Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004791
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:	3
Number of vacancies on the date of inspection:	2

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:
29 October 2015 09:00	29 October 2015 19:00
30 October 2015 09:00	30 October 2015 16:00

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

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

Summary of findings from this inspection

This inspection was the second inspection of the centre. The centre was previously part of another designated centre and was inspected in that context in March 2015. Following that inspection the provider established this centre as a separate designated centre as the two houses did not share a common statement of purpose and function.

The centre provides respite services to 30 residents with a broad range of differing needs and requirements; it is the provider's only community-based respite facility. There was evidence that the provision of respite services to such a large group was

complex but it was planned and managed so as to match demand, needs and available resources.

Prior to the inspection residents and relatives were invited to complete on a voluntary basis questionnaires to ascertain their experience of the supports and services provided; four completed relatives and five completed resident questionnaires were returned. Overall the feedback was positive. Where dissatisfaction was expressed, this is addressed in some of the inspection findings; specific matters complained of were brought to the attention of the provider for their review and follow-up with the Health Information and Quality Authority (HIQA). Confirmation and reassurance of their review and management was provided to HIQA.

The inspector was satisfied that the provider had appointed appropriate persons to manage the service and there was evidence that the person in charge and the area manager had put systems in place to enhance regulatory compliance. The inspector's observations of staff and resident interactions during the inspection were positive. Residents were obviously happy to avail of respite but also eager to speak of their life lived independently of the service. Residents were comfortable in their environment and with staff and referred to the person in charge by her first name. Staff assisted residents to prepare for a planned social event and the inspector saw that this was a happy, equitable and respectful process.

However, overall the level of regulatory compliance achieved was not satisfactory and of the 18 outcomes inspected the provider was judged to be compliant with six and in substantial compliance with one; in moderate non-compliance with six and in major non-compliance with five. These latter five outcomes were safeguarding and safety, health and safety, the submission of notifications, medication management and governance and management.

Given the demands of planning and providing respite services to 30 residents, based on these and previous inspection findings the inspector was not satisfied that the governance arrangements were adequate to ensure regulatory compliance and that the service and the supports provided to residents were effectively monitored on a consistent basis to ensure their quality and safety.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The inspector saw that residents were relaxed in the centre and engaged freely with staff discussing their day, their plans and any concerns that they had. Residents were seen to be facilitated with their choice of bedroom on their arrival at the centre. Residents surveyed said that they made their own decisions and choices but also at times welcomed guidance and support from staff or family.

The person in charge said and records seen indicated that resident meetings were convened frequently to reflect the dynamic nature of the respite service provided and were generally convened twice a week. The minutes of these meetings indicated that staff consulted with residents as to their preferences and choices and the respite stay was then planned around what residents had expressed. Both residents and staff signed the minutes of the meetings.

The person in charge explained to the inspector how the planning of the respite service sought to match residents of similar needs and preferences. However, there was evidence in the complaints records and resident committee meetings of conflicting abilities and preferences such as residents expressing different choices about staying in or going out to socialise. Staff described a process of negotiation and compromise with residents so as to facilitate all residents' preferences. This is discussed again in Outcome 17: Workforce.

Staff were aware of resident's religious beliefs and routines and facilitated these at weekends. As residents were living at home and registered to vote from home, staff

were not ordinarily involved in residents exercising their right to vote but said that topical issues such as referendums were discussed at the residents' committee meetings.

The provider operated a structured advocacy service and all residents had access to this in their respective day services. Any issues that could not be resolved locally were progressed through advocacy or, given the part-time nature of the service brought to the attention of the advocate and then back to the person in charge. The person in charge gave the example of a recent request from residents for additional vanity mirrors, and; these were subsequently provided.

The person in charge told the inspector that while on respite residents were facilitated to continue with their normal routine and the level of independence that they enjoyed such as accessing local transport and shops. Residents spoken with confirmed this and relatives surveyed welcomed the independence that residents enjoyed and experienced in the centre.

There was no CCTV in use in any part of the centre.

The provider continued to review the policy and procedure on the receipt and management of complaints in line with inspection findings to date. The person in charge and area manager were aware of their responsibilities as outlined in the most recently revised version of the policy. The person in charge confirmed that she had discussed the policy and their role and responsibilities with all frontline staff. A complaints log was maintained in the centre and each bedroom had an easy read version of the complaints procedure prominently placed.

