

**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-0005179
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:	9
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:
23 September 2015 09:30	23 September 2015 19:00
24 September 2015 09:00	24 September 2015 16:30

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

This inspection was the first inspection of the centre by the Authority.

Prior to the inspection residents and family members were invited by the Authority to complete questionnaires so as to ascertain their experience of the care and services provided. The feedback received from both residents and family was consistently positive.

Residential and respite services were provided to nine residents in two houses within a short car commute from each other.

The inspection was facilitated by the area manager and the person in charge; the inspector also met with frontline staff on duty, the quality and risk manager and the head of community services. The inspector reviewed records including policies and procedures, health and safety and fire safety records, complaint records, staff and resident related records. The inspectors met and spent time with all residents when they returned in the evening from their respective day care services. Residents had been informed of the upcoming inspection and engaged openly with the inspector.

The inspection findings were satisfactory. The inspector was satisfied that the centre was effectively governed and that effective systems for the monitoring of the quality and safety of services and supports provided to residents were in place. Staff were clearly focused on facilitating the rights, choices and decisions of residents and sought to strike a reasonable balance between resident autonomy, risk and safety. Residents were clearly comfortable in their environment and with staff and had been facilitated to develop a sense of ownership over their personal space and each house.

Of the full eighteen Outcomes inspected the provider was judged to be fully compliant with 12 and in substantial compliance with four, in moderate non-compliance with one; medication management and in major non-compliance with one; health & safety. The inspector was not reassured that given the stated purpose and function of each house that the existing fire safety measures were adequate.

In further correspond the provider advised that a Fire Safety Engineer had prepared a report on this designated centre. The provider requested that a specification be developed from this report in order to identify what works were required in order to make the houses compliant with fire safety regulation. That report was completed and was submitted to the statutory body, as part of a business case for funding.

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):

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

Findings:

Having spoken with staff, met with residents and reviewed relevant records the inspector was satisfied that residents' rights, choices and decisions were respected and facilitated.

The provider operated a structured advocacy service. One resident (living in another designated centre) was the local advocate; there were local weekly meetings and monthly regional meetings and the annual national conference was up-coming. Matters raised and unresolved at the weekly house meetings were at times progressed through the advocacy network such as a request from residents for enhanced access to computers in the day service.

Records indicated that house meetings were convened weekly and there was evidence that these were structured and convened to suit resident's individual requirements. For example in one house the meetings were held on a Friday evening so as to shorten the timeframe between the planning of events and actual participation thereby preventing unnecessary anticipation and anxiety for residents. The structure of the meetings was monitored by the person in charge to ensure that they were a meaningful process of consultation with residents. Standard items for discussion each week in addition to planned activities and meals were safeguarding, complaints and personal plans. The minutes demonstrated to the inspector that the planned activities for the week reflected residents' preferences and priorities as set out in their personal plans.

In response to inspection findings to date, the provider continued to review and amend its complaints policy and procedures. The revised policy would be made available in an easy read and plain English versions for residents and families and information sessions for staff were planned. Staff spoken with were clear on the revised complaints process including roles and responsibilities for receiving and managing complaints. However, having reviewed aspects of the new policy the inspector concluded that further review was required as it did not clearly differentiate between appeal and review. For example it was not clear from the policy who the person specified in Regulation 34 (3) (a) and (b) was and how and how often they would ensure that all complaints were appropriately managed and recorded. It was also not clear what role if any the local area managers had in resolving complaints locally in conjunction with the person in charge rather than requiring their escalation to a more senior manager.

There was however evidence of good complaint management practice. A record of complaints received was maintained in each house. These records indicated that residents felt at ease to complain, were listened to, action was taken by staff to resolve the matters of concern to them and the resident's satisfaction at the action taken was established. Relatives surveyed said that they either had no reason to complain or if they had their complaint was managed by staff to their satisfaction. Residents said that they could "talk-up" for themselves.

Staff said that all residents were registered to vote and residents confirmed that they exercised control over their decision to vote or not. Information on the issues to be voted on was provided to residents through the advocacy network.

