

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Kingfisher 4
Centre ID:	OSV-0004119
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 28 March 2017 08:15 To: 28 March 2017 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 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

Background to the Inspection:

This inspection was the third inspection of the centre by The Health Information and Quality Authority (HIQA); the last inspection was undertaken in October 2015. This current inspection was undertaken to follow-up on the actions that had emanated from that inspection and to monitor on-going regulatory compliance so as to inform a registration decision.

The inspection was facilitated by the person in charge and the area manager who was the person participating in the management of the centre (PPIM); inspectors also met with the frontline staff on duty; the head of community residential services attended verbal feedback at the conclusion of the inspection.

How we gathered our evidence:

Prior to the inspection inspectors reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the

application for registration of the centre, the previous inspection findings and action plan and notice received of any incidents that had occurred in the centre. In the centre inspectors reviewed records including policies and procedures, fire and health and safety related records, and records pertaining to staff and residents.

Inspectors met with all of the residents availing of respite (four residents) in the centre at the time of this inspection. This engagement was guided by each resident and their choices and needs; some residents conversed freely with the inspectors while others indicated their comfort and general demeanour through gesture and facial expression. Residents welcomed inspectors, spoke of their plans for the day in their respective day service, how they liked to spend their time when on respite, their general interests such as sport, how they liked the house and the staff.

The inspector observed that residents and staff mixed easily with each other; the person in charge was seen to be accessible to and known to residents.

Description of the service:

Respite services were provided to approximately 26 residents in a domestic style premises located in an estate of houses within a short commute of the city centre.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. While some amendment was required to satisfy regulatory requirements, inspectors found that the service to be provided was as described in that document.

Overall Findings:

There was evidence of improvement on the previous inspection findings but at times the action taken was not sufficient to achieve full compliance and some actions were reissued, for example in relation to residents personal plans and healthcare support plans.

The provider had taken action to consolidate the governance structure. There was a clear management structure; the person in charge was now responsible only for this designated centre, was based in the house and was visible and accessible to residents, staff and families.

There was evidence of improved systems that supported safe medicines management.

Residents spoke positively of staff and the inspector's observations of staff and resident interactions were positive.

However, the provider had not completed any of the fire safety improvement works identified as required by a fire safety review carried out on behalf of the provider in January 2016. This failure was judged to be at a level of major non-compliance and an immediate action plan was issued in relation to one specific aspect of fire safety management; the failure of the provider to complete works necessary to ensure that there was an effective fire barrier between the designated centre and the attached private dwelling. The fire safety review had concluded that in the event of fire in

either house that smoke and toxic fumes could spread freely between the two attic spaces. The risk was compounded by other failings in fire safety measures including the absence of emergency lighting and fire detection systems that were not of the required specification. The initial response from the provider to the immediate action plan was rejected by HIQA as the provider did not identify what action it had taken or was going to take to address the identified failing. In line with HIQA internal processes the provider was afforded a second opportunity to submit a satisfactory response. The second response was also rejected at which juncture the provider was requested by HIQA to submit assurance from a competent person that the premises was safe for occupation by both residents and staff. Further engagement was required of HIQA and the requested assurance in the format required was received on 13 April 2017. HIQA was assured that in the short-term, the premises could not be regarded as an unsafe place for residents to live. It was however reiterated to the provider that this HIQA inspection had identified deficits in referenced fire safety measures core to the safety of residents and staff.

Based on these inspection findings and the providers response to the immediate action plan the evidence was that the centre was not adequately resourced to ensure the consistent delivery of safe quality supports and services to residents.

Additional failings were identified in the recording of the management of complaints, the planning of supports based on assessed needs including healthcare needs and the recording of the progression of personal goals and or priorities.

Of the 13 Outcomes inspected the provider was judged to be compliant in two, in substantial compliance with three and in moderate non-compliance with five. The provider was judged to be in major non-compliance with three Outcomes; Health and Safety and Risk Management, Governance and Management and Use of Resources. The findings to support these judgements are discussed in the main body of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

A new system of recording financial transactions had been introduced and complaints were being reviewed in a timelier manner. However, while reviewing the complaints log it was noted that the action taken in response to two complaints was not always provided for.

At the previous inspection it was found that no financial records were maintained in the centre to ensure accountability, transparency and safeguarding where staff assisted residents in managing their finances. During this inspection it was found that a specific procedure around the assistance provided to residents in managing their finances had been introduced. This new procedure included the introduction of individual ledgers for such residents.

These ledgers were used to record any money received and returned to residents along with purchases made by residents during their respite stay. All receipts of transactions were signed by one staff member and subject to review by the person in charge. Inspectors reviewed a sample of these ledgers and the associated receipts and found that the transactions and balances recorded in the ledgers corresponded with the receipts. One slight discrepancy between one ledger entry and a receipt was noted which was brought to the attention of the person in charge, who undertook to address it.

The complaints log was reviewed by inspectors and it was found that issues raised were being reviewed by the person in charge in a timely manner. However for one complaint, only the nature of the complaint was recorded and it was not clear what action has been

taken on foot of this. In another complaint it was noted that specific action had been recommended to address the matter complained of by the member of staff in receipt of the complaint. While the person in charge had reviewed the complaint it was not clear from the complaint record if the recommended action was being followed through on. Both of these complaints were discussed with the person in charge who informed inspectors that action not reflected in the records had been taken or was being considered.