However, based on these inspection findings the inspector concluded that prior to this inspection the procedure for reporting and reviewing complaints was not sufficient to ensure that all complaints were appropriately managed and responded to and in a timely manner. The person in charge told the inspector that a complaint made in late July 2015 was not brought to the attention of the person in charge by staff or seen by her until late October 2015. The person in charge confirmed that the required action had now been initiated. Given the nature of this complaint, the fact that the person in charge had no knowledge of it and the theme of other complaints logged, it could not be stated that these other complaints had been satisfactorily resolved as the unknown and outstanding complaint may have had a bearing on them.

The person in charge confirmed that some residents managed their finances independently but others did not. Staff were required to ensure that receipts were retained and sent home with the residual monies once the respite period was complete. There was a recently revised policy and procedure on the management of residents' finances but it did not appear to substantially address the management of residents' finances and personal property while availing of respite services. The policy did however, outline the overall requirement for record keeping by staff including the maintenance of a ledger where staff recorded all lodgements and transactions. The person in charge confirmed that no financial records including such a ledger were maintained in the centre to ensure accountability, transparency and safeguarding for both residents and staff particularly where staff support and assistance was required in

the management of finances.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Staff spoken with were aware of the specific communication requirements of residents. The inspector saw that these requirements and the supports required were set out in a communication plan. Training records indicated that training on specific augmentative methods of communication had been provided to staff to allow them to communicate effectively with residents. There was evidence in support plans that residents had access to and were facilitated to attend support meetings with their peers who shared similar sensory disabilities. The person in charge confirmed that residents as required had been assessed for and provided with assistive technology to alert them to emergency situations such as fire.

There was some limited evidence of augmentative communication strategies within the centre itself; for example the easy read complaints procedure and the use of a visual staff roster. The notice board however was "busy" with much of the displayed material in narrative format. By way of recommendation the inspector advised that this may benefit from further review and enhancement such as the display of non-verbal communication signage that would enhance and reinforce both residents and staff knowledge and communication skills.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Given the nature of respite services the service was provided in close consultation with residents and their families. Access to the service was planned but there was also flexibility so as to allow the provider to respond to any unexpected demand such as a requirement for emergency respite. The person in charge and area manager confirmed that a general meeting had been convened in June 2015 with all families availing of the service to discuss the operation of the centre. The meeting was reported to have been well attended and received and the minutes were circulated to families who were unable to attend.

The provider had in 2014 completed an internal audit of the provision of respite services and following this an information booklet for families was compiled and circulated.

Residents ordinarily lived at home but the person in charge had a sound knowledge of each individual resident's situation and what it was that they wished to achieve while in respite. This may be some quiet time and relaxation for some or for others an opportunity to participate in activities, social engagement and to meet up with friends and peers; opportunities that may not be ordinarily available to them. On the days of inspection the inspector saw that residents were facilitated by staff to either stay in or go out socially.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
There were policies and procedures including a multi-disciplinary forum that governed admission to and transfer and discharge from the services provided.

There was a specific respite committee that met and planned on a monthly basis the provision of respite services. In planning, the committee sought to meet and match needs, both the need for respite and the needs of the residents who availed of respite at

the same time. The person in charge maintained an explicit plan for the proposed occupancy of the centre each month.

Residents were provided with a contract for the provision of supports and services; the contract was also made available in an easy read accessible format. A sample of contracts seen were signed and dated by the resident, a family representative and the provider's representative. However, the contract was the provider's generic contract for the provision of residential services on a long-term basis and therefore did not fully accurately reflect the support, care and welfare of the resident and the services to be provided when availing of respite care.

Judgment:
Non Compliant - Moderate

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:
It was not clear how the providers procedures facilitated the person in charge to exercise her regulatory responsibilities in relation to the assessment, planning and review of residents needs and supports as outlined in Regulation 5 (1),(3), (4), (6), (7) & (8).

Each resident did have an individualised personal plan and a key-worker who was responsible for compiling and maintaining the plan. However, the assessment, planning and review process was the responsibility of the day care services and was overseen by the respective day service senior instructor; approximately six different services inputted into this process. There was evidence that the person in charge had input at times such as attending personal planning meetings or requesting multi-disciplinary reviews but this was not an agreed, structured or frequent process. Each resident brought their support plan with them from the day service to the respite service; this was a relatively new initiative.