Residents' religious preferences were established and facilitated by staff both in each respective house, in the day service and annually when a mass and celebration was held to which families and significant others were invited. Records seen by the inspector indicated that attendance at religious services also had a social dimension for residents as they met with friends and past acquaintances.

Staff confirmed that recently revised policy and procedures were introduced on the management of residents' personal assets including their monies; personnel to audit and oversee these systems were also recently centrally recruited. The inspector saw that each resident had a financial plan; records including supporting receipts were maintained for each transaction; records were signed by a staff member. The records seen had been audited for accuracy and accountability on a quarterly basis by the person in charge. However, neither policy nor procedure included the requirement for a counter signature including where possible and appropriate the resident's signature.

Judgment:
Substantially 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):

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

Findings:

Staff had clearly identified and recorded each resident's communication strengths and needs and practical interventions were in place to enhance communication with and for residents. For example there was strong evidence of the use of augmentative communication strategies including PECS (a picture exchange communication system) and other visual cues such as activity and meal planners and a visual staff roster that identified for residents the staff that were coming on duty in each house. The PEC's were also seen to be integrated into the weekly house meeting and into the person plan where agreed goals and priorities were visually represented. There was reported consistency and continuity of visual aids between the centre and day services. As appropriate there was evidence that residents had access to assistive technology to further enhance non-verbal communication.

Staff spoken with had a sound evidence based understanding of behaviours as a means of communication and were seen to be respectful of these in practice. Detailed records were in place for each exhibited behaviour and its meaning so that staff could understand and respond meaningfully to what the resident was communicating. However, much of this information was included in behaviour management plans rather than in therapeutic stand alone communication plans. The segregation of the two was discussed by way of recommendation at verbal feedback so as to more accurately reflect the good person-centred practice seen in the centre.

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):

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

Findings:

Having spoken with residents and staff and reviewed records including the questionnaires completed by family members it was clear that maintaining, developing and supporting relationships and social integration for residents was central to the provision of care and services.

Staff maintained a log of family contact which was regularly undated and residents took great pride in showing the inspector photographs of family events in which they fully participated including weddings, birthdays and other celebrations. It was clear that staff worked with residents and families to facilitate ongoing family integration such as home visits and holidays and in so far as was practicable provided any supports required. An example of the effort made by staff was the establishment of significant events such as sibling birthdays and then supporting the resident to purchase a card or gift of their choosing. Two residents spoken with told the inspector that they had "two homes"; the centre and their family home.

Apart from the residents role of family member there was evidence that staff supported residents to achieve independence as a member of the community and in developing other friendships and relationships. A weekly "flyer" of local events was available to each house from which residents choose their preferred activity and there was strong pictorial and narrative evidence of residents' enjoyment of concerts, cinema, restaurants, and trips to places of interest to them such as a donkey sanctuary. One resident told the inspector of how staff supported her in visiting the residents of another designated centre where she had previously availed of respite services.

Staff said that the service was well supported by the local community and in return the provider held an annual open day.

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):

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

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 inspectors that the admission and placement process took due regard of the wishes, needs, safety and wellbeing of residents, individually and collectively both on admission and on an on-going basis. All of the current residents had established tenure in the houses having lived there for three or more years.

Residents were provided with an explicit contract for the provision of supports and services that detailed the services to be provided to the resident and the charge to be levied for these services. With due regard to the nature of the residents disability the contract was also available in an accessible format.

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):

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

Findings:

The inspector was satisfied that there was a meaningful, effective, person- centred process in place for assessing each residents abilities, needs, goals and aspirations and for planning and reviewing the supports required by each resident to enable them to achieve quality outcomes.

The assessment and review process was informed by resident, family and multi-disciplinary input. A sample of completed assessment/information gathering tools seen by the inspector were current, detailed, very personalised to the resident and completed in both an empathetic and evidence based manner. From these assessments supports, goals and priorities were identified and agreed with the resident; responsible persons and achievement timeframes were identified. The achievement or otherwise of residents goals and priorities was monitored on a quarterly basis by staff and the most recent reviews indicated that any barriers to achieving a goal had been successfully addressed. Agreed goals were seen to be integrated into the weekly house meetings.

