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:	Waxwing 1
Centre ID:	OSV-0004918
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):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	4

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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 July 2017 08:30	18 July 2017 17:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA); the last inspection was undertaken in July 2016. Previous inspection findings were not satisfactory with significant regulatory non-compliance evidenced. Regulatory actions taken by HIQA in response to these findings included meetings with the provider and the issuing of a warning letter in October 2015. Improvement was evidenced in July 2016 as were the actions to be taken by the provider as committed to in the response to the previous action plan. This inspection followed up on the action plan that issued from that July 2016 inspection.

How we gathered our evidence:
The inspection was unannounced. The inspection was facilitated by the person in charge and the area manager. The head of community residential services attended the verbal feedback at the conclusion of the inspection on behalf of the provider. Inspectors met and spoke with the frontline staff on duty. Inspectors reviewed records including records of complaints, fire safety and health and safety, reports of reviews and audits; records pertaining to residents and staff-related records such as the rota and training records.

Inspectors met and spoke with all of the residents. Inspectors saw that residents looked well and presented as relaxed and content. Each resident communicated with the inspectors in the manner that was suited to their individual needs. Residents spoke of their plans for the day and social outings that were planned and eagerly anticipated. Inspectors saw that residents gave a warm welcome to the person in charge when she came on duty. Residents told inspectors that everything was "fine" in the house.

Description of the service:
The premises was a domestic-type single-storey premises; it was well-maintained, homely and welcoming in presentation. The premises was situated in a small residential development in a rural location where transport was required to access all amenities.

The provider is required to produce a document that sets out the purpose and function of the centre; this document stated that residential services were provided to six residents identified as requiring increased supports due to personal health requirements and increasing age. Inspectors were satisfied that the service provided was as stated.

Overall findings:
It was confirmed for inspectors that the provider continued to fail to substantially implement the findings of a fire safety report commissioned by the provider in October 2015. The rationale provided for this ongoing failing was the absence of the funding required to complete the required works. The provider had however addressed the deficits identified by inspectors at the time of the last inspection in the provider's own fire safety systems and measures, for example, the servicing and testing of equipment such as the fire detection system.

While improvement was noted, based on evidence gathered during the inspection, inspectors concluded that the medicines management training provided was insufficient to equip staff with adequate knowledge and skills to administer medicines as prescribed.

There was evidence to support further actions taken by the provider to conclude a safeguarding matter, however, the issue was still not satisfactorily resolved.

Overall however, significant improvement was evidenced and a good level of regulatory compliance was evidenced by inspectors.

The provider had consolidated the governance arrangements of the centre and inspectors were satisfied that the provider's systems of monitoring and review effected improvement in the quality and safety of the supports and services provided to residents.

The quality of life and outcomes for residents continued to be supported by the consistent provision of additional staffing resources, constructive input into their care and supports from the multidisciplinary team and consistent oversight by the person in charge.

While this was ostensibly a social model of care, given the needs of this particular cohort of residents, inspectors were reassured that their holistic needs including their physical and healthcare needs were monitored and appropriately supported.

Improvement was noted in the management of complaints.

Of the nine outcomes reviewed and reported on by inspectors, the provider was judged to be compliant with six, in moderate non-compliance with two and in major non-compliance with one; Outcome 7: Health and Safety and Risk Management. The findings to support these judgments are presented in the relevant outcomes in the body of the report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors met with all of the residents living in the centre. Residents welcomed the inspectors into their home. Inspectors explained to residents what is was that they did when they visited a house. Residents told the inspectors that everything was fine in the house and that they were happy.

At the previous inspection, it was identified that the template for residents' meetings was not being used to its full potential. The action required was satisfactorily implemented. Inspectors reviewed a sample of residents' meeting records. Residents' meetings were held weekly and acted as a forum for residents to discuss various matters including complaints, safeguarding, activities, holidays, menu planning, fire safety, evacuation plan and any other business. Any issues raised at the previous meeting were revisited at the subsequent meeting. Records indicated that all residents were supported to engage and contribute to residents' meetings. Actions from residents' meetings were clearly recorded and there was evidence that staff and management had followed up on actions.