While the inspector acknowledged this good practice it was not clear how staff in the respite service familiarised themselves with and implemented a plan into which they had no input; staff spoken with confirmed that given time constraints one would "scan" the plan and exchange verbal information with day service staff when residents arrived and left the service .

The inspector was provided with a sample of support plans to review; failings were identified and it was then not clear how the person in charge was accountable for and would be in a position to address the failings given the structures in place as described above.

In the support plans the inspector saw that each resident had a comprehensive assessment that was reviewed annually; the assessment process was informed by resident, family and multi-disciplinary input. From these assessments supports, goals and priorities were identified and agreed with the resident; responsible persons and achievement time frames were identified. The achievement or otherwise of residents goals and priorities was monitored on a quarterly basis by staff.

However, the inspector saw that the focus of the plan and supports was the provision of day rather than respite services; the latter was referenced at times but not in a substantive manner. A very simple example was the completion of intimate care plans which did not reference the supports required for showering or bathing as these were not undertaken in the day service. Bedtime routines and choices were not ascertained and recorded as they were "not applicable" to the assessor, day services.

Some agreed priorities were seen to be still unmet 12 months after they were agreed; these included access to physiotherapy services and the review of personal accommodation so as to ascertain adjustments required to enhance resident functioning. It was not clear how review influenced the progression of priorities and the providers system for identifying and escalating barriers was not seen to be implemented. Where it was recorded on review that a priority was still unmet there was additional narrative evidence in the plan that it had actually been met.

The provider's annual review of the quality and safety of the care and services did not review and monitor the quality of the support plans or their adherence with regulatory requirements as "they were the responsibility of the key-worker in the day-services".

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

Findings:
The inspector was satisfied that the design and layout of the house was suited to its stated purpose and function. The person in charge confirmed that this did however, require planning so as to ensure that residents with limited mobility had access to the ground floor bedroom.

The house was a domestic type dwelling located in a residential area within close proximity of local amenities.

The main entrance was ramped and a hand-rail was in place.

While there was some evidence of scuffed painting, overall the house presented as welcoming and maintained.

Each resident was allocated a single bedroom of their choosing; a maximum of five residents could be accommodated and one bedroom was provided at ground floor level. Bedrooms were of a suitable size and layout and offered adequate provision for personal storage.

Bedrooms did not offer en-suite sanitary facilities but adequate separate facilities were provided. There was a bathroom with shower, toilet and wash-hand basin on the first floor and a universally accessible bathroom, again with shower, toilet and wash-hand basin on the ground floor.

The kitchen and dining area was combined and offered sufficient space for the number of residents accommodated; the kitchen was adequately equipped.

Residents had access to one main communal area that was homely and welcoming in presentation; a second television was available in the kitchen if required.

Facilities were in place for the laundering of residents personal possessions.

Storage was not seen to present with any difficulties and staff had access to an external storage area.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The provider's organisational health and safety statement was in place as was its risk identification and management policy and the procedures for the management of accidents and incidents and adverse events.

However, the register of risks was not sufficient and it did not encompass the identification and assessment of risks throughout the designated centre. The risk assessments specified 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 were not included in the risk register.

There was no evidence of completed centre specific risk assessments, for example the stairwell was of somewhat unusual construction and diverged in two directions at first floor level, one of which finished/started in close proximity to one bedroom door. There were some generic templates in place that outlined generic controls and measures but these were not complete or centre specific.

The person in charge had completed specific risk assessments as they pertained to individual resident requirements. There was evidence of the escalation of risks that could not be resolved at local level.

There was a centre specific emergency plan that outlined the supports available to staff and the contingencies for responding to emergencies including the relocation of residents if necessary.

Training records indicated that staff had completed training in manual handling within the required mandatory timeframes.

A certificate of the inspection and testing of gas installations was seen and a carbon monoxide monitor was in place.