Each resident had their own “green folder” that was obviously a very important document to them and which they generously shared with the inspector. This folder attested to the goals and priorities as agreed with the resident with photographic or other evidence of their implementation. The narrative notes maintained by staff reflected the personal support plan.

Judgment:
Compliant

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

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

Findings:

The designated centre consisted of two domestic style houses within a short car commute from each other. The inspector reviewed both houses and was satisfied that each was suited to its stated purpose and function and substantially compliant with regulatory requirements.

However, one house had undergone an extensive refurbishment process and did present as much more welcoming, comfortable and homely than the other house which required some redecoration and maintenance and upkeep internally and externally.

Each resident was provided with their own bedroom; rooms were of a suitable size and layout and residents clearly had pride, ownership and control over their personal space.

Bedrooms did not offer en-suite sanitary facilities but adequate separate facilities were provided in each house for the number and needs of the residents living in them; privacy locks were provided.

Both kitchens were adequately equipped and were seen to be both functional and social areas with residents and staff engaging with each other while meals were being prepared; some residents participated in the household duties.

Adequate communal and dining space was provided.

Adequate facilities were in place for the laundering of residents personal possessions.

Both houses offered adequate parking and access to a garden.

Staff confirmed that no resident required equipment or assistive devices.

Storage space was not seen to present any difficulty, however the external storage area in one house was in a poor condition of maintenance; it was not safely accessed and its roof was in a poor state of repair.

Judgment:

Substantially 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):

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

Findings:

There were measures in place for identifying, assessing and managing risks. These included a health and safety statement, a risk management policy, register of risks and an emergency plan that incorporated the alternative placement of residents should an evacuation of the centre be required.

The inspector saw a range of completed risk assessments both centre and resident specific. These assessments indicated that the process of risk management was dynamic, risks were kept under review and controls were reduced where possible until they were the least restrictive. Inspectors saw that staff sought to strike a reasonable balance between resident autonomy and independence and safety. There was evidence that staff adhered to internal procedure and escalated some risks; there was evidence of consultation between staff and management in relation to the management of the escalated risks. There was evidence of the input of the multi-disciplinary team in the process of risk assessment and management. Risk assessments were integrated into both personal support plans and behaviour management plans, were discussed at staff meetings and the inspector saw the practical implementation of identified controls.

Risk assessments were in place for the specific risks identified in Regulation 26(1) (c) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The person in charge confirmed that no resident had a manual handling requirement but staff still received training within mandatory timeframes.

There was documentary evidence that vehicles used by residents and staff were maintained on a regular basis so as to ensure their safety and roadworthiness.

There was a fire procedure and evacuation procedure, staff received fire safety training generally on an annual basis, staff convened fire drills with residents, staff tested the existing fire detection devices on a weekly basis, fire fighting equipment was in place and serviced annually, escape routes were indicated by running man signs. Where a risk had been identified during fire drills (poor resident compliance with the evacuation procedure) staff had risk assessed this risk and implemented a plan to try to reduce the risk with a clear timeframe for re-evaluation of the effectiveness of the plan; the multi-disciplinary team had input into the plan. Residents spoken with confirmed their participation in the fire drills and described the evacuation procedure to the inspector. Staff spoken with confirmed that while the provider had commissioned fire surveys of both houses in March 2015, based on other recent inspection findings by the Authority the provider had re-commissioned these surveys and these reports were awaited.

However, having taken in to account the design and layout of each house, the nature of the services provided and the supports required by residents, the inspector was not reassured as to the adequacy of the fire safety management systems in place. Neither house had emergency lighting; staff and residents were provided with flash-lamps. Neither house had an interlinked domestic type fire detection system with a control panel that provided coverage throughout most of the building. Fire detection was dependent on battery operated smoke detectors in one house; there was some evidence that fire detection may have been linked to the mains electrical system in the other. There was some evidence that some fire doors may have been provided in one house during its refurbishment.

