

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	No.2 Brooklime
Centre ID:	OSV-0003560
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Southern Services
Provider Nominee:	Una Nagle
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	7
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 renewal 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:
30 January 2017 10:00	30 January 2017 18:00
31 January 2017 08:20	31 January 2017 15:30

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

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

Summary of findings from this inspection

Background to the inspection:

This report sets out the findings of an announced inspection by the Health Information and Quality Authority (HIQA) of a centre managed by Brothers of Charity Services following an application by the provider to register the centre. The Brothers of Charity Services provided a range of day, residential and respite services in Cork. This was a follow up to the previous inspection in March 2016.

Description of the service:

The centre consisted of two houses, one a detached bungalow and the second a

detached house in a large town just outside Cork City. It provided a home to nine residents' of varying ages with varying levels of support requirements. On the date of inspection seven residents' were living in the service.

The person in charge was the area manager for the service and was suitably qualified and experienced to discharge his role. Since the previous inspection a review of the remit of the person in charge had taken place and the person in charge no longer had responsibility for day service provision and still had responsibility for seven designated centres in total.

How we gathered our evidence:

During the course of the two days of the inspection six of the seven residents met and spoke with the inspector. Two resident and five family feedback forms were received by HIQA prior to the inspection with one of the families saying "it was not a centre – it is his second home where he lives with his other family. He is safe, respected and well cared for there." The inspector also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

Overall judgment of findings:

There was evidence of good practice. At the last inspection by HIQA it was found that some residents required additional staffing support and this had been provided by the service. Staff were very committed to ensuring that each resident had the best quality of life possible. The inspector observed that staff were respectful of residents at all times

However, of the 18 outcomes inspected, two were at the level of major non-compliance as follows:

- the centre did not meet the assessed needs of all residents and residents needs were not being assessed to reflect changes in need and circumstances (outcome 5)
- as was found on the previous inspection restrictive procedures were not in line with national policy, evidence based practice or the organisation's own policy.(outcome 8)

Improvement was also required in relation to:

- admission practices and policies were not transparent with one of the residents having been admitted to this centre in 2011 as an emergency admission as a "temporary measure". However, the resident was still living in the centre (outcome 4).
- the entrance to the kitchen area required floor covering as there was duct tape on the ground (outcome 6).
- management and ongoing review of risk on the centre risk register (outcome 7).
- reviews of quality and safety of care provided to residents to ensure that the service being provided to residents was being effectively monitored (outcome 14).
- some improvement was required in relation to the recording of healthcare appointments (outcome 18).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were consulted with and participated in decisions about their care and the organisation of the centre.

There were weekly meetings with residents and issues discussed included activities and menu planning. One of the families in feedback to HIQA prior to the inspection said that "he chooses things himself with amazing staff support"

The inspector reviewed the management of residents finances and found the process to be transparent. There was a policy on residents finances and all items purchased for and by residents were verified by receipt. Each receipt and expense was verified by two staff signatures.

The organisation had a complaints policy and easy-to-read versions were displayed throughout the centre. The complaints policy identified a nominated person to manage complaints in the organisation. The inspector reviewed the complaints log since January 2016 and saw that they had been managed in accordance with the centre policy.

Residents could keep control of their own possessions. There was an up to date property list in each resident's personal outcomes folder which identified when the resident bought or received items like furniture or bedside lamps. There was adequate space for clothes and personal possessions in all bedrooms.

Judgment:

Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

There was a policy on communication and in the sample of care plans reviewed there was evidence that residents were assisted and supported to communicate. However, some improvement was required to ensure all residents communication needs were assessed as required.

The inspector reviewed residents' personal plans and found that where residents had communication needs, this was captured in personal plans. Residents who required it had personal communication booklets that outlined how they communicated and how they expressed choices.

There were communication strategies in place for residents with hearing impairments. Inspectors saw that residents with hearing impairment were being reviewed by an audiologist every two years. Throughout the two days of the inspection staff were observed to communicate effectively with all residents including through the use of LÁMH which is a manual sign system used by children and adults with intellectual disability and communication needs.

Inspector observed a communication boards in both houses of the centre which contained a picture rota of which staff were on duty. One resident showed the inspector the menu plan for the week.

There were communication assessments completed by the speech and language therapist reviews to guide staff as to how the resident communicated and also gave guidelines to staff in how to help the resident communicate.

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.