Training records indicated that staff had attended fire safety training in 2014/2015. Staff maintained weekly records of the testing of the existing smoke detection devices. Records indicated that frequent fire drills were convened by staff with residents and generally satisfactory evacuation times were achieved. Residents surveyed said that they participated in fire drills and knew what to do when the alarm sounded. Personal emergency evacuation plans were in place for residents; however these had not been reviewed and updated to reflect the provision of assistive technology or difficulties encountered with particular residents on two occasions during simulated evacuation exercises.

Agreed escape routes were indicated at ground floor level, however, diagrammatic fire evacuation notices and fire action notices were displayed only at ground floor level with no escape route indicator evident at first floor level.

The house was not equipped with emergency lighting; staff and residents were provided with flash-lamps. The house did not have 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; there was no smoke detector in the main kitchen.

Staff had access to fire fighting equipment and a certificate of its inspection in February 2015 was in place

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 from being harmed or abused; these measures included policies and procedures, staffing training, resident education and designated persons. As discussed below however, they were not always implemented.

Staff training records indicated that all staff had attended protection training in 2014/2015. Those staff spoken with were clear on the providers protection policies and procedures and their responsibility to report any known, suspected or reported abuse. Residents surveyed said that they felt safe in the centre, enjoyed their time there and that they "liked" the staff. The inspector's observations of staff and resident interactions were positive.

However, there was evidence, discussed and agreed with the area manager and the person in charge that all staff did not demonstrate and implement a sound

understanding of the covert nature of abuse and did not adhere to the provider's policy and procedure for reporting any alleged abuse. It was of concern to the inspector that an allegation of physical abuse, while recorded had not been reported to the person in charge, the area manager or the designated person to ensure that it was investigated and substantiated or not. Action was taken by the person in charge just prior to this inspection once the allegation was made known to her.

Staff had received training on responding to and managing behaviours that had the potential to challenge. Staff reported that there were no restrictive practices in use in the centre and there was no evidence to the contrary available to the inspector.

Staff told the inspector that residents did not present with behaviours that challenged however, this did not concur with the support plans seen by the inspector. Where behaviours that challenged and posed a risk to others had been identified, the inspector did not see supporting behaviour management guidelines.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
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. However, while there was evidence that staff took appropriate action, there was no accident report in place for one accident and injury sustained in September 2015.

All incidents where required had not been notified to the Chief Inspector. Based on these inspection findings these included an allegation of abuse and an injury which required medical review and treatment.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
The inspector was satisfied that the provider had arrangements in place to ensure that residents had opportunities for social engagement, education and skills development. This was predominately facilitated through the day services to which all residents had access. Residents attended approximately six different day services and the person in charge said that the service was selected based on an assessment of the residents needs and ability; this ensured that they participated in programmes that suited them and were therefore successful. Programmes were based on skill development such as cooking, money management and wood-work, activity and well-being such as swimming, horse riding and tai-chi. Some residents had accessed education through the local third level institution while another resident was participating in boat-building classes.

While availing of respite services residents had ongoing access to their day service and were collected from and returned to the centre each day. A social dimension was also integrated into the respite stay; preferred social activities were discussed and agreed between residents and staff and included trips to the cinema, restaurants, pub and shopping.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Residents were ordinarily resident at home with family, therefore the person in charge

said that their healthcare needs and requirements were managed and supported by their family; this would concur with the records seen by the inspector. The person in charge said that residents did not attend respite if unwell but if they became unwell on respite both the resident and family were supported as necessary. Residents did have access to the provider's multi-disciplinary team; staff did monitor each resident's general well-being and request as necessary a multi-disciplinary meeting when concerns were identified. The inspector saw evidence of such a request from the person in charge and subsequent referral to the social worker.

Staff did ascertain and record detail as to each resident's healthcare needs and requirements. Staff did as and when necessary seek medical advice and treatment for residents, for example in the event of a fall.

There was a process within the support plan for identifying healthcare requirements. Based on the support plans seen residents did have identified health care needs including mobility, falls prevention, and the management of diabetes. The provider did have a specific template for addressing healthcare related issues and plans, however, the required plans outlining for staff the interventions required to maintain resident health and wellbeing were not in place.

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:
There was evidence that action had been taken since the last inspection to seek improvement in the safety and accountability of medication management.