Improvement was noted in the local management of complaints. In line with the provider's complaints policy and procedure, staff maintained two complaint records; the local issues record and the informal complaints record. These records indicated that residents knew how to complain, who to complain to, and that their complaints were acknowledged, resolved or escalated as necessary to the person in charge who took further action to resolve the matter to the satisfaction of the residents.

Inspectors reviewed a sample of records pertaining to the management of residents'

personal finances. Staff confirmed that residents had access and control over their personal finances but required staff support. Inspectors saw that a financial ledger was maintained for each resident; a record was maintained of each transaction, the purpose for which monies were used; transactions were signed and countersigned by staff and receipts to support purchases were retained. The person in charge confirmed that she had to be advised of any purchase supported by staff that was in excess of €250. Each key worker had to compile a monthly financial report for the person in charge. The person in charge was required by the provider to audit, for accuracy and accountable management, a minimum of one resident financial ledger each month and report her findings to the head of community residential services.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
At the previous inspection, there was some evidence of unsigned, undated alterations and obliterations of text and it was difficult to establish and verify that referrals, reviews and multidisciplinary team (MDT) recommendations were followed up on and integrated into the resident's individual personal plan. The actions from the previous inspection were satisfactorily implemented.

A sample of residents' personal plans ('My Profile My Plan' (MPMP)) was reviewed. An information gathering document was used to assess the health, personal, social care and support needs of the resident annually. The information gathered was individualised, accurate, person centred and comprehensive.

A plan (MPMP) had been developed for each resident which included information across three domains - 'myself, my world and my dreams'. Goals and objectives were clearly outlined. There was evidence of resident involvement in agreeing and setting goals. There was also evidence that individual goals were achieved. Goals outlined would improve the residents' quality of life and support residents to maximise their personal

development such as creating a life story, using services in the community independently and improving money management skills. The person responsible for supporting the resident in pursuing these goals and associated timeline was clearly identified. Goals were reviewed on a quarterly basis to monitor progress, identify barriers and document achievement. Where barriers were identified, appropriate action was taken to address the barriers or amend the goal.

Residents were consulted with and participated in the development of the MPMP. The MPMP as made available to each resident in an accessible format in line with their needs. Residents were aware of the information contained in the MPMP and the goals identified. Residents spoke of social outings and planned holidays identified as goals.

The MPMP was subject to a review on an annual basis, or more frequently if circumstances changed, with the maximum participation of the resident. The review was multidisciplinary and assessed the effectiveness of the plan. Goals and aspirations identified were reviewed. Changes in circumstances and new developments were included in the MPMP and amendments were made as appropriate. The layout of the MPMP was clear and inspectors could clearly establish and verify that referrals, reviews and MDT recommendations were followed up by the person in charge and integrated into the MPMP.

A booklet was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The booklet was completed in advance and contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare.

Residents were afforded the opportunity to participate in meaningful activities, appropriate to their individual interests and preferences. Residents attended a day service external to the centre, in line with their needs and interests. Some residents had a later start in the morning and this was facilitated in the centre. Residents were supported to participate in a range of activities in the local and wider community including meals out, bowling, swimming, cinema and concerts. Residents were encouraged to shop and use services locally.

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:
It was confirmed to inspectors that recommended fire safety works, as outlined further to a fire safety survey commissioned by the provider in late 2015, had not been completed. In 2015, the centre had been equipped with fire safety measures including an automated fire detection system, emergency lighting, escape route signage and fire resistant doors. However, the survey had identified deficits in some of these completed works and inadequate provision for the containment of fire and the protection of some escape routes. For example, inspectors saw that there was no fire resistant door-set between the utility, the kitchen and the main communal room. Inspectors were again advised that the required works had not been completed as the required funds were not available.

While there was evidence that some remedial works had been completed on self-closing devices attached to the fire resistant doors, records of checks completed by staff indicated recurring problems with these devices; two doors were recorded as not closing adequately as recently as the 12 July 2017.