<p>Theme: Individualised Supports and Care</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Residents were supported to develop and maintain personal relationships and links with the wider community. Families were involved in the lives of residents.</p> <p>The inspector received a number of completed relative questionnaires from family members which were highly complementary of the service. One family said that their loved one "has a very good social life and is cared for very well. I just want to say thank you to everyone who supports him".</p> <p>Residents were supported to use local services such as leisure and sports facilities. The centre of the town was accessible to one of the houses and one of the residents went to the shop for "the messages".</p> <p>Positive relationships between residents and family members were supported. Many residents spent weekends and holidays with family. Residents were facilitated to keep in regular contact with family through telephone calls and residents could request to use the telephone in private. Staff stated and the inspector saw that families were kept informed of residents' well being on an ongoing basis. In feedback received, one family said that "the residents receive the best of care and attention".</p>
<p>Judgment: Compliant</p>

<p>Outcome 04: Admissions and Contract for the Provision of Services <i>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.</i></p>
<p>Theme: Effective Services</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The admission practices and policies were not transparent.</p> <p>The statement of purpose, which is a document that describes the service provided in the centre, did not provide any clear guidance as to how residents were admitted to the</p>

centre. In particular, one of the residents had been admitted to this centre in 2011 as an emergency admission as a "temporary measure".

However, by the date of inspection he was still living in the centre and there was evidence from healthcare professionals available to show that the prolonged temporary nature of the placement was very distressing and anxiety provoking. This was of particular relevance as the person in charge outlined that new admissions may be occurring as there were currently a number of vacancies in the centre.

Some of the residents had tenancy agreements with an independent housing association, whereas others did not.

The inspectors reviewed a sample of resident contracts of care. All had either been signed, or sent for signing by the resident and/or their family. For residents unable to sign on their own behalf the Brothers of Charity service was engaging with the national advocacy service to advance the requirements of all residents.

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):

No actions were required from the previous inspection.

Findings:

A major non-compliance was identified as the designated centre did not meet the assessed needs of all residents. While overall, the personal plan was detailed and individualised, improvements were required as outlined below.

The inspector found that the designated centre did not meet the assessed needs of all residents. Two residents had been formally identified as requiring alternative more suitable accommodation and a referral had been made to the organisation's relevant committees that oversee such placement issues (the Admissions, Discharges and Transfers Committee).

There was evidence that the centre did not meet the individual needs of a third resident. There was documentary evidence that their living arrangements were having a negative impact on the behaviours of both the resident themselves and other residents in the house. While the issues had been discussed by individual members of the multidisciplinary team there were no concrete plans in place to review the issue.

There was evidence that residents' needs were not being assessed to reflect changes in need and circumstances. In one internal service report from January 2017 it had been identified that there was a "large gap in (one resident's) diagnostic profile". Staff outlined to the inspector that the most recent psychological report available for the resident had been in 1998. Staff said that this report had not been available to them until recently. In addition, a number of residents had been referred in July 2016 for support following a recent bereavement. However, this counselling had not yet been made available to the residents.

There were two sets of resident records: the person's support plan, and a separate file for medical records. In the person support plan there was a summary profile of the resident which outlined things that staff and carers must know about the resident; a summary of multidisciplinary healthcare issues; and it included issues that were important to the person like communication.

In relation to social care needs there was evidence that each resident was supported to develop an individual lifestyle plan each year with input from the resident, family member and staff. At this planning meeting various issues were discussed and in particular things that the resident liked to do.

However, the process for person-centred planning required improvement as it was not the subject of a multidisciplinary annual review as required by the regulations. Therefore the process did not address the supports that may be required from other healthcare professionals that would best meet the resident's needs using combined strategies.

In relation to healthcare needs e care plans had been developed for identified healthcare needs. These care plans were in the person centred planning folder. The supplementary information in relation to these healthcare needs was in the separate file for medical records.

There had been some admissions to hospital by residents in the last 12 months. However, there was no information on file in relation to one of these hospital admissions. In particular an assessment of residents' health needs had not been completed and their care plan had not been updated to reflect the instructions of the discharging hospital team. In addition, one resident was on the waiting list for a consultant review but the care plan did not reflect the healthcare issue.

Judgment:

Non Compliant - Major

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 location, design and layout of the centre was suitable for its stated purpose and met residents' needs in a comfortable and homely way. Some minor repair work was required.

The centre consisted of two separate houses in a large town on the outskirts of Cork city. The centre provided a home to nine men who all needed varying levels of support. On the date of inspection there were seven men living in the centre.

