said that residents with higher needs were obviously prioritised and that consequently all residents may not get the same attention from staff. 80% of staff spoken with articulated consistent concerns in relation to the inadequacy of morning time staffing levels. 40 % of relatives who completed HIQA questionnaires said that staffing numbers were not adequate and that staff were working under pressure. The inspector saw particularly in the morning that staff were busy. Staffing levels meant that all personal care was seen to be delivered by staff working on their own and residents leaving the centre for the day were prioritised for care. Staff said and the inspector saw that there were insufficient staff resources to implement meaningful and effective one-to-one staff supervision required to manage an identified risk. There was documentary evidence that a goal for one resident was not achieved as the required staff supports were not available.

The person in charge said and staff confirmed that there was current discussion on the outsourcing of services such as laundering and catering so as to free staff to attend to direct care supports required by residents. Staff had used an accepted and widely used objective tool to measure each resident's level of independence/dependence in activities of daily living such as personal care and mobility. A review of this by the inspector indicated that the needs of all residents had increased since originally assessed and nine resident's needs were assessed as moderate to high. While helpful this tool did not however take into account other factors such as time and psychosocial elements such as behaviours that challenged. For example staff said that two residents required staff

assistance for 45 minutes each, each morning; however, there were only three staff on duty.

In conclusion and as also stated at the time of the last inspection a full review of the centre, its purpose and function, services provided, the number and needs of residents including their psychosocial needs, risk assessments and behaviour support plans was required to ensure that staff numbers were at all times appropriate to the needs of residents and the delivery of safe quality supports and services.

Staff files were available for the purpose of inspection. The random sample reviewed by the inspector was well presented and contained all of the documents required by Schedule 2.

There was documentary evidence seen of current registration with their regulatory body for each nurse employed.

Training records were available for each staff member. The records indicated and staff spoken with confirmed that all staff had attend mandatory training within the specified timeframes. The person in charge monitored attendance at staff training and also ensured that staff had access to education and training that reflected resident's needs. Staff completed recent training on communication, person centred care and the code of practice. Other relevant education completed by staff included dementia care, the management of diabetes, first aid, food safety and completing care plans. In addition the review of staff files indicated that staff employed held core relevant qualifications including social care, disability studies and healthcare studies to FETAC (Further Education and Training Awards Council) Level 5.

There were processes for and evidence of the vetting and training of persons who provided services but were not employed directly by the provider. Agency staff were not utilised and the person in charge confirmed that relief staff only worked in the two designated centres that she had responsibility for and were therefore familiar with the centre and the residents.

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:

Overall and on balance the inspector was satisfied that the records listed in Part 6 of the Regulations were in place. A deficit in relation to the completeness, accuracy and ease of retrieval of information in records pertaining to residents was addressed as a failing in Outcome 5.

Policies and procedures were specific to the organisation and the majority were current and within their agreed review date.

A directory of residents was maintained and it was seen to include all of the required information.

There was documentary evidence that the provider was insured against accidents to residents, staff and other persons.

The residents guide was presented in an accessible format. However, it required review and amendment as it did not clearly specify how a resident could access any inspection reports on the centre.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Action Plan

Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004745
Date of Inspection:	12 May 2016
Date of response:	28 June 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 05: Social Care Needs

Theme: Effective Services

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

Each plan contained a detailed assessment that was person-centred and respectful in tone and language; those reviewed however were undated.

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

- Both My Profile My Plan and the daily working file to be reviewed by keyworkers in consultation with CNM1. The clinical support team will be consulted where required.
- Both files will be reviewed and any inconsistencies between the two files will be corrected.
- The process will be reviewed by the Person in Charge who has prepared a scheduled for this work to be completed.
- Any undated reviews will be rectified part of this review.
- Staff will be advised that they are required to date and sign all entries.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

While extensive information was available there was duplication, contradiction and a lack of consistency in the residents' records seen and no one clear record that outlined and guided the supports currently required to maximise the resident's wellbeing and personal development.

2. Action Required:

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

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

- The Clinical Team supporting residents in this designated centre have commenced the process of reviewing each resident to ensure that the plan to support the resident is current, effective and reflects the residents' current presentation.
- The Person in Charge, PPIM and keyworkers will work with the Clinical Team as part of this review.
- The review will be prioritized based on the needs of the residents.