While reviewing the complaints log it was noted that one recorded complaint was of a safeguarding nature but had only been managed as a complaint and did not sufficiently demonstrate how it had addressed the alleged safeguarding component. This is discussed further under Outcome 8.

This outcome was not inspected in full as inspectors followed up on the actions from the last inspection. It was observed however by inspectors that staff members interacted with residents in a positive and empathetic manner during the course of inspection.

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):

No actions were required from the previous inspection.

Findings:

Given the number of residents that availed of the service, residents presented with a broad range of communication abilities and needs. From the personal plans reviewed inspectors saw that resident's individual communication strengths and any strategies required to support effective communication were clearly outlined. Some residents had detailed communication passports and dictionaries that explained the communication significance of words, gestures and actions. The person in charge confirmed that staff had completed Irish Sign Language training as this was one resident's first language. Residents had also been assessed for and provided with assistive technology to alert them to emergency situations such as fire.

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):

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

Findings:

At the previous inspection it was found that the contracts for the provision of the services were generic in nature and did not reflect that the designated centre provided a respite service. Inspectors reviewed a sample of contracts during this inspection and found the contracts had been amended to reflect that the centre provided a respite service. The contracts reviewed were also noted to have been signed by the residents and or their representatives. The person in charge informed inspectors that the contracts had recently been reissued to provide a more accurate reflection of the fees to be charged.

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:

Based on the findings of the last inspection the person in charge had created a respite specific personal plan for each resident attending the service; inspectors reviewed a sample of these personal plans.

The plans were based on an assessment of each resident's needs generally completed by the person in charge and informed by consultation with the resident, their family, other stakeholders such as the day service and the person in charge's attendance at personal plan and multidisciplinary (MDT) reviews.

However, one complete assessment that comprehensively addressed residents' needs was not always in place and inconsistency was noted across assessments; for example inspectors noted needs identified in a communication passport that were not evident from the assessment tool.

Some plans of support did not clearly describe the supports required to maintain the resident's safety and wellbeing. A plan of support was not in place for each identified need, though there was evidence of supports in practice; for example aids to support mobility and the provision of modified diets.

The plans were signed as reviewed and updated at regular intervals; there was evidence that the resident, their needs and their supports were the subject of review by the MDT at regular intervals. The person in charge said that any changes to the plans were discussed at staff meetings.

A respite specific process for the progression of resident's personal priorities and goals had been implemented; priorities were identified by the resident themselves and or their family and pertained to the time spent in respite. There was evidence from other sources such as photographs that goals were achieved in 2016, for example, a holiday enjoyed by a group of residents supported by staff. However, timescales, responsible persons, actions taken to progress priorities or obstacles to their achievement were not clearly identified and recorded.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

None of the recommendations arising out of a fire safety audit carried out a year prior to this inspection on behalf of the provider had been acted upon; this failure resulted in the issuing by HIQA of an immediate action plan.

The fire safety audit carried out by an external fire consultant in January 2016 (the report of same issued in February 2016) recommended remedial works to enhance fire safety systems and address fire containment defects in the centre. These works included upgrading the fire detection system, installing emergency lighting in the centre, improving mobility egress at one of the designated fire exits and improvements to the fabric of the building so as to ensure adequate fire containment provisions within the centre; this latter recommendation included work required to provide an effective fire barrier in the attic area.

This deficit raised a particular concern to inspectors as the designated centre was adjoined to a private residence and the fire safety report clearly stated that in the event of fire in either property, smoke and toxic fumes could spread freely between the two attic spaces. The provider was issued with an immediate action plan to ensure the maintenance of the building fabric so that there was an effective fire barrier to contain fire, smoke and toxic fumes thereby promoting and protecting the safety of residents, staff and other persons in the event of fire in either property.

This risk in the event of fire in either property was compounded by the failings in other fire safety management systems. For example, the fire detection system was not of the recommended specification and comprised of one wired detector and some battery operated detectors. This system had received quarterly maintenance checks by an external company but inspectors did not find any record of such a check between August 2016 and February 2017. Inspectors were told that there was a smoke detector in the attic area but this had not been checked for at least a year. Fire extinguishers were present in the centre and it was noted that these had not received a maintenance check since February 2016.

The centre was not equipped with emergency lighting.

Fire drills were being carried out at regular intervals at varying times of the day with records maintained of these indicating low evacuation times. The evacuation procedure was on display on both floors of the designated centre. All service users who availed of respite in the centre had a personal emergency evacuation plan (PEEP) in place, all of which has signed as having been updated within the past 12 months. However, when reviewing the personal plan of one resident, a risk assessment contained within this made reference to a specific method of evacuation for the resident but there was no mention of this in the resident's PEEP.

While the centre was not open on a continuous basis, internal staff checks on matters relating to fire safety were being carried in an inconsistent manner. For example, a daily visual inspection of fire exits was recorded as being carried out four times in January 2017, nine times in February 2017 and five times in March 2017. It was also noted on a review of training records that one staff member had not undergone fire safety training.