Staff confirmed that they now recorded all medications that they administered to residents where previously they had not maintained such records. Residents were now required to bring all medications to the centre in a medication administration compliance aid issued by a pharmacist. This altered practice was communicated to residents and their families in the information booklet and at the meeting referred to in Outcome 3. The medication management policy had been reviewed in May 2015 and set out the revised arrangements for the supply and administration of medications in respite services. The person in charge did say that some family members struggled with the

required changes.

Secure storage was available for medications. Residents only bought the required supply of medications for the duration of respite with them to the centre. The person in charge confirmed that medications requiring stricter controls were not in use and no resident required their medication in an altered format; for example, crushed. No stocks of medication were kept in the centre.

Medications and medication prescription and administration records were not ordinarily retained in the centre as they travelled with each resident to the day service as did their support plan; also some residents were reported to have no prescribed medications. However, based on discussion with the person in charge and the area manager and the sample of medication prescription and administration records available to the inspector, the inspector was not satisfied that medication management policies, procedures and practice were sufficient to guide safe medication management practice in respite services.

There was insufficient oversight of medication management practice and this was further complicated by the role and input of day service staff. The inspector saw that;
• while some residents were facilitated to continue to self-administer their medications while in respite there was no assessment or policy to support this practice particularly in relation to the role and accountability of staff
• medication seen by the inspector while in a compliance aid did not have a pharmacy label attached; the content and administration instructions affixed were handwritten. The person in charge confirmed that this was not done by staff but staff should not have accepted the compliance aid and had not brought it to her attention
• the frequency and maximum dosage of p.r.n. medicines (a medicine only taken as the need arises) was not stated on the prescription record
• the person in charge confirmed that the providers template for the monitoring of the usage of p.r.n medicines was not used in the centre
• the policy and procedure on the administration of over the counter analgesics was ambiguous. There was no guidance for staff as to the monitoring of effectiveness, when to seek medical advice or indicators for repeat administration
• one signed entry of a medication administered was subsequently crossed out but not signed, dated or explained
• there were narrative notes only "antibiotic administered" to support the administration of the medication by staff. The person in charge confirmed that there was no supporting prescription for the antibiotic. There was a further issue of accountability as other records confirmed that while respite staff had administered the antibiotic, staff in day services were to ensure that the antibiotic was retrospectively prescribed.

There were five staff, including the person in charge, currently allocated to work in the centre and training records seen indicated that only the person in charge had up to date medication management training. One staff had no recorded attendance at medication management training; three staff had not had training since 2010. This was also a failing identified on inspection in March 2015.

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose submitted with the application to register the centre contained most but not all of the required information.

The statement was revised based on the verbal feedback from the inspector and the revised version was fully compliant with the requirements of Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
There was an established management structure. There was some lingering evidence of the overlap of roles and responsibilities of the area manager and the person in charge such as the management and communication of accidents and incidents, but staff

spoken with were not unclear as to whom they would report to in specific instances be it the person in charge or the area manager.

The inspector was satisfied that the planning and delivery of respite services was managed, however, based on these inspection findings the inspector was again not satisfied that the governance arrangements were adequate to ensure regulatory compliance and that the service and the supports provided to residents were effectively monitored on a consistent basis to ensure their quality and safety. The evidence to support this conclusion includes the failings identified in complaints management, medication management, safeguarding, planning supports including healthcare supports, the completion of risk assessments, the monitoring of staff training and the submission of notifications.

The person in charge was suitably experienced and qualified. 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 recently completed further postgraduate education to masters level, and was also engaged in the providers education and training programme. The person in charge was supported in her role by the area manager; they met formally on a weekly basis.

However, the person in charge was person in charge of two designated centres, one residential and this respite service. The inspector was not satisfied that this governance structure, the demands of planning and providing respite services to 30 residents with a diversity of needs and requirements and, the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities in both centres as set out in the regulations. The previous inspection findings of March 2015 were not satisfactory; of the eight outcomes inspected at that time the provider was judged to be in major non-compliance with five including governance and management and in moderate non-compliance with the remaining three.

Persons in charge participated in an on-call rota and were on call three days out of every 14. The person in charge said that some on-calls were quiet while others were not; for example the person in charge said that she recently had to work a sleepover shift in another centre as no replacement staff were available. In the event that the person in charge needed advice and support, the on-call arrangements for the area managers were not explicitly set out for the persons in charge.