The first house was well maintained, nicely decorated and had a large kitchen/dining room, and a large sitting room. Each resident in this house had their own bedroom which was decorated according to each resident's own taste. Two of the bedrooms had ensuite facilities with shower, toilet and wash hand basin. A number of adaptations had been made to this house to make it accessible for all.

The second house provided accommodation to three residents. Two of the residents lived in the main part of the house that consisted of a kitchen area, a dining room and a living room. Both residents in this part of the house had their own bedroom and there were adequate bathroom facilities. There was a large garden to the rear of this house. It was noted that the entrance to the kitchen area required a proper floor covering as on the date of inspection there was duct tape on the ground.

The second house also had a self contained apartment where one resident lived. This consisted of a small kitchen/dining area, a bedroom and bathroom facilities. The resident had decorated the apartment himself according to his own tastes.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The health and safety of residents, visitors and staff was promoted and protected. Some improvement was required in relation to the management and ongoing review of risk.

There was a risk management policy that included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. Each resident had participated in identifying specific hazards relating to their lives, for example burning from a hob on a cooker and the safe storage of cleaning products. These were contained in what was called a "summary risk profile" for each resident.

The centre had two risk registers in place, one for each of the two houses. A centre risk register is designed to log all the hazards that the centre is actively managing. The centre's risk register had many of the issues included that had been assessed for each individual resident. The person in charge and the regional manager explained how specific issues were escalated from the designated centre to senior management of Brothers of Charity services.

However, these risks were not always recorded on the centre risk register. For example, there had been an issue of inappropriate placement that had been escalated to senior management and resolved but it had not been managed via the risk register. There were other issues that needed to be included on the risk register but were not on it, for example access for residents to psychology and behaviour support services.

The inspector saw evidence that suitable fire prevention equipment was provided throughout both houses of the centre and the equipment was adequately maintained by means of:

- servicing of fire alarm system and alarm panel October 2016
- servicing of emergency lighting system October 2016
- servicing of fire extinguishers July 2016

Each resident had a personal emergency evacuation plan which outlined what assistance, if any, the resident required in the event of an evacuation. There were records of evacuation drills being carried with the most recent being in December 2016. There were fire doors available throughout the two houses; and there was emergency signage identifying escape routes.

There was a policy in relation to control and prevention of infection and the centre was visibly clean. However, it was noted that hand drying facilities were not available in one of the bathrooms.

Judgment:

Substantially Compliant

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:

As was found on the previous inspection restrictive procedures were not in line with national policy, evidence based practice or the organisation's own policy.

At the last inspection it was found that plans in place to support residents to manage their behaviour had not been updated to inform existing practice. The inspector reviewed the incident reporting system relating to recorded incidents of "challenging behaviour" from January 2016 to December 2016. In one of the houses records were seen for 48 incidents, 42 of which related to residents striking/pushing and being verbally aggressive towards staff and 5 relating to other residents. In the second house there had been 17 incidents recorded, 16 of which related to residents throwing objects or striking/pushing and being verbally aggressive towards staff or other residents. While a summary report from the behaviour support specialist from August 2016 was available for one resident, a number of recommendations from that report were still outstanding.

The service provider was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in September 2016 that two restrictions were in place, a door lock and a lock on a side gate restricting access and egress.

There was a Brothers of Charity service policy on the use of restrictions entitled the "Fuller Safer Lives Policy" that outlined the process for the sanctioning of any restriction. However, there was evidence that this policy was not being followed. The policy stated that prior to the use of any restriction a detailed multidisciplinary risk assessment was required. This had been followed in relation the use of a lock on the side gate. However, as outlined on the previous HIQA inspection in March 2016 there had been the installation of an internal door between a separate apartment and the main house. This was also a restriction but had not been the subject of a multidisciplinary review.

The "Fuller Safer Lives Policy" outlined that full sanctioning of any restriction was by the behaviour standards committee. However, staff were not always clear on the process for approval of restrictions and in particular which committee approved of restrictions. For any restriction that had been approved by the behaviour standards committee the

"Fuller Safer Lives Policy" outlined that it was to be reviewed every three months. This was not being complied with. For example, the locked side gate had been approved by the behaviour standards committee in February 2016 but had not been reviewed since.

In relation to access to the main house from an outside door, which was locked, there were records to show that this had been referred to "rights review committee in June 2015". It was noted on the records that the outcome of this referral "remains outstanding".