In the context of the collective fire safety deficits and failings, the provider did not submit a satisfactory response to the immediate action plan despite being afforded two opportunities to do so. HIQA required assurance that the premises was safe for occupation for both residents and staff and following further engagement this assurance from a competent person was provided. However, it was reiterated to the provider that

this HIQA inspection had identified failings in the measures cited as core to this fire safety assurance.

Since the previous inspection the risk register had been reviewed to include resident specific risks while risks specific to the centre as a whole were also present. A sample of risk assessments was reviewed and it was noted that these had been recently updated. However, while reviewing personal plans inspectors noted that there was some inconsistency between the register of risks and the personal plans, for example, it was noted that a resident was identified as being at a risk of choking and while the plan identified risk management interventions, there was no risk assessment in place.

In addition while reviewing records of accidents and incidents in the designated centre the person in charge informed inspectors that such adverse events were not subject to monitoring or audit but were reviewed on an individual basis. This did not provide assurance that systems were in place for the ongoing review and learning from incidents; this is also reflected in the failings identified in Outcome 1 and 8 in relation to complaints and safeguarding.

Inspectors were informed at the outset of the inspection that the centre was transitioning to a new electronic system for the recording of accidents and incidents.

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):

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

Findings:

There were measures in place for protecting residents for being harmed or abused; these measures included policies and procedures that were referenced to national policy, staffing training, a designated person and support from the social work department if and when required.

Training records indicated that all staff had received safeguarding training though one

staff was due refresher training as per the provider's own timelines. Staff spoken with confirmed attendance at training and had knowledge of their reporting responsibilities and the provider's reporting procedure.

Inspectors saw plans that provided guidance for staff on supporting residents in the provision of personal care.

However, records seen (complaint records and incident records) referenced events that had possible welfare and or safeguarding themes; these events included a bruise noted by staff and complaints made by a resident as to how they perceived they had been treated by peers and spoken to by a staff. These records while reflecting the actions that were taken, did not demonstrate the robustness required to demonstrate assurance that there was no safeguarding concern at the core of these events.

Records seen indicated and the person in charge confirmed that some residents did present with behaviours that required strategies for their prevention and management. Communication plans seen referenced the role of behaviours as a means of communication. Inspectors saw that the person in charge was in receipt of current behaviour management guidelines that were applicable to respite and informed by input from the psychologist.

Training records indicated that all staff working or who may be required to work in the centre had received training in the management of behaviour that was of concern or risk to the resident, themselves or others.

There were no identified restrictive practices in use in the centre; there was a policy on the use of restrictive practices dated as reviewed in February 2017 and referenced to the literature and national guidance.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

Inspectors reviewed the records of accidents and incidents maintained in the centre; the records seen reflected the notifications received by HIQA. However, as discussed under

Outcomes 1 and 8, there had been a complaint made which alleged a breach in the expected standard of support by a staff. This had not been notified to the Chief Inspector as required.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Residents were ordinarily resident in the community. The person in charge said that residents did not attend respite if unwell but if they became unwell on respite, family were contacted and the required support was made available; this would concur with records seen by inspectors.

Based on the records seen, some residents did access the provider's multidisciplinary team (MDT) and records of the MDT reviews were in place. In general, the records seen demonstrated that families, day service and respite staff collectively inputted into the maintenance of resident health and wellbeing; oversight was monitored at MDT.

Staff did collate information on resident's general health and wellbeing; there was a process within the support plan for specifically identifying and planning for healthcare requirements. Based on the support plans seen, residents did have specific identified health care needs including mobility, falls prevention, seizure activity, a requirement for modified diet and the management of diabetes. The person in charge had a good knowledge of these requirements and there was evidence of interventions such as the provision of aids to support independence and mobility, and supervision at mealtimes.

However, healthcare plans to support and guide care while on respite were not in place for all identified needs such as osteoporosis, dementia and diabetes. It was also of concern given the action that emanated at the time of the last inspection, that risk assessments seen indicated that seizure management plans had contained insufficient detail to guide care when residents had experienced seizure activity while on respite; it was assessed that this deficiency may have led to "poor or insufficient care". Inspectors saw that seizure activity management plans were in place but still lacked the specificity required to guide care including clear guidance for staff as to when to administer the prescribed rescue medicine. Based on records seen, clarity was required as to how a

cluster of seizures was defined.

MDT minutes seen indicated that one resident was awaiting review by both speech and language and a dietician since at least March 2016.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Improvement was noted in policies and procedures that supported the safety of medicines management.

The inspectors saw that the medicines management policy had been reviewed and amended to include a clear procedure on the management of medicines in respite services; staff spoken with described practice that reflected this procedure.

The person in charge said that she had further meetings with families to explain the requirement to provide on admission to the centre, medicines supplied by their pharmacist either in a compliance aid or in the original container with the pharmacy label affixed. The inspector saw that medicines in stock at the time of inspection satisfied these criteria and were securely stored. Staff maintained a checklist of all medicines received. Staff confirmed that they only accepted medicines supplied by a pharmacist.

An audit of medicines management had been completed by the area manager in July 2016. Overall, good compliance was evidenced but where two anomalies were noted it was not clear if action was necessary or not and if so whose responsibility it was. This was highlighted by way of recommendation at verbal feedback.