The provider had however addressed other deficits identified at the time of the last inspection. Certificates were seen of the inspection and testing of the fire detection system, emergency lighting and fire fighting equipment at the prescribed intervals, to the relevant standard (as cited on the records seen) and most recently in May 2017, June 2017 and March 2017 respectively. In addition, records seen by inspectors indicated that staff were consistently undertaking the required in-house checks and testing of the fire detection system and designated fire exits. Staff had to date in 2017, completed six simulated evacuation exercises with residents; any challenges encountered were recorded and reflected in resident's personal emergency evacuation plans (PEEPS). All of the residents were recorded to have successfully participated; all of the recorded evacuation times were less than two minutes.

Inspectors reviewed the register of risks that was maintained by the person in charge. The identified risks were specific to the centre, to the individual and collective needs of the residents and reflected regulatory requirements, for example the assessment of the risk of abuse. There was evidence that the person in charge kept each identified risk, its management and residual risk rating under regular review and that controls (with the exception of the fire safety works referenced above) identified as required to reduce the level of risk were implemented. For example, referral to and input from the multidisciplinary team and preventative and protective clinical interventions to reduce the risk of a fall and injury subsequent to a fall.

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 to protect residents from harm and abuse; including national and organisational policies and procedures, staff training, access to a designated safeguarding person, regular discussion with residents at the resident meetings on safeguarding and complaints, an effective complaints procedure, and access to and support from members of the multidisciplinary team.

The person in charge confirmed that there were no safeguarding concerns since the last inspection; safeguarding plans remained in place and were reviewed in consultation with resident choice.

Training records indicated that all staff had attended both safeguarding training and training in responding to behaviours of concern or risk (MAPA, the Management of Actual and Potential Aggression).

However, while there was evidence made available to inspectors of further action taken by the provider to progress a safeguarding matter ongoing since 2015, this matter was still not satisfactorily resolved so as to provide reassurance that the matter had been appropriately investigated and responded to.

Residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges. Efforts were made to alleviate the underlying causes of behaviour that challenges for each individual resident. MDT meetings were convened to identify support strategies for individual residents and timely referrals were made based on MDT recommendations. Residents had access to support from a specialist behaviour support team, psychology and psychiatry. Positive behaviour support plans were developed by the specialist behaviour support team and were subject to regular review. The plans were comprehensive and demonstrated a proactive approach to supporting residents and promoted residents to develop self-management skills. Residents were involved in the development of the plan. Incident reports demonstrated that staff implemented the plans in practice and there was a clear reduction in the number of incidents following input from the MDT and implementation of positive behaviour supports.

Environmental restrictive practices were in place at the time of the inspection. A clear rationale was outlined for the use of these restrictions; less restrictive alternatives were considered and the decision to implement restrictive practices was made by the MDT.

Restrictive practices were reviewed quarterly by the person in charge and members of the social work and specialist behaviour support team. The use of restrictive practices was also reviewed at the annual review of the MPMP by the entire MDT.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Residents were supported on an individual basis to achieve and enjoy best possible health.

Residents' healthcare needs were met through timely access to healthcare services and appropriate treatment and therapies. A medical practitioner of their choice was available to each resident and an 'out-of-hours' service was available if required. Inspectors noted that residents were reviewed by the medical practitioner regularly. Medical advice and consultation in the event of clinical deterioration was seen to be sought in a timely fashion. There was clear evidence that the treatment recommended and agreed by residents, was facilitated. Residents' right to refuse medical treatment was respected. There was a process in place for annual medication review, individual health screening and preventative healthcare.

Where referrals were made to specialist services or consultants, the inspector saw that staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals and services including speech and language therapy, occupational therapy, psychiatry, neurology, psychology, chiropody, dental and optical.

Individualised healthcare plans were developed for residents, in line with their individual needs. Healthcare plans were specific and outlined clear interventions to be implemented to support residents to achieve best possible health. Evidence of implementation of required interventions was seen including monthly monitoring and recording of body weight, seizure management, eating, drinking and swallowing interventions and bowel management plans. Healthcare plans were current and updated regularly to reflect any changes or recommendations from specialist services.

Residents were encouraged and enabled to make healthy living choices in relation to

exercise, weight control and healthy eating. Residents' weights were monitored on a monthly basis and residents' weights were stable and within a healthy range. The recommendations from the speech and language therapist were seen to be implemented. Residents were encouraged to be active through swimming, yoga and dance classes.