Diagrammatic fire evacuation notices were displayed, however, the actions to be taken in the event of fire were not.

One staff member had not attended recent fire safety training; the last recorded date was 2011, it was unclear if this was correct but it was confirmed by the person in charge that updated training was required.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

There were measures in place for protecting residents for being harmed or abused; these measures included policies and procedures, staffing training, resident education and designated persons. There was evidence that staff and the provider took appropriate action in response to any alleged, suspected or reported abuse including notification to the Chief Inspector. The area manager confirmed that the provider was, in the interest of learning, best practice and regulatory compliance undertaking a full review of its safeguarding procedures.

In the context of safeguarding the inspector reviewed in consultation with staff risk assessments, support plans and behaviour support plans. The inspector was satisfied that all reasonable protective measures were implemented by staff; measures were identified in consultation with the designated person for safeguarding, the multi-disciplinary team, and family as appropriate and other statutory bodies. It was clear to the inspector that staff had a sound understanding of complex situations and sought at all times to safeguard residents. Safeguarding plans and protective measures were set out as risk assessments that were reviewed by the area manager and the person in charge; the review identified the trial, success or otherwise of safeguarding interventions and any further action necessary.

Staff spoken with and records seen indicated a therapeutic evidence based approach by staff to the management of behaviours that challenged staff and other residents. The inspector saw detailed management plans that outlined the behaviour, its meaning and the practical strategies for staff to employ so as to reduce or manage the behaviours. The inspector noted consistency and continuity between multi-disciplinary reviews and recommendations, the residents personal support plan and the daily narrative notes. Where a restrictive practice was identified as a potential requirement in the management of behaviours this was clearly outlined in the plan but only as a last resort following the failure of therapeutic interventions. The daily narrative notes supported staff knowledge of the plan and its implementation with positive outcomes and without the requirement for any restrictive practice.

Judgment:

Compliant

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

There were policies and procedures for the identification, recording, investigation and learning from accidents and incidents. A sample of accident and incident records seen by the inspector were completed in detail by staff and reviewed by the person in charge or the on-call manager. There was evidence of the analysis of accident and incident data and learning. For example staff told the inspector that such analysis had identified an increase in accidents and incidents when residents did not have access to structured day services due to annual leave; each house now implemented a structured planned schedule of activities for residents during such periods.

The inspector was satisfied that staff had knowledge of the events that required notification to the Chief Inspector. However, there was discussion and clarification as to what constituted an unexplained absence of a resident from the designated centre. Records indicated that incidents of resident (s) leaving the centre in an unplanned manner and against the advice of staff had occurred. The inspector was satisfied that the incidents and the risk of reoccurrence had been satisfactorily managed but not however notified by staff on the basis that they were aware of, intervened and resolved each incident.

Following clarification from the inspector there was agreement that these events would be notified retrospectively.

Judgment:

Substantially 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):

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

Findings:

As seen in each resident's assessment and personal plan 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 one and five and it was clear to the inspector that staff and the care and services provided were focussed on the residents and their choices and preferences. Each resident on a daily basis attended off-site day services structured to meet their needs and agreed priorities. For example one resident attended day services specific to their disability while another travelled to their place of origin. Learning focussed on the practical acquisition of new skills such as social skills or learning the boundaries of behaviours, cooking or arts and crafts. Staff spoken with were aware of each resident's particular skills and preferences and ensured that they participated in programmes that suited these and were therefore successful.

Practice was not risk adverse and as appropriate activities and new experiences were supported by risk assessments that facilitated rather than inhibited resident participation.

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):

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

Findings:

Staff said that residents attended their General Practitioner (GP) of choice and that four different GP's attended to the medical needs of the residents. Staff reported that residents enjoyed good health and had no specific healthcare requirements. However, to maintain resident health and wellbeing and as an adjunct to the management of established co-morbidities the inspector saw that residents had timely and regular access not only to their GP but also to other healthcare professionals. Records seen indicated that the provider facilitated access to psychiatry, psychology, neurology, behaviour therapy, speech and language, chiropody, dental and optical treatment. There was evidence of regular blood profiling including the monitoring of medication therapeutic levels and health screening.