Residents who managed their own medicines, were supported to continue to do so while availing of respite in the centre. Policies and procedure to support this were implemented in December 2016. However, procedure required review as records seen in individual plans indicated how capacity was assessed but did not clearly demonstrate the assessment of risk as required by Regulation 29(5). There was a tool in the procedure that could be implemented to satisfy this component.

All staff who worked on a regular basis in the centre had completed medicines management training; there were gaps in training for relief staff and this is addressed in Outcome 17.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors were informed at the outset of this inspection that the statement of purpose was in the process of being updated. The most recent version of the document was reviewed and it was noted that while most of the required information was present, some of this required more detailed. For example, the criteria for admissions, the procedures around emergency admissions, the complaints arrangements, room sizes and the whole time equivalents of the staffing complement required further clarity. These were highlighted to the person in charge.

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):

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

Findings:

There was evidence of action taken by the provider, as committed to in the response to the previous action plan, to support the effective governance of the centre. However, it was of concern to HIQA, that three actions were required of HIQA to gain the required fire safety assurance; and that deficits were identified in the fire safety measures core to the provided assurance.

The person in charge previously had responsibility for two designated centres but was now responsible solely for this designated centre. The person in charge was also now based in the centre and worked shifts that corresponded to times when both staff and residents were present in the centre; this included mornings, evenings and weekends. This facilitated the person in charge to have direct contact with both residents and staff and to supervise the care and support provided. Staff spoken with confirmed this and inspectors saw that the person in charge was clearly known to residents.

The person in charge had established experience within the organisation in the provision of supports and services to residents; she was suitably qualified and had completed further postgraduate education to masters level; the person in charge continued to engage in the provider's education and training programme.

The person in charge was supported in her role by the area manager who was one of the persons participating in the management of the centre (PPIM). The area manager told the inspector that his role had also changed and that he now worked in a manner that was less office based and that he started each working day in one of the designated centres under his remit. The area manager said that this allowed him to have greater oversight of the services and input into their operational management. The person in charge confirmed this and said that there was clarity on roles and responsibilities, accessibility and support. The person in charge and the area manager met at least twice a week; one of these was a formal weekly meeting.

The provider operated an out-of-hours on call system. The person in charge participated in the on-call rota but said that on-call was now structured and supported so that it did not impact on the substantive role and responsibilities of person in charge.

The person in charge completed formal supervisions with all staff on a quarterly basis and said that no issue other than the outstanding training had emerged from this process. The person in charge had formal supervision with the area manager.

The annual review as required by Regulation 23 (1) (d) and the unannounced visits as required by Regulation 23 (2) had both been undertaken on behalf of the provider and reports were available for the purpose of this inspection. The annual review included consultation with and incorporated feedback received from residents and their families. This internal process of review incorporated the monitoring of the implementation of HIQA action plans and the actions that emanated from the providers own reviews.

There was evidence of completed actions, however, some findings from the December

2016 unannounced provider review were not resolved and were still evidenced on this HIQA inspection, for example, there was still one staff without medicines management training, the progression of residents personal goals was poorly recorded and the PEEP for one resident had not been updated following a manual handling review.

Judgment:

Non Compliant - Major

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):

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

Findings:

The person in charge said that some residents still found it difficult to access the transport provided but staff had discretion to source other means of more suitable transport as required by individual residents; staff spoken with confirmed this.

However, there were further evidence that the centre was not always adequately resourced to ensure the effective and consistent delivery of care and supports. When planning respite, the person in charge did endeavour to meet both residents and family requirements, however, the provider had on three occasions in 2016 cancelled planned weekend respite; the reason cited was "no staff". The person in charge confirmed this and it was also evidenced in complaints received from families affected.

Records seen (the records of unannounced provider reviews) stated that fire safety upgrading works had not been completed as "additional funding" was required; this additional funding was stated to not be available to the provider.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

The person in charge and the area manager described the controls in place to ensure that the staffing levels and arrangements were adequate to meet the needs of the residents in a safe and effective manner. There was ordinarily one social care staff on duty at any time in the house; this included a sleepover staffing arrangement.

The controls described included the presence on site of the person in charge; the person in charge worked a seven day rota and was present in the house at times when residents and staff were in the house; the reduction in the maximum number of residents to be accommodated from five to four; the planning of respite so that residents needs were matched; occupancy fluctuated from one resident to four residents and averaged three residents based on records seen.

Staff spoken with said that they were satisfied that they could meet residents needs adequately both in the house and socially; staff said that would bring any staffing concerns or reservations to the attention of the person in charge. During the inspection, inspectors noted that staff encouraged residents to be independent; for example in making refreshments for themselves. This inspection was unannounced; the house was visibly clean; homely but tidy and organised.

Recruitment of staff was centralised; staff files are not held locally and were not reviewed on this inspection. Staff files have been reviewed previously and regularly on inspection and have been found to be well presented and compliant with the requirements of Schedule 2 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 as there were two regular social care staff allocated to the centre, there was limited requirement for relief staff; no agency staff were utilised. Relief staff were reported to be from the provider's own pool of relief staff and worked in a prescribed group of centres; there were three regular relief staff so that consistency for residents was maximised.