A choice was offered for all meals. The meals outlined in residents' meeting records were nutritious and varied. Ample supplies and choice of fresh food were available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks. There was adequate provision for residents to store food in hygienic conditions.

Residents were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy-to-read format.

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

Findings:
Improvements were noted in the area of medicines management but inspectors concluded that there was inadequate oversight in relation to medicines management to ensure that practices were safe and residents received medicines as prescribed. This outcome was examined by a specialist medicines management inspector.

A medicines management policy was in place which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines, dated May 2016. The area manager and the head of community services outlined that the policy was currently under review. Medicines were stored securely throughout. Medicines requiring refrigeration and those requiring additional controls were not in use in the centre at the time of the inspection.

Medicines and pharmaceutical services were provided by a local community pharmacy. The pharmacist was facilitated to meet the obligations under relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

All staff had received medicines management training since the last inspection. The area manager outlined that staff received a one day classroom training programme in the area of medicines management. The training programme focused on the organisation's policy in relation to medicines management and good practice for medicines administration. However, based on evidence gathered during the inspection relating to inadequate documentation, gaps in staff knowledge and a discrepancy that had not been previously identified, inspectors concluded that the training provided was insufficient to equip staff with adequate knowledge and skills to administer medicines as prescribed.

A sample of prescriptions, administration records and monitored dose systems were reviewed. A prescription was identified which was ambiguous to both inspectors. The dose on the prescription did not correspond to the dose dispensed in the monitored dose system. This was brought to the attention of the person in charge immediately who investigated the discrepancy and arranged for the prescription to be amended. The prescription had been in use for at least four weeks prior to the inspection and the discrepancy had not been identified by staff. Staff confirmed that they were not familiar with a common abbreviation used by the prescriber but had not clarified this prior to administering the medicine.

It could not be demonstrated that medicines were administered as prescribed due to the documentation practices in the centre. Staff documented 'blister pack' on the medicines administration record and therefore did not document the dosage, the name of the medicine and the method of administration as required by Schedule 3 of the regulations. In addition, it was noted that the times of administration recorded on the administration record were often inaccurate and did not correspond to the prescription or actual time the medicines were administered.

Medication-related incidents were identified, reported on an incident form and there were arrangements in place for investigating incidents. Medication-related incidents were reviewed by the person in charge to identify trends and measures were implemented to prevent recurrence.

Medicines, which were expired or dispensed to a resident but were no longer needed, were stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

A system was in place to review and monitor medicines management practices. Audits of medicines management were completed by the area manager, pertinent deficiencies were identified and action plans emanated from the audits.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

Findings:
The provider had consolidated the management arrangements of the centre and its systems of oversight and monitoring; these actions, based on these inspection findings, provided evidence of governance arrangements that supported the quality and safety of the services, supports and care provided to the residents.

There was a clear management structure; roles, responsibilities and reporting relationships were clear. Frontline staff reported to the person in charge, who reported to the area manager, who in turn reported to the head of community residential services. Overall, oversight was maintained by the director of services who was the provider's nominated representative.

The person in charge had been fulfilling that role since just prior to the HIQA inspection of July 2016. In the intervening period, it was evidenced that the person in charge had implemented systems and the oversight required to support the quality and safety of the service and enhance the level of regulatory compliance achieved; for example in the management of complaints, the maintenance of fire safety measures, the assessment and monitoring of each resident, their needs and required supports.

The person in charge was employed full-time and held core qualifications in social care studies. The person in charge continued to engage in the provider's programme of education and training; some of the training completed focussed on the managerial responsibilities and duties of a person in charge. The person in charge was based in the house, worked alternate weekends and shifts that corresponded to times when both residents and staff were present in the house. The person in charge confirmed that this arrangement supported the supervision of staff and of the services, care and supports delivered to residents.

The person in charge confirmed that she had access to advice and support from the area manager as required and that they met at least once each week. Residents were clearly familiar with both the person in charge and the area manager.

The provider's representative had commenced meetings to which all managers and members of the multidisciplinary team were invited. The person in charge confirmed that she had attended two of these meetings and said that the meetings supported

good communication of relevant information and developments.