There were policies in place to protect residents from being harmed or suffering abuse. There was evidence that all serious adverse incidents including allegations of abuse had been appropriately investigated and resolved. The designated liaison officer person with responsibility for reviewing any allegation was a social worker. Since the last inspection three such incidents had been referred to the service designated liaison officer. Documentation reviewed by the inspector demonstrated that each incident had been followed up appropriately by the service and an appropriate recording of the incident was available in a written format. Each had been processed in accordance with the national safeguarding policy, with preliminary screening completed and forwarded to the Health Services Executive (HSE) safeguarding team. The person in charge was aware that any such incidents were to be reported to HIQA.

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:

It was a requirement that all serious adverse incidents were reported to HIQA within three working days of the incident. Since the last inspection a record of all incidents occurring had been maintained and all notifications had been sent to HIQA as required.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training

and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

A comprehensive assessment of residents' educational, employment and training goals was available to ensure that their skills development, education and training was suited to individual residents' abilities.

Each resident had an assessment available of their skills development and education needs. In some examples this assessment had been incorporated into the resident's person centred planning "goals" for the year.

Each resident attended a day service that was appropriate to their needs. Some residents were "actively retired" and chose to remain at home two or three days a week, and "go to work" on the other days. The service also facilitate an individualised day service for residents who did not wish to attend a day service facility.

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

The person in charge outlined that residents attended a general practitioner (GP) of their own choice. There was evidence that following GP visits medical notes were available. There was evidence that residents were referred for review by consultant specialists as required. There was evidence of effective communication and collaboration between consultant specialists for example in the areas of neurology and psychiatry

There was evidence that residents were referred for review as required to allied health professionals.

In one of the two houses the kitchen was the hub for all activities and residents relaxed and shared meals with staff throughout the two days of the inspection. The kitchen in the second house was small and residents were able to make hot drinks and had access to snacks as required. In both houses meals were prepared by staff but residents helped with preparation. A copy of the menu in picture format was available on the notice board.

A number of residents had up to date assessments from speech and language therapists available and staff were knowledgeable about residents likes and dislikes and also knew which residents were on special diets. In the apartment attached to one of the houses residents and staff prepared meals together.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Each resident was protected by the centre's policies and procedures for medication management.

There was a comprehensive medication policy that detailed the procedures for safe ordering, prescribing, storage, administration and disposal of medicines.

Medications for residents were supplied by a local community pharmacy. Staff confirmed that there was appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland. Staff with whom inspectors spoke confirmed that there was a checking process in place to confirm that the medicines delivered correspond with the medication prescription records. Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

Staff demonstrated an understanding of medication management and adherence to

guidelines and regulatory requirements. Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure.

A sample of medication prescription and administration records was reviewed by an inspector. Some residents had protocols in place for "as required medication" (or PRN medication). A record of each use of PRN medication was maintained. Records for residents in one of the houses showed that in 2016 PRN medication had been used 57 times.

The person in charge confirmed that medication management training had been given to all staff.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose that accurately described the service provided in the centre.

The statement of purpose described the service and facilities provided to residents, the management and staffing and the arrangements for residents' wellbeing and safety. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre.

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The centre was managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service. However, improvement was required to the reviews of quality and safety of care provided to residents to ensure that the service being provided to residents was being effectively monitored

The person in charge was the area manager for the service and was suitably qualified and experienced to discharge his role. Since the previous inspection a review of the remit of the person in charge had taken place and the person in charge no longer had responsibility for day service provision and still had responsibility for seven designated centres in total.

An annual review of the quality and safety of care of the service had been completed in September 2016. This review had identified a number of areas that improvement had occurred including the accessibility of the complaints procedure, the personal planning process, risk management process and the safeguarding of vulnerable adults. However, improvement was required to the process of annual review to ensure that the care and support provided was in accordance with standards.

For example, the annual review identified that where required, behaviour support plans were regularly reviewed. However, during this inspection it was found that plans in place to support residents to manage their behavior had not been updated to inform existing practice. This was also a finding on the previous inspection of this centre.

Similarly the annual review identified that there were two restrictive practices in the centre. However, it did not identify that the "Fuller Safer Lives Policy" was not being followed and was not fully understood by all staff. This was also a finding on the previous inspection of this centre.

As part of the annual review the Brothers of Charity service had engaged in consultation with the families of residents on the quality of care provided by the centre. Families had identified positive features of the service including that they were able to discuss care with for example the speech and language therapist. One family said that "the quality of care and support is excellent." A number of areas for improvement were also identified including better transport for the centre and that residents needed better holidays.