The training records for all staff who worked in the centre were available for inspection. Based on the review of these records and discussion with staff and the person in charge, one staff required fire safety training; one staff required general medicines management training; one staff required refresher training in safeguarding; one staff required training in the administration of rescue medicines.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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-0004119
Date of Inspection:	28 March 2017
Date of response:	03 May 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

In the record of complaints it was not always recorded what action was taken in response to the complaints made.

1. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person

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

maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

- The Complaints Procedure will be reviewed with staff in the designated centre to ensure understanding of staffs' role in recording issues raised and the resolution of same.
- Person in Charge will continue to respond to all complaints in line with the procedure.
- Where appropriate the person in charge will staple supplementary documentation to each complaint logged which will evidence all of the steps completed to respond appropriately to each complaint.
- Complaints will be reviewed as part of the oversight process by the Area Manager during visits to the designated centre.

Proposed Timescale: Completed

Proposed Timescale: 03/05/2017

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:

Timescales, responsible persons, actions taken to progress priorities or obstacles to their achievement were not clearly identified and recorded.

2. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

The person centred plan is specific to respite and the paper work in the person's folder reflects their own unique priorities.

The person in charge has consulted with both the individual and their families where necessary in agreeing 2017 priorities and goals.

The PCP process will run per calendar year.

Where a goal is proposed the rationale for same, timescale and person responsibility will be identified.

In 2017 each PCP will be reviewed every quarter by the Person in Charge and will outline the status of each goal achieved.

Area Manager will review this process as part of ongoing oversight and supervision.

Proposed Timescale: 31/12/2017

Theme: Effective Services

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

One complete assessment that comprehensively addressed residents' needs was not always in place and inconsistency was noted across assessments.

3. Action Required:

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

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

All current health care needs will be reviewed through a full file review of each person who attends respite.

This will be carried out between the Area Manager and the Person in Charge by 30th June 2017.

Where current care plans require updating this will be completed as part of this process.

Relevant clinical input will be sought where required.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

Some plans of support did not clearly describe the supports required; a plan of support was not in place for each identified need including healthcare needs.

4. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

The osteoporosis care plan mentioned in the plan is now in place after being completed by the person in charge in consultation with a nurse within the organisation.

The diabetes care plan referenced at the feedback session is now in place after being completed by the PIC in consultation with the day service and the GP.

All current health care needs will be reviewed through a full file review of each person who attends respite.

This will be carried out between the Area Manager and the Person in Charge by 30th June 2017.

Where current care plans require updating this will be completed as part of this process.

Relevant clinical input will be sought where required.
Where new admissions are accepted to this respite service the area manager and person in charge will discuss future care plans. Where medical expertise is warranted then the care plan will be written under medical advice. Families and the person using the service will also be consulted where necessary.

Proposed Timescale: 30/06/2017

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:

Inspectors were informed that accidents and incidents were not subject to monitoring or audit but were reviewed only on an individual basis.

5. Action Required:

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

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

Incident and/or accident reports are now computerised in the designated centre.

The Person in Charge is currently uploading all incident and/or accident reports in the centre onto the computerized system. This system requires sign off by the Person in Charge of each accident and incident.

The Person in Charge and Area Manager will review all incident and/or accident reports in a timely manner with a view to identifying trends and managing risks. MDT will be consulted as appropriate.

The Person in Charge will continue to bring incident and/or accidents up at monthly staff meetings so that learning can be shared among the team.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

Inconsistencies were noted between the register of risks and residents' personal plans.

6. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

All plans will be reviewed with the Area Manager and the Person in Charge to rectify any inconsistencies in the files.

This review will set out a time scale and schedule of works on how to address and rectify this issue.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

Failed to ensure the safety of residents, staff and other persons in the event of fire in either house by failing to undertake the works identified to them in February 2016 as required to provide an effective fire barrier between the designated centre/place of work and the adjoining house.

7. Action Required:

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

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

HIQA did not agree elements of this action plan response with the provider despite affording the provider two opportunities to submit an acceptable action plan response. However, in the interests of transparency the response received from the provider is published as follows;

- Following feedback from the Inspector following the unannounced inspection the Provider Nominee engaged immediately with the Fire Safety Engineer who prepared the Fire Safety report on this designated centre with regard to the issue of compartmentalisation between the house and the neighbouring house.

- The Fire Safety Engineer advised the following in relation to the concerns articulated by the Inspector at the feedback session and the subsequent immediate action issued:-

In terms of fire safety of occupants, a number of issues were highlighted in the Fire Safety report of the designated centre. The building currently lacks:

A suitable fire alarm system

A suitable emergency lighting system

Suitable fire doorsets

Suitable structural fire separation, both within the building itself and from the adjoining property.

In general terms, a suitable and effective automatic fire alarm system, in conjunction with a suitable and effective emergency lighting system, would be deemed to be the most crucial items in any particular dwelling. This is so, on the basis that, should a fire occur (from any source) evacuation is the priority and with these measures in place, the residents and care staff would have the earliest possible warning of same and thus

have the maximum time available, in which to effect escape.

To achieve full compliance with Fire Regulations all of the above measures should be installed within the building and this could be achieved by putting in place a contract for upgrade works. Any upgrade should also include for Disability Access features.