Proposed Timescale: 31/10/2016

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:

Resident specific risk assessments particularly where there was a clearly identified risk required further review as they lacked specifics on the controls required and did not

provide reassurance that the controls were appropriate, sufficient and in place so as to manage the identified risk.

3. Action Required:

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

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

- A risk register is maintained in the designated centre.
- This risk register is subject to regular monitoring by the PIC in consultation with the Clinical Support Team.
- A number of safety related risks have been identified and are rated as low to moderate level risks.
- Following the issuing of this immediate action plan by HIQA on 16th May 2016, a preliminary review of the risk register, which is maintained in the centre, by the Multi-Disciplinary Team consisting of Consultant Psychiatrist, Senior Psychologist, Social Work Team Leader, Senior Speech & Language Therapist, Senior Physiotherapist, Person in Charge, Head of Integrated Services and Head of Quality & Risk took place on the 18/05/16. The conclusion of the meeting is that there was no immediate, foreseeable, catastrophic level safety risks as a consequence of behaviours that challenge.
- A thorough review of each resident to include a review of the antecedents to behaviours, the effectiveness of the behaviour management strategy and the risk was conducted by a Multi-Disciplinary Team with the Person in Charge on 15/05/16 and 24/05/16.
- The controls in place were reviewed to provide reassurance that the controls were appropriate and sufficient to manage the identified risk.
- As part of this process greater clarity and detail was documented in the control and mitigation sections.
- If and when new risks present the PIC in consultation with the clinical team will ensure that the controls are appropriate and sufficient to manage the risk.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

Some facilities and practices required review to ensure compliance with infection prevention and control standards. These included the use of open top bins for discarded items including personal protective equipment, the storage of environmental hygiene products in the sluice room, and, while their use was minimal, the management and cleaning of commodes to avoid the risk to staff of manual sluicing and cleaning.

4. 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:

- All open top bins have now been replaced with covered bins.
- Environmental hygiene products are now stored in a locked press.
- All clinical waste will be stored in a locked shed outside of the residence.
- All commodes will be brought to the sluice room for cleaning after use where staff will use PPE while cleaning.
- A handwashing sink is currently being installed in the sluice room.

Proposed Timescale: 31/07/2016

Theme: Effective Services

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

On the day of inspection the inspector noted that equipment was stored in the lobby of one main fire escape route.

There was evidence that a person with the required fire safety expertise was requested to review the evacuation procedure in line with the safe compartments available within the building; this review was awaited.

5. Action Required:

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

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

- Currently equipment is stored opposite the fire exit door.
- Alternative storage will be arranged for wheelchairs and equipment to address this concern.

Proposed Timescale: 30/07/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Failing to have adequate arrangements in place to ensure that all residents and staff were protected at all times from all forms of harm and abuse as a consequence of behaviours that challenged.

Failing to have robust safeguarding plans in place in response to allegations of abuse so as to reduce the risk of reoccurrence.

6. Action Required:

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

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

- A risk register is maintained in the designated centre.
- This risk register is subject to regular monitoring.
- A number of safety related risks have been identified and are rated as low to moderate level risks.
- Following the issuing of this immediate action plan by HIQA on 16th May 2016, a preliminary review of the risk register, which is maintained in the centre, by the Multi-Disciplinary Team consisting of Consultant Psychiatrist, Senior Psychologist, Social Work Team Leader, Senior Speech & Language Therapist, Senior Physiotherapist, Person in Charge, Head of Integrated Services and Head of Quality & Risk took place on the 18/05/16. The purpose of this meeting was for the multidisciplinary team to satisfy themselves that that there was no immediate, foreseeable, catastrophic level safety risks as a consequence of the behaviours that challenge. The conclusion of the meeting is that there was no immediate, foreseeable, catastrophic level safety risks as a consequence of behaviours that challenge.
- A recommendation of the meeting was that a thorough review of each resident to include a review of the antecedents to behaviours, the effectiveness of the behaviour management strategy and the risk will be conducted by a Multi-Disciplinary Team with the Person in Charge by 19/06/16.
- The Clinical Nursing Specialist in Behaviour Support is attending the centre as scheduled on 20/05/16, and will review the Behaviour Support Plan of both resident with the Person in Charge and the staff. All staff have been advised that the CNS will also be available if they have any questions or concerns in regard to supporting residents who display with challenges.
- A resident who displays challenges meets with a member of the psychology team on a monthly basis. Additional support from the psychologist will be offered and provided if the resident requests this.
- The Person in Charge will ensure that where changes occur which reduce or increase risks these changes will be documented through the Multi- Disciplinary meetings and through the review of risk assessments.
- All Multi-Disciplinary meetings will now be held in a location to ensure that as many team members as possible can be in attendance for discussion and agreement on actions. These will be held monthly and can be scheduled more often as necessary. This arrangement will be reviewed after 3 months.
- All staff in the designated centre will be requested to identify areas where they will benefit from further training to assist them in their personal development and in supporting the residents in the centre.
- Following this engagement and the thorough review of the risk register the Multi-Disciplinary Team will identify areas where staff may benefit from further training.
- Based on this information, a training programme will be developed by 19/06/16 and training will be provided to staff in the designated centre. The date for this training programme will be confirmed following the 19th June 2016. This training programme will be evaluated from feedback from staff and follow up training will be provided if required.
- The Provider Nominee has revisited, with the PIC and PPIM, the residential placement of one of the individuals with challenging behaviour in the context of relocating this