The Brothers of Charity service had ensured that two unannounced visits to the designated centre in relation to the quality and safety of care had been completed with the most recent in December 2016. There was a prepared written report available in

relation to the “outcomes” that had been reviewed including: social care, risk management, safeguarding, healthcare, medication, governance and workforce.

However, improvement was also required to this review to ensure that the service being provided to residents was being effectively monitored. For example, this review had not identified that the designated centre did not meet the assessed needs of all residents or that residents’ needs were not being assessed to reflect changes in need and circumstances.

Judgment:

Non Compliant - Moderate

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:

Adequate arrangements were in place through the appointment of a named person to deputise in the absence of the person in charge.

The person in charge had not been absent for a prolonged period since commencement and there was no requirement to notify HIQA any such absence. The provider was aware of the need to notify HIQA in the event of the person in charge being absent.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

The centre was maintained to a good standard inside and out and had a fully equipped kitchen and laundry. Equipment and furniture was provided in accordance with residents' wishes.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The inspector found that, based on the assessed needs of residents, there were sufficient staff with the right skills, qualifications and experience to meet those needs. Staffing levels reflected the statement of purpose and size and layout of the buildings.

An actual and planned staff rota was maintained. The rotas for each of the two houses in the centre were completely separate and were staffed independently of each other. A copy of this rota was available in a picture format so that residents were aware of which staff were on duty. At the previous inspection of this centre it had been identified that some residents required additional staffing support and this had been provided by the service.

Staff training records demonstrated all staff had received mandatory training including fire safety, crisis prevention and safeguarding.

The inspector reviewed a sample of staff files and noted that all of 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 and the National Standards for Residential Services for Children and Adults with Disabilities were available.

Judgment:

Compliant

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The Brothers of Charity services had prepared, adopted and implemented policies and procedures relevant to the operation of the centre. However, some improvement was required in relation to the recording of healthcare appointments.

The policies available on the date of inspection were centre specific and some were available in an easy-to-read format.

A copy of the residents' guide was available and a directory of residents was maintained in the centre and was made available to the inspector.

Staff outlined that they accompanied residents to healthcare appointments either with a general practitioner or a consultant doctor. The person in charge outlined that following such a healthcare appointment staff recorded the outcome of the appointment.

However, this practice could not ensure an accurate record was being maintained of healthcare appointments.

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:

Kieran Murphy
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 Southern Services
Centre ID:	OSV-0003560
Date of Inspection:	30 and 31 January 2017
Date of response:	13 April 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 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 admission practices and policies were not transparent.

1. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in

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

accordance with the statement of purpose.

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

- 1.The Procedures to be followed in relation to Residential Transfers within and between Designated Centres has been reviewed with local Multidisciplinary Disciplinary Team and a clear process has been agreed to ensure all admissions are assessed based on the support needs of the individuals, the statement of purpose of the Centre and having regard to the wishes and preferences of the individuals concerned
- 2.The Services Admissions, Discharges and Transfers Procedures will be reviewed and updated to provide further clarity on procedures.
3. The Provider and Person in Charge will ensure that all future admissions will be conducted in accordance with the Services procedures.

Proposed Timescale: 04/04/2017

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:

The personal planning process was not the subject of a multidisciplinary annual review as required by the regulations. Therefore the process did not address the supports that may be required from other healthcare professionals that would best meet the resident's needs in using combined strategies.

2. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

A process for the Annual multidisciplinary review of the Personal Plans has been agreed and will be implemented in full in this centre as each review falls due from 1 March 2017.

Proposed Timescale: 30/09/2017

Theme: Effective Services

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

The designated centre did not meet the assessed needs of all residents.

3. Action Required:

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

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

1. An application for transfer for one resident was processed by the Admissions Discharges and Transfers Committee (ADT) and a transition plan with MDT input has been agreed. It is anticipated that this transition to the new centre will be completed by 31st May 2017.
2. A suitable alternative residential placement has been identified for a second resident. His ADT application will be finalised at the next scheduled meeting of the Committee on 25th April 2017. It is anticipated that his transition to the new centre will be completed by 23rd June 2017.
3. The Person in Charge will ensure that the multidisciplinary review of the support needs of another resident will include recommendations on the suitability of the current centre in meeting the assessed needs of the individual. This review commenced in January 2017 with a psychological review (reference in Page 10 of the Report) and will be completed by 23th June 2017.

Proposed Timescale: 31/05/2017 & 23/06/2017

Proposed Timescale: 23/06/2017

Theme: Effective Services

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

Residents' needs were not being assessed to reflect changes in need and circumstances.