No one spoken to including the person in charge, the area manager and the provider nominee disputed the inspection findings on governance; all agreed that the governance of the respite centre required a dedicated post of responsibility.

The annual review as required by Regulation 23 (1) (d) and the unannounced visit 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 process of review included consultation with residents and their families. However, while there was evidence of some improvement, overall the inspector concluded that these had not contributed in a constructive manner to learning or addressing the deficits in the governance structure. For example the unannounced visit undertaken in May 2015 had identified the need for

a review of residents PEEP's, all risks were not identified and staff were to work with the day services to ensure that support plans were complete. Based on these inspection findings these deficits were not addressed.

Following the annual review completed in April 2015, staff were provided with training in augmentative communication methods, a notice board had been erected, a log of visitors was introduced and arrangements were put in place to ensure that each resident brought their support plan with them to respite. However further areas identified as requiring improvement were still unaddressed at the time of this inspection including the completion of a complete risk register, the management of accidents and incidents, the absence of meaningful intimate care plans and the compilation and monitoring of residents support plans. It was clear from the report and these inspection findings that progress of the completion of some required actions was not tracked until the required action was completed.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge confirmed that she had not been absent from the centre for a period of time that required notification to the Chief Inspector. There were arrangements for the management of the service in the absence of the person in charge. The area manager was the nominated person participating in the management of the service (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):
No actions were required from the previous inspection.

Findings:
There was evidence in complaints records and in the minutes of resident meetings that the available transport was not suited to the needs of all residents. However, the area manager and the person in charge confirmed that an alternative arrangement was in place where staff had authority to procure a suitably adapted taxi when required and that this had been communicated to all staff.

The person in charge and the area manager confirmed that access to respite services was planned and part of this planning process was to ensure that in so far as was reasonably possible residents with similar needs and preferences were accommodated at the same time. However, there was some evidence that this was not always possible; for example one resident had a preference for not socialising or may request to return to the centre early. As there was ordinarily only one staff member on duty this impacted on the choices and preferences of other residents.

Both the area manager and the person in charge agreed and told the inspector that the availability of an additional staffing resource at intervals would address this and ensure that the arrangements in place were suitable to residents needs. However, this additional staffing resource was not available.

Judgment:
Non Compliant - Moderate

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:
Recruitment of staff was centralised. Staff files were supplied for the purpose of inspection and the inspector saw that they were well presented and fully 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.

Training records were also provided and these indicated that staff training in protection of residents, fire safety, responding to and managing behaviours that challenged and manual handling were all current and within any required legislative timeframes. Further training provided to staff was relevant to their role and included food safety, augmentative non-verbal means of communication and the administration of medications required to manage seizure activity. However, a deficit was identified in the provision of training and refresher training to staff on the management of medications. Also given the findings in Outcome 8: Safeguarding and Safety, it was not clear how learning and knowledge gained by staff from training was evaluated.

A staff rota was available in the centre. The person in charge said that this was a dynamic document that was re-circulated to staff as required based on changes made to it.

The centre could accommodate five residents and this was the maximum number of registered beds applied for. However, the area manager and the person in charge said that the centre was infrequently occupied to full capacity; occupancy was dependent on demand and the needs of residents and families. Occupancy was planned and managed and the average reported maximum occupancy was three. This concurred with the record of occupancy seen by the inspector; three residents were availing of respite services at the time of this inspection. Two staff were on duty but this was as a result of a temporary induction process; ordinarily there was only one staff member on duty and this staff member was sleepover staff. There were nights when only one resident was present in the centre.

Overall, the inspector was satisfied that the service was planned and managed so that demand, needs and available resources were matched in so far as was reasonably possible. However as discussed in Outcome 16: Resources, there were occasions where the available staffing resources did not meet the needs and choices of all residents. In addition to planning, staff negotiated with residents and sought compromise. However, both the area manager and the person in charge agreed and told the inspector that the availability of an additional staffing resource on occasion, when planning respite would enhance flexibility and the facilitation of residents differing needs and choices.

There were no volunteers working in the centre and if there was a requirement for relief staff, two staff with knowledge of the residents and the centre were reported to be available.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in

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

Theme:
Use of Information

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

Findings:
Overall and on balance any records required to be held by the provider were in place and made available to the inspector as requested. These included policies and procedures, staff records, resident related records and general records. Where deficits were identified in the maintenance of the records such as financial records, accident and incident and medication records these have been addressed in the overall findings of the respective Outcome.