Healthcare support plans were in place where there was an established healthcare need such as epilepsy; general nursing care was accessed from the community if required.

The inspector saw that residents looked forward to their meals, were involved in the planning of meals and were encouraged by staff to make healthy eating choices. Residents were seen to be provided with healthy balanced meals including fresh vegetables and fruit, fish and pasta.

Judgment:
Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

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

Findings:

There was a recently reviewed and redrafted medication management policy in place.

Training records indicated that all staff had attended medication management training in 2014 or 2015. The person in charge said that there were no identified medication management errors to report.

Medications were seen to be securely stored and there were procedures including verified records for both the receipt of and the return of medications to the pharmacy.

The person in charge confirmed that medications that required stricter controls were not in use and no resident required medications to be administered in an altered format; crushed. There was minimal usage evidenced of medication as part of the plan for managing behaviours that challenged.

However, all medications were managed by staff and there were no policies and procedures to support staff in assessing and facilitating residents to manage their own medications.

Policy and procedure required of staff that they check the accuracy of all medications supplied to the centre; staff spoken with confirmed that this included both quantity and content of the blister pack. However when staff recorded the administration of medication they recorded only that the blister pack was administered rather than each individual medication as indicated on the prescription record. The inspector was of the view that this practice was not adequate in terms of safety and accountability as staff who checked the accuracy on supply may not be the staff who administered the medication to the resident; some staff were reported to have concerns as to their role and responsibility in ascertaining the accuracy of supplied medications as they believed that it was not within the remit of their scope of knowledge and practice.

The policy and procedure on the administration of over the counter analgesics was ambiguous. Staff were allowed by policy to administer paracetamol to residents without a prescription but it was unclear from the policy if this was done following consultation

with the pharmacist on each occasion it was required or just periodically as reported by staff. There was no guidance as to the monitoring of effectiveness, when to seek medical advice or indicators for repeat administration. There was no clear indication as to why staff decided to administer paracetamol to a resident when the resident had an existing prescription for an alternative analgesic.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The statement of purpose contained most of the information required by Schedule 1. It required some minor amendment to be fully complaint; this was completed and the revised statement of purpose was submitted prior to this report being issued to the provider.

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):

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

Findings:

In March 2015 the provider reconfigured the centre from one larger centre to two smaller designated centres each consisting of two houses. The governance structure was clear and staff were clear on their roles, responsibilities and reporting relationships. While the area manager and both persons in charge continued to work together in a collaborative and supportive manner to ensure safe, quality outcomes for residents in both centres, there was no ambiguity in relation to the management of each centre individually. The recent inspection findings from both centres would support that this was an effective model of governance.

The person in charge was suitably qualified for the role; she was an actively registered nurse in intellectual disability and had also completed post graduate education in both nursing and management. The person in charge worked full-time, was present in the centre on a daily basis, had established experience within the organisation and the service as prior to the reconfiguration as referred to above she was the person in charge for all four houses. The person in charge maintained her skills and knowledge through ongoing participation in the staff education programme and had also in 2014 completed a two day programme on the role of the person in charge, the regulations and the standards. The person in charge facilitated the inspection with ease and was clear on her role, regulatory responsibilities and the individual requirements of each resident.

There were effective systems in place for the review and monitoring of care, supports and practice. Local weekly management meetings were convened at which issues of relevance to both centres were discussed such as complaints, safeguarding of residents and accidents and incidents. Issues that could not be resolved locally were escalated to the provider via the monthly management meetings. The person in charge received the minutes of these meetings and had daily access to the area manager.

On a regular and routine basis the person in charge monitored the quality of the residents meetings and personal support plans; there was evidence of action taken to improve practice including templates to be used by staff for both the meetings and the review of the support plans.

The annual review as required by Regulation 23 (1) (d) and the unannounced visit as required by Regulation 23 (2) had both been undertaken and reports were available for the purpose of this inspection. The unannounced visit had in March 2015 identified areas requiring improvement including the updating of the personal plans, the frequency and quality of fire drills and multi-disciplinary input into behaviour management plans. The person in charge said that the action plan had been fully implemented and this would concur with these inspection findings.