Such a contract for these upgrade works would require a full design, complete with detail drawings and specification documentation. This would then form the basis to seek competitive tenders, from suitably qualified contractors and allow the works be carried out and managed, to a defined standard and to a defined schedule. This methodology ensures a regulatory compliant and a value for money, end product.

If funding approval was granted from the HSE, the estimate of time involved from nomination of a design consultant, to completion of the works, would take approximately 15 weeks before residents could return to the premises.

- Fire Safety Strategy was developed by the BOCSI Limerick Region in 2016 that identified the requirement for extensive investment in upgrade of properties (including this Designated Centre) in respect of Fire Safety.
- Fire Safety Strategy was completed by a qualified Fire Safety Engineer.
- Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million.
- The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy
- Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings.
- Fire Safety risk is included as part of the Service Arrangement contract with the HSE signed and returned by the BOCSI Limerick Region in February 2017.
- No funding from the HSE has been allocated to fund this fire safety strategy to date.
- A copy of the Fire Safety Strategy was submitted to HIQA during 2016.
- The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment.
- The Provider Nominee has reengaged with the HSE with regard to funding and submitted the supporting costings.
- The Provider Nominee cannot act unless funding is allocated by the HSE (Funder) for this necessary upgrade work in respect of Fire Safety.
- A comprehensive programme of fire safety measures are in place in the designated

centre and these will continue to be implemented as mitigations to the fire safety risk. This list of measures has been forwarded to HIQA as part of the immediate action plan response. Additional measures were introduced following the inspection.

•It is the view of the Fire Safety Engineer that given the design and construction of the house, the comprehensive nature of these fire safety measures and their continued implementation, that this house, while it is not compliant with current regulations, could not be regarded in the short term, as an unsafe place for the residents to live, pending the installation of the required fire safety upgrading works, as set out in the report on the building.

HIQA did not accepted the qualified timescale provided by the provider.

Proposed Timescale: Complete (actions which can be progressed within available resources)

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

One staff member had not received fire safety training.

8. 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:

The staff member in question completed fire safety training on 26.04.17. This training is completed by the office of a fire engineer.

Proposed Timescale: Completed

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

The PEEP of one resident had not been updated to reflect a specific evacuation technique.

9. 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:

- The Person Emergency Evacuation Procedure (PEEP) identified by the Inspector has been updated.
- PEEP forms are kept current by staff. This will continue to be monitored by the Person in Charge.
- The Area Manager will also review as part of his ongoing oversight and management of the centre.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

The fire alarm system and containment provisions in the centre were not adequate.

10. Action Required:

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

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

HIQA did not agree elements of this action plan response with the provider despite affording the provider two opportunities to submit an acceptable action plan response. However, in the interests of transparency the response received from the provider is published as follows;

- Following feedback from the Inspector following the unannounced inspection the provider nominee engaged immediately with the Fire Safety Engineer who prepared the Fire Safety report on this designated centre with regard to the issue of compartmentalisation. The Fire Safety Engineer advised the following in relation to the concerns articulated by the Inspector at the feedback session and the subsequent immediate action issued:-
 - o In terms of fire safety of occupants, a number of issues were highlighted in the report. The building currently lacks:
 - A suitable fire alarm system
 - A suitable emergency lighting system
 - Suitable fire doorsets
 - Suitable structural fire separation, both within the building itself and from the adjoining property.
 - o In general terms, a suitable and effective automatic fire alarm system, in conjunction with a suitable and effective emergency lighting system, would be deemed to be the most crucial items in any particular dwelling. This is so, on the basis that, should a fire occur (from any source) evacuation is the priority and with these measures in place, the residents and care staff would have the earliest possible warning of same and thus

have the maximum time available, in which to effect escape.

o To achieve full compliance with Fire Regulations all of the above measures should be installed within the building and this could be achieved by putting in place a contract for upgrade works. Any upgrade should also include for Disability Access features.

o Such a contract for these upgrade works would require a full design, complete with detail drawings and specification documentation. This would then form the basis to seek competitive tenders, from suitably qualified contractors and allow the works be carried out and managed, to a defined standard and to a defined schedule. This methodology ensures a regulatory compliant and a value for money, end product.

o If funding approval was granted from the HSE, the estimate of time involved from nomination of a design consultant, to completion of the works, would take approximately 15 weeks before residents could return to the premises.

- Fire Safety Strategy was developed by the BOCSI Limerick Region in 2016 that identified the requirement for extensive investment in upgrade of properties (including Designated Centres) in respect of Fire Safety.

- Fire Safety Strategy was completed by a qualified Fire Safety Engineer.

- Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million.

- The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy

- Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings.

- Fire Safety risk is included as part of the Service Arrangement contract with the HSE signed and returned by the BOCSI Limerick Region in February 2017.

- No funding from the HSE has been allocated to fund this fire safety strategy to date.

- A copy of the Fire Safety Strategy was submitted to HIQA during 2016.

- The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment.

- The Provider Nominee has reengaged with the HSE with regard to funding and submitted the supporting costings.

- The Provider Nominee cannot act unless funding is allocated by the HSE (Funder) for this necessary upgrade work in respect of Fire Safety.

- A comprehensive programme of fire safety measures are in place in the designated centre and these will continue to be implemented as mitigations to the fire safety risk.