individual to a more appropriate residential environment that will better support the individual's needs.

- The organisation has a suite of safeguarding policies and procedures in place. These procedures outline the process in the event of an allegation of abuse.
- Safeguarding plans, where relevant, are in place for any resident who has had involvement with the Designated Officer to mitigate against safeguarding risks.
- The risk to staff of a false allegation being made against them has been assessed in consultation with the Designated Officer, Head of Human Resources and the Person in Charge and while this risk cannot be fully eliminated it is robustly controlled through the due process mechanism outlined in the Safeguarding documents to support investigation of allegations.
- All staff in the designated centre will be requested to identify areas where they will benefit from further training to assist them in their personal development and in supporting the residents in the centre
- Following the thorough review of the risk register the Multi-Disciplinary Team will identify areas where staff may benefit from further training.
- Based on this information, a training programme will be developed, with the support of the training department. This training programme should be provided by 31st October 2016 and will be evaluated from feedback from staff and follow up training will be provided if required.

Proposed Timescale: 31/10/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

Given these inspection findings, the range and complexity of residents needs and the staffing supports available, precise detail was required and requested on the acceptance or not of emergency admissions to the centre.

7. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

- All transfers are approved by the Admissions Discharge and Transfer committee who decide how vacancies that arise in designated centres are filled.
- Statement of Purpose and Function has been reviewed and amended to show that emergency admissions are not accepted to the centre given the needs of the residents but that any admissions are organised in a planned manner.
- The number of residents in this designated centre is currently under review with the intention of reducing the number of residents in this designated centre from 10 to 9.

Proposed Timescale: 30/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

As outlined in Outcome 17 there was evidence that staffing numbers and arrangements were not sufficient at all times to meet residents' needs.

8. Action Required:

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

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

- The Provider Nominee has revisited, with the PIC and PPIM, the residential placement of one of the individuals with behaviours of concern in context of relocating this individual to a more appropriate residential environment that will better support the individual's needs. Currently there is a vacancy in this designated centre and the transfer has been approved by the Admissions Discharge and Transfer Committee.
- A transition period has been planned for this individual and it is hoped to have this individual transferred to his new area by 30/07/2016.
- This residential vacancy that will arise in this designated centre will not be filled.
- The number of residents in this designated centre is under review based on the staffing levels and the changing needs of residents.
- The Services is not in a position to employ additional staff over and above funded levels per the direction of the HSE.
- Staff training is being addressed through the process of completing individual training needs assessments in order to identify the training needs of staff and ensure that staff have the required expertise and knowledge to support the residents. This training will also support staff in their role. The training programme will be scheduled following the review of the individual training needs assessments by the PIC, Clinical Support Team and the Training department.

Proposed Timescale: 31/10/2016

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 resident's guide did not clearly specify how a resident could access any inspection reports on the centre.

9. Action Required:

Under Regulation 20 (2) (d) you are required to: Ensure that the guide prepared in respect of the designated centre includes how to access any inspection reports on the centre.

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

- The residents guide will be reviewed and amended in conjunction with the quality department and the advocacy group on how best to provide the residents with access to the inspection reports on the centre

Proposed Timescale: 31/10/2016