The annual review based on the 18 Outcomes monitored on inspection by the Authority, had been completed by the area manager and the person in charge in April 2015 with follow-up by them of the required actions in June and August 2015. The updates indicated that actions were either completed or still in progress such as the upgrading of the physical environment; again this would concur with the findings of this inspection. The review incorporated consultation with both residents and their families. The findings of the review and the actions required were reflected in the minutes of staff meetings seen by the inspector.

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):

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

Findings:

The person in charge confirmed that she had not been absent from the centre for any period of time that required notification to the Authority.

Arrangements were in place for the management of the centre in the absence of the person in charge on a routine or unexpected basis. Both persons in charge provided support to each other and to each centre as required. The area manager was available to staff on a daily basis, was actively engaged in the administration and operational management of the centre and was the nominated person participating in the management (PPIM).

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):

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

Findings:

There was no evidence to indicate that the centre was not adequately resourced; staff told inspectors that it was adequately resourced. Where a resident had not achieved a desired goal or objective and this was linked to a lack of resources, e.g. the risk assessment had concluded that two staff were required for a resident to safely engage

in a particular activity, there was evidence that this was progressed by staff and satisfactorily addressed by the provider.

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):

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

Findings:

The inspector reviewed a sample of staff files and found that they were well presented and contained all of the information required by Schedule 2 of the Regulations. There was some ambiguity as to the relevance and origin of referees as this was not clear from the reference template; this was discussed by way of recommendation at verbal feedback. The inspector was however satisfied having cross-referenced with the employment history that references were in place from persons most recent employers.

The person in charge confirmed that the rota was planned and circulated in advance to each house; the rota identified staff on duty but also the availability of the person in charge and the manager on call. The rota was updated and re-issued as required and a visual staff rota was available to residents daily.

Based on these inspection findings the inspector was satisfied that the staffing arrangements met the needs of the residents. The person in charge confirmed that additional staffing resources were available as required in response to specific situations such as an exacerbation of behaviours that challenged. Residents attended daily structured day services Monday to Friday; resident choice and flexibility in their routines was augmented by the "cara" programme of volunteer staff. The person in charge said that further residents were currently being considered for participation in this programme; assessment ensured a suitable match between resident and cara was found. The area manager described the recruitment, vetting, training and supervision arrangements for volunteers and confirmed that their role and responsibilities were explicitly set out.

Night-time staffing was a sleepover arrangement and there was no evidence that this was not suited to the needs of the residents. There was a later start and finish sleepover time at weekends to facilitate a more relaxed routine for residents.

Relief staff were employed but the person in charge said that they worked only in the two local designated centres and were therefore familiar with the residents, their routines and required supports.

There was a centralised training department but the person in charge confirmed that she was responsible for maintaining oversight of staff attendance at training. Training records seen by the inspector indicated that all staff had attended required training in 2014 and 2015 including manual handling, the management of behaviours that challenged, and protection. Staff had also completed training on medication management, food hygiene/safety, report writing and personal planning with residents. One deficit was identified in staff attendance at fire safety training and this has been addressed in Outcome 7.

Staff described systems of staff supervision including monthly staff meetings, unannounced visits to each house and the invoking of disciplinary procedures if necessary. However, staff confirmed that there was no formal process for supervising staff.

The inspector's observations of care, practice and staff/resident interaction in both houses were positive. The feedback received from residents and family members was positive.

Judgment:
Substantially Compliant

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

Findings:

The inspector was satisfied that the records as 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 were in place and were maintained by staff in an a manner that ensured completeness, accuracy and ease of retrieval.

There was evidence with the application for registration that the provider was insured against accidents or incidents or injury to residents, staff and visitors.

The residents guide was available in a format that was accessible to residents as were other relevant documents and policies; residents showed the inspector their copy of the residents guide.

Judgment:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0005179
Date of Inspection:	23 September 2015
Date of response:	22 October 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Financial policy and procedure did not include the requirement for a counter signature including where possible and appropriate the resident's signature.