There was documentary evidence that the provider had the required employers and public liability insurance in place.

A directory of residents was maintained; it did not however contain all of the required information such as the contact details of each resident GP.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Moore
Inspector of Social Services

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004791
Date of Inspection:	29 and 30 October 2015
Date of response:	03 December 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:
No financial records were maintained in the centre to ensure accountability, transparency and safeguarding for both residents and staff particularly where staff support and assistance was required in the management of finances.

1. Action Required:

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

Under Regulation 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:
1. The Area Manager has linked with the Finance Department regarding findings of HIQA inspection in this regard.
2. Fi0nance Department will work with Person in Charge to develop procedures around supporting respite attendees to manage their finances when they are in respite.
3. The Personal Assets policy will be updated to include this procedure.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure for reporting and reviewing complaints was not sufficient to ensure that all complaints were appropriately managed and responded to and in a timely manner

2. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
1. The complaints procedure has been revised based on feedback received from HIQA inspectors following visits to other designated centres.
2. The new complaints procedure will be rolled out in Q1 2016.

Proposed Timescale: 31/03/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract was the provider's generic contract for the provision of residential services on a long-term basis and therefore did not fully accurately reflect the support, care and welfare of the resident and the services to be provided when availing of respite care.

3. Action Required:
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

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

1. Person in Charge will update the contract of care for people who avail of respite to accurately reflect the support, care and welfare of the resident and the services to be provided when available of respite care. 31/2/2016.
2. Contracts will be issued to respite recipients and their families for return by 31/3/2016.

Proposed Timescale: 31/03/2016

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:
It was not clear how the providers procedures facilitated the person in charge to exercise her regulatory responsibilities in relation to the assessment, planning and review of residents needs and supports as outlined in Regulation 5 (1),(3), (4), (6), (7) &(8).

Failings were identified as discussed in Outcome 5 and it was then not clear how the person in charge was accountable for and would be in a position to address the failings given the structures in place as described above.

4. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
1. The process of using My Profile My Plan will continue.
2. A respite specific section will be added to My Profile My Plan.
3. The Person in Charge will conduct routine reviews of My Profile My Plan for respite users.
4. The Head of Community Services will support the Person in Charge in ensuring that required information is present.

Proposed Timescale: 31/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The register of risks was not sufficient and it did not encompass the identification and assessment of risks throughout the designated centre. The risk assessments specified 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 were not included in the risk register.

5. 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:
1. The risk assessments specified 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 are included in the form of generic templates in the risk management procedure. These templates will be completed for respite attendees where there is a foreseeable risk.
2. Risk identification was an agenda item on staff meeting on 18/11/2015 and risks identified will be assessed and appropriate mitigations put in place.
3. A risk identification workshop will be arrange for area manager, Person in Charge and respite staff facilitate by Head of Quality and Risk to further develop the risk register.

Proposed Timescale: 31/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
PEEP's had not been reviewed and updated to reflect the provision of assistive technology or difficulties encountered with particular residents on two occasions during simulated evacuation exercises.

Fire action notices and escape route indicators were not evident at first floor level.

6. 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:
1. All PEEPS will be reviewed.
2. Fire action notice and escape route indicators will be put on first floor level.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

The house was not equipped with emergency lighting. The house did not have 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; there was no smoke detector in the main kitchen.

7. 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:
1. An architect was contracted to conduct a fire safety review of the designated centre in 2015.
2. A second opinion is now being sought from a fire safety engineer.

Proposed Timescale: 15/01/2016

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:
Staff told the inspector that residents did not present with behaviours that challenged however, this did not concur with the support plans seen by the inspector. Where behaviours that challenged and posed a risk to others had been identified, the inspector did not see supporting behaviour management guidelines.

8. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
1. All staff received training in the management of behaviours that challenge.
2. Respite attendees who have a behaviour support plan will have their plans reviewed and amended if required.

Proposed Timescale: 31/03/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of physical abuse, while recorded had not been reported to the person in charge, the area manager or the designated person to ensure that it was investigated and substantiated or not.