This list of measures has been forwarded to HIQA as part of the immediate action plan response.

- Following feedback from the Inspector following the unannounced inspection the provider nominee engaged immediately with the Fire Safety Engineer who prepared the Fire Safety report on this designated centre with regard to the issue of compartmentalisation. The Fire Safety Engineer advised the following in relation to the concerns articulated by the Inspector at the feedback session and the subsequent immediate action issued:-

o In terms of fire safety of occupants, a number of issues were highlighted in the report. The building currently lacks:

- A suitable fire alarm system

- A suitable emergency lighting system

- Suitable fire doorsets

- Suitable structural fire separation, both within the building itself and from the

adjoining property.

o In general terms, a suitable and effective automatic fire alarm system, in conjunction with a suitable and effective emergency lighting system, would be deemed to be the most crucial items in any particular dwelling. This is so, on the basis that, should a fire occur (from any source) evacuation is the priority and with these measures in place, the residents and care staff would have the earliest possible warning of same and thus have the maximum time available, in which to effect escape.

o To achieve full compliance with Fire Regulations all of the above measures should be installed within the building and this could be achieved by putting in place a contract for upgrade works. Any upgrade should also include for Disability Access features.

o Such a contract for these upgrade works would require a full design, complete with detail drawings and specification documentation. This would then form the basis to seek competitive tenders, from suitably qualified contractors and allow the works be carried out and managed, to a defined standard and to a defined schedule. This methodology ensures a regulatory compliant and a value for money, end product.

o If funding approval was granted from the HSE, the estimate of time involved from nomination of a design consultant, to completion of the works, would take approximately 15 weeks before residents could return to the premises.

- Fire Safety Strategy was developed by the BOCSI Limerick Region in 2016 that identified the requirement for extensive investment in upgrade of properties (including Designated Centres) in respect of Fire Safety.
- Fire Safety Strategy was completed by a qualified Fire Safety Engineer.
- Fire Safety Strategy was submitted to the HSE during 2016 for their review and for funding. The estimates of the cost of implementing the recommendations are in the region of €2.3 million.
- The Brothers of Charity Services Ireland Limerick Region does not have the resources to fund the requirements of this fire safety strategy
- Fire Safety Strategy is discussed with the HSE as part of ongoing Service Arrangement meetings.
- Fire Safety risk is included as part of the Service Arrangement contract with the HSE signed and returned by the BOCSI Limerick Region in February 2017.
- No funding from the HSE has been allocated to fund this fire safety strategy to date.
- A copy of the Fire Safety Strategy was submitted to HIQA during 2016 following a request to review the document.
- The Brothers of Charity Service Ireland Limerick Region will continue to seek funding from the HSE for this important area of investment.
- The Provider Nominee has reengaged with the HSE with regard to funding and submitted the supporting costings.
- The Provider Nominee cannot act unless funding is allocated by the HSE (Funder) for this necessary upgrade work in respect of Fire Safety.
- A comprehensive programme of fire safety measures are in place in the designated centre and these will continue to be implemented as mitigations to the fire safety risk. This list of measures has been forwarded to HIQA as part of the immediate action plan response.
- It is the view of the Fire Safety Engineer that given the design and construction of the house, the comprehensive nature of these fire safety measures and their continued implementation, that this house, while it is not compliant with current regulations, could not be regarded in the short term, as an unsafe place for the residents to live, pending the installation of the required fire safety upgrading works, as set out in the report on

the building.

HIQA did not accept the qualified timescale provided by the provider.

Proposed Timescale: Complete (actions which can be progressed within available resources)

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

Emergency lighting had not been installed in the centre while a recommendation to improve mobility egress at one of the designated fire exits had not been actioned.

11. Action Required:

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

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

HIQA did not agree elements of this action plan response with the provider despite affording the provider two opportunities to submit an acceptable action plan response. However, in the interests of transparency the response received from the provider is published as follows;

- The installation of Emergency lighting in the designated centre is identified in the Fire Safety Strategy submitted to the HSE.
- Recommendations from the Fire Safety report will be implemented in full once funding is secured from the HSE.
- The Brothers of Charity Services Ireland Limerick Region does not have the capital funding to implement the recommendations of the Fire Safety engineer.
- A comprehensive programme of fire safety measures are in place in the designated centre and these will continue to be implemented as mitigations to the fire safety risk. A number of these measures have been implemented since the inspection.
- This list of measures has been forwarded to HIQA as part of the immediate action plan response.
- It is the view of the Fire Safety Engineer that given the design and construction of the house, the comprehensive nature of these fire safety measures and their continued implementation, that this house, while it is not compliant with current regulations, could not be regarded in the short term, as an unsafe place for the residents to live, pending the installation of the required fire safety upgrading works, as set out in the report on

the building.

HIQA did not accept the qualified timescale provided by the provider.

Proposed Timescale: Complete (actions which can be progressed within available resources)

Proposed Timescale: 03/05/2017

Theme: Effective Services

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

Internal staff checks were not being carried out on a regular basis.