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

1. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

- A new process is in place in the Designated centre whereby the residents for whom it is meaningful, sign all withdrawal receipts from ATM.
- PIC will continue to review the residents ledgers and check receipt entries and cash balance is correct in line with the new policy.
- Discussed with Head of finance on the 19th October. Policy will be reviewed to include the signing of receipts by residents where it is meaningful for them to do so.

Proposed Timescale: 30/01/2016

Theme: Individualised Supports and Care

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

The complaints policy did not clearly differentiate between appeal and review. For example it was not clear from the policy who the person specified in Regulation 34 (3) (a) and (b) was and how and how often they would ensure that all complaints were appropriately managed and recorded.

2. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

- The complaints policy will be revised to clearly differentiate between appeal and review.
- The Area Manager will review complaints with the PIC as part of Supervision.
- The review of complaints will be conducted on an ongoing basis as part of the centres 6 month unannounced visit process.

Proposed Timescale: 31/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

One house required some redecoration and general maintenance and upkeep internally and externally.

The external storage area was in a poor condition of maintenance; it was not safely accessed and its roof was in a poor state of repair.

3. 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:

- PIC and Area manager have identified all work required. An engineer and quantity surveyor surveyed the house and grounds on the 16th October and are preparing a plan and the costing of same, which will be submitted to the Director Of Services. Some of this work will require planning permission.
- Submission for funding for this capital works will be submitted to the HSE as the Brothers of Charity Services Limerick does not have the resources to fund this work.
- Advice was sought on the external storage area. Following this advice the storage area will be demolished and replaced with a steel garden shed. This will be completed by the end of this year.

Proposed Timescale: 30/09/2016

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:

Neither house had emergency lighting. Neither house had an interlinked domestic type fire detection system with a control panel that provided coverage throughout most of the building.

Diagrammatic fire evacuation notices were displayed, however, the actions to be taken in the event of fire were not.

4. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- A specialist fire safety engineer has been engaged to audit the designated center and will report on and recommend the type of lighting and fire detection systems required.
- The diagrammatic fire action notices have been developed by the PIC and will be put into place following consultation with the fire safety engineer.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

One deficit was identified in staff attendance at fire training.

5. Action Required:

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

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

A specialist fire engineer has been consulted and will provide training for staff on dates to be arranged.

Proposed Timescale: 31/12/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Clarification and on the basis of this clarification retrospective notification to the Chief Inspector was required of the unplanned absence (s) of a resident from the designated centre.

6. Action Required:

Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

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

- The unexplained absence referred to in the report occurred in September 2013, prior to the requirement for notification.
- A report of the incident has been prepared and will be forwarded to the inspector for her records by the 27th October.

Proposed Timescale: 27/10/2015

Outcome 12. Medication Management

Theme: Health and Development

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

The policy and procedure on the administration of over the counter analgesics was ambiguous.

Medication policy and procedure required of staff that they check the accuracy of all medications supplied to the centre; staff spoken with confirmed that this included both quantity and content of the blister pack. Practice was somewhat ambiguous in terms of safety and accountability as staff who checked the accuracy on supply may not be the staff who administered the medication to the resident; some staff were reported to have concerns as to their role and responsibility in ascertaining the accuracy of supplied medications as this was reasonably not within the remit of their scope of knowledge and practice.

7. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

- The medication policy has been reviewed and the amended as per feedback from the HIQA inspection. The amended policy will be taken to policy review committee on the 29th October.
- An assessment tool for self administration of medication is currently being developed within the organisation.

Proposed Timescale: 30/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was no formal process for supervising staff.

8. 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:

Support and Supervision is being reviewed at Senior Management Team level in the context of:-

- Culture of the organisation

- Understanding structures within the Services that are effective. The learning from understanding these structure can be shared across the organisation.
 - Recognising underlying management issues in the area of supervision and identifying the training that is required to support managers in addressing these underlying issues as part of the management role.
- From this review a process of formal supervision will be introduced across the organisation

Proposed Timescale: 31/01/2016