4. 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:

1. As mention above two residents have been identified as presenting with changing need and are currently under review.
2. We will ensure that Service Users Individual Risk Profile is completed on a quarterly basis. This review should inform if the assessments need to be completed more frequently than on an annual basis.

Proposed Timescale: 30/05/2017

Theme: Effective Services

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

There had been some admissions to hospital by residents in the last 12 months. However, there was no information on file in relation to one of these hospital

admissions. In particular an assessment of residents' health needs had not been completed and their care plan had not been updated to reflect the instructions of the discharging hospital team.

In addition, one resident was on the waiting list for a consultant review but the care plan did not reflect the healthcare issue.

5. Action Required:

Under Regulation 25 (2) you are required to: On the return of a resident from another designated centre, hospital or other place, take all reasonable actions to obtain all relevant information about the resident from the other designated centre, hospital or other place.

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

- a. The Design of the Health Care Management Plans (HCMP) will be reviewed and updated to direct staff to complete a HCMP for all health care issues and especially in relation to (a) all issues where a referral has been made for review including Consultant Review
 - b. All hospital admissions and Consultant appointments are documented in the Medical File and
 - c. All Discharge summaries are sourced from the appropriate medical practitioner and a copy will be kept on file.
- All existing healthcare plans for the residents will be reviewed and updated accordingly

Proposed Timescale: 31/03/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

It was noted that the entrance to the kitchen area required a proper floor covering as there was duct tape on the ground.

6. Action Required:

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

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

Replacement floor covering for the kitchen area will be put in place.

Proposed Timescale: 15/03/2017

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:

Improvement was required in relation to the management and ongoing review of risk on the centre risk register.

7. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

The risk register will be reviewed and up-dated to fully reflect all current risks, including inappropriate placements and access to multi-disciplinary supports.

Risk Register updates will be part of the Team Meetings in the Centre

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

Hand drying facilities were not available in one of the bathrooms.

8. Action Required:

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

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

Hand-drying facilities have been replaced in one bathroom.

Proposed Timescale: 01/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The policy on the use of restrictions was not being followed and was not fully understood by all staff. In addition, there were restrictions in place that still required review.

9. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures

including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

One Restrictive Practice in relation to a connecting door to the self-contained apartment is under review with the local multidisciplinary team to make a decision to either remove the restriction or to advance the restriction for formal sanction by the Behaviour Standards Committee in accordance with the Policy of ensuring the least restrictive measures are in place. [30/04/2017]

A review of the second restrictive practice in the Centre was carried out on 15th February. This has been submitted to the Behaviour Standards Committee for formal sanction. [15th March 2017]. All staff have been instructed on the correct procedure in the implementation of restrictive practices.

Proposed Timescale: 30/04/2017

Theme: Safe Services

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

While a summary report from the behaviour support specialist from August 2016 was available for one resident, a number of recommendations from that report were still outstanding.

10. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The recommendations of the behaviour support specialist in August 2016 are being addressed as part of the multidisciplinary review of the support needs of the resident which commenced in January 2017 (see Action 2 Item 2 and Action 3 Item 1 above)

Proposed Timescale: 30/04/2017

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:

Improvement was to required to the six monthly reviews of quality and safety of care provided to residents to ensure that the service being provided to residents was being effectively monitored.

11. 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 will review the format of the unannounced visits to the centre to ensure that the safety and quality of care issues and actions taken in relation to these issues are reviewed and reported on as part of these visits.

Proposed Timescale: 31/03/2017

Theme: Leadership, Governance and Management

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

Improvement was to required to the annual review of quality and safety of care provided to residents to ensure that the care and support provided was in accordance with standards.

12. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

In future the annual review will detail all safety and quality of care issues and where required any short-comings in relation to the standards, the report will give detail of how these will be addressed.

Proposed Timescale: 01/11/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Staff outlined that they accompanied residents to healthcare appointments either with a general practitioner or a consultant doctor. The person in charge outlined that following such a healthcare appointment staff recorded the outcome of the appointment. However, this practice could not ensure an accurate record was being maintained of healthcare appointments.

13. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for

inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

Every effort will be made to ensure that an accurate record is maintained of all healthcare appointments with GPs and healthcare professionals. We will do this by

1. Requesting a written note from GP/Consultant at each visit OR if not possible
2. Staff will complete a Health care Management Plan (HCMP) during the visit and ask the GP/Consultant to review and sign off on the plan OR if not possible
3. Staff will complete a HCMP immediately on return and note why 1&2 have not been possible

Proposed Timescale: 08/03/2017