9. 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:
1. This allegation was referred to the Designated Person immediately upon identifying the oversight in reporting (the day before the HIQA inspection took place). The Designated Person carried out a screening of the allegation.
2. Two day training on the protection of vulnerable adults has been organised for all persons in charge for the 11th and 14th of December. This training will further support managers in their role in the ongoing supervision of staff in terms of the protection of vulnerable adults.
3. The Person in Charge will meet with the staff member who received the original complaint to review staff' reporting responsibilities. The staff member will be referred for refresher training in the protection of vulnerable adults.

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:
All incidents where required had not been notified to the Chief Inspector and included an injury that required medical review and treatment.

10. Action Required:
Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:
1. All incidents which occur in the designated centre will be reported in line with notification requirements and HIQA guidance.

Proposed Timescale: 27/11/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All incidents where required had not been notified to the Chief Inspector; these included an allegation of abuse.

11. 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:
1. All incidents which occur in the respite centre will be reported in line with notification requirements and HIQA guidance

Proposed Timescale: 27/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did have a specific template for addressing healthcare related issues and plans, however, the required plans outlining for staff the interventions required to maintain resident health and wellbeing were not in place.

12. 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:
1. The process of using My Profile My Plan will continue.
2. A respite specific section will be added to My Profile My Plan to include interventions required to maintain residents health and wellbeing while in respite.

Proposed Timescale: 31/03/2016

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:
As discussed in detail in Outcome 12 the inspector was not satisfied that medication management policies, procedures and practice were sufficient to guide safe medication management practice in respite services. There was insufficient oversight of medication management practice and this was further complicated by the role and input of day service staff.

Training records seen indicated that only the person in charge had up to date medication management training.

While residents were facilitated to continue to self-administer their medications there

was no assessment or policy to support this practice particularly in relation to the role and accountability of staff.

13. 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:
• A section on the administration of medication while in respite will be added to the Operational procedure for the administration of medication.
• All staff working in the designated centre will receive medication management training.
• An assessment tool for self-administration is being developed.

Proposed Timescale: 31/01/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on these inspection findings the inspector was not satisfied that the governance arrangements were adequate to ensure regulatory compliance and that the service and the supports provided to residents were effectively monitored on a consistent basis to ensure their quality and safety

14. 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:
1. The Person in Charge is currently responsible for two designated centres.
2. Following review one of these designated centres will be reassigned within resources.
3. Alternative on call arrangements after 10.30p.m. are currently being finalised.

Proposed Timescale: 31/01/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The unannounced visit and the annual review had not contributed in a constructive manner to learning or addressing the deficits in the governance structure. Areas

identified as requiring improvement were still unaddressed at the time of this inspection. Progress of the completion of some required actions was not tracked until the required action was completed.

15. 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:
1. The area manager has now included progress on annual review and unannounced visits as part of ongoing supervision with Person in Charge.

Proposed Timescale: 27/11/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At times, staffing resources were not adequate to ensure that the arrangements in place were suitable to all residents needs.

16. 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:
1. The number of people at any one time attending respite is being limited to 3 where possible.
2. Efforts are made to ensure that the people attending respite have similar levels of ability and interest.
3. The Office of the Person in Charge will be relocated to respite.
4. A business case will be submitted to the HSE to fund support hours for use within the respite service as this is over and above the budget assigned to respite services.

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

the following respect:
An additional staffing resource required on occasion to meet residents differing needs and choices was not available.

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

Please state the actions you have taken or are planning to take:
1. The number of people at any one time attending respite is being limited to 3 where possible.
2. Efforts are made to ensure that the people attending respite have similar levels of ability and interest.
3. The Office of the Person in Charge will be relocated to respite.
4. A business case will be submitted to the HSE to fund support hours for use within the respite service as this is over and above the budget assigned to respite services.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A deficit was identified in the provision of training and refresher training to staff on the management of medications. Also given the findings in Outcome 8: Safeguarding and Safety, it was not clear how learning and knowledge gained by staff from training was evaluated.

18. 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:
1. The list of required training will be reviewed. The time frames for refresher training will be clarified.

Proposed Timescale: 31/01/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not contain all of the required information such as the

contact details of each resident GP.

19. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:
1. The directory of residents will be updated by the Person in Charge in consultation with day services.

Proposed Timescale: 31/12/2015