12. 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:

- Staff in the house have a daily visual inspection of fire exits and complete a tick box to state the time that the exit has been checked and sign same. This has been in place since April 1st following the HIQA inspection.
- Staff also complete a weekly fire alarm check. This involves the staff setting the fire alarm off weekly. This is signed and dated by staff. This is in place since 31.03.17 following the recent HIQA inspection.
- The Person in Charge and Area Manager will monitor all fire safety records above.

Proposed Timescale: Completed

Proposed Timescale: 03/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Records seen (complaint records and incident records) referenced events that had possible welfare and or safeguarding themes. These records did not demonstrate the robustness required to demonstrate assurance that there was no safeguarding concern at the core of these events.

13. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

- In the situation referenced a notification was not sent to HIQA. Having reviewed the documentation and having consulted the designated officer the organisation is satisfied with the approach taken by the Person in Charge in following up on an incident and complaint (in issues raised book).
- The incident was recorded in a transparent manner both in the Issues raised book and also in the Incident form.
- Supplementary documentation relating to complaints will be stapled to complaints in future in order to be clearer on the action taken.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

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:

An allegation of a safeguarding nature had not been notified as required.

14. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

- In the situation referenced a notification was not sent to HIQA. Having reviewed the documentation and having consulted the designated officer the organisation is satisfied with the approach taken by the Person in Charge in following up on an incident and complaint (in issues raised book).
- The incident was recorded in a transparent manner both in the Issues raised book and also in the Incident for.
- Supplementary documentation relating to complaints will be stapled to complaints in future in order to be clearer on the action taken.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

in the following respect:

MDT minutes seen indicated that one resident was awaiting review by both speech and language and a dietician since at least March 2016.

15. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

- Residents who live in the community, which includes people accessing respite, are eligible to access SLT and Dietician services through Primary Care.
- The person in question has been referred to SLT on the Primary Care Team and no response has been received to date.
- As part of the Service Arrangement engagement with HSE the Provider Nominee has raised the absence of SLT service from Primary Care to people with intellectual disability accessing the BOCSI Limerick Region.
- Currently all referrals from the BOCSI Limerick Region are on hold.
- Resident who has already been referred to dietician and whose referral was acknowledged by the HSE will be followed up with by the Person in Charge.

Proposed Timescale: 30/05/2017

Theme: Health and Development

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

Seizure activity management plans were in place but still lacked the specificity required to guide care including clear guidance for staff as to when to administer the prescribed rescue medicine. Based on records seen, clarity was required as to how a cluster of seizures was defined.

16. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

Where individuals who access the respite service have a seizure activity management plan these will be reviewed with the GP around defining cluster of seizures. This will be communicated to staff.

Proposed Timescale: 30/06/2017

Outcome 12. Medication Management

Theme: Health and Development

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

Records seen in individual plans indicated how capacity was assessed but did not clearly demonstrate the assessment of risk as required by Regulation 29(5).

17. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

- For the people who are currently administering their own medication, risk assessments have been implemented. This applied to seven people who currently use the service. This was completed following this inspection.
- All people who will be assessed to self administer will also have a risk assessment completed as per regulation.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

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:

Some information contained in the statement of purpose required more detail to ensure that all the information required by the regulations was contained in the document.

18. 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:

A new Statement of Purpose has been devised by the organisation. This has been adapted locally by the Person in Charge and reviewed by the Area Manager. This has been sent to HIQA on 19.04.17

Proposed Timescale: Completed

Proposed Timescale: 03/05/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

It was of concern to HIQA that three actions were required of HIQA to gain the required fire safety assurance and that deficits were identified in the fire safety measures core to the provided assurance.

19. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

- The Provider Nominee accepts that she should have returned the assurances from the Fire Safety Engineer with her response.
- The full list of Fire Safety measures that are in place in the designated centre should have been returned with the initial action plan as well as the additional measures that were introduced following the inspection.

Proposed Timescale: Complete

Proposed Timescale: 03/05/2017

Theme: Leadership, Governance and Management

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

There was evidence of completed actions, however, some findings from the December 2016 unannounced provider review were not resolved and were still evidenced on this HIQA inspection.

20. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

6 month unannounced report will be reviewed to ensure that all actions identified are completed.

Proposed Timescale: 31/05/2017

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was evidence that the centre was not always adequately resourced to ensure the effective delivery of care and supports.

21. Action Required:

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

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

- The service was closed on 3 occasions in 2016. This was due to an issue in retaining staff at this time. To resolve this issue the provider nominee gave a commitment to the area that full time relief staff could be employed in the area. Two full time "floating staff" work in the kingfisher area and cover the respite house. This has meant that the area has not been closed and staff are staying in the service as they no longer have 0 hour contracts.
- The service has also opened on short notice to accommodate families on other dates where it was due to be shut.
- The service is funded for 21 out of 28 days and has some flexibility in providing emergency respite for people who require it.

Proposed Timescale: Completed

Proposed Timescale: 03/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were deficits in staff training.

22. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- One staff who required Fire Safety Training completed same on 26-04-17
- One staff who requires general Medication Management training has been booked in for this training on 8th May 2017.
- One staff who required refresher training in Safeguarding is currently on long leave and will be booked for training on their return to work. The timescale for completion of

this action is determined on when the staff returns from leave.

- All staff who required training in the administration of rescue medicines have received this training on 27th February 2017

Proposed Timescale: 08/05/2017