There was an on-call support system, the details of which were included on the staff-rota. The person in charge participated in this rota but said it was structured and managed so as not to impinge on her person in charge role and responsibilities.

Since the last inspection inspectors saw that the provider had undertaken two unannounced visits to the centre in November 2016 and May 2017, and had completed the annual review of the safety and quality of the supports and services provided to residents as required by Regulation 23. The nominated provider and the head of community residential services participated directly in these reviews. The annual review sought and incorporated feedback from residents and their representatives. Each review followed up on the action plan that had emanated for the previous review and the actions that had been issued from HIQA inspections. The findings, while continuing to highlight deficits, also supported the implementation of the required actions and a consequent pattern of improvement.

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:
Based on the evidence available to inspectors, staffing numbers and arrangements were adequate to meet the assessed needs of the residents. A review of the staff rota reflected the staffing levels described to inspectors. There was generally two staff on duty in the centre when the maximum numbers of residents were present in the centre. Monday to Friday, there were two staff on duty from 17:30hrs to 22:30hrs and again between 08:00hrs and 08:45hrs. At the weekend there were two staff on duty between 11:00hrs and 21:00hrs.

The person in charge was also based in the house and was not included in these staffing numbers; the person in charge worked alternate weekends and was in the house when both residents and staff were present.

The sleepover staffing arrangement continued to be one staff member on sleepover duty. The person in charge told inspectors that there was an ongoing system in place to monitor the safety and adequacy of this arrangement; for example; the monitoring of residents' sleep patterns. The person in charge said that she was satisfied that the current staffing arrangements were appropriate to the number and assessed needs of the residents.

Relief staff, if required, were sourced from the pool of relief staff that worked only in the Waxwing group which consisted of three designated centres. This maximised consistency and residents were seen to be familiar with the staff on duty.

Training records for staff were maintained on an individualised basis. A review of these records by inspectors demonstrated that all mandatory training requirements in safeguarding, fire safety and responding to behaviours of concern or risk were met. Additional training completed by staff included medicines management training including the administration of a rescue medicine; supporting residents with compromised eating and drinking ability, supporting a resident with dementia, food safety and safeguarding residents' personal assets. The scope of the training provided to staff reflected residents' assessed and changing needs.

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

Findings:
Inspectors saw that 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 were in place and retrieved by the person in charge as requested by inspectors.

The records reviewed were well-maintained and inspectors retrieved with ease the

information they required.

There was documentary evidence that the provider had appropriate insurance in place.

A directory of residents was maintained; it included all of 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.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004918
Date of Inspection:	18 July 2017
Date of response:	02 August 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 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:
Recommended fire safety works, as outlined further to a fire safety survey commissioned by the provider in late 2015, had not been completed. The survey had identified deficits in some completed works and inadequate provision for the containment of fire and the protection of some escape routes.

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

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

Please state the actions you have taken or are planning to take:
• A Fire Safety Strategy was developed by BOCSILR in 2016 and submitted to the funding statutory body for funding. No funding for Fire Safety upgrade has been allocated to date. This remains on the agenda as part of our engagement with the funder. The timeline for upgrade of fire safety infrastructure is dependent on funding being secured from the funding statutory body.
• The issue of funding for the Fire Safety Strategy was raised with the Head of Estates with the funder on 6th June 2017. A copy of the report was sent to the Head of Estates following this meeting.
• In the meantime measures are consistently carried out in the Designated Centre to ensure the safety of residents in the centre in relation to fire. This includes daily checks by staff, weekly checks by the person in charge as well as weekly tests of the fire alarm. Staff carry out drills monthly and all fire related equipment is tested quarterly.

Proposed Timescale: Point 3 above is completed. The timeline for point 1 and 2 is outside our control at this time while awaiting additional funding.

Proposed Timescale: 04/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding concerns ongoing since 2015, were still not satisfactorily resolved so as to provide reassurance that the matter had been appropriately investigated and responded to.

2. 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:
• After a number of attempts to organise a meeting with the legal authorities, the Director of Services, Area Manager and Designated Officer met with them in March of 2017. The requested information was forwarded to the legal authorities on 14/04/17 but there has been no response since. An additional letter was sent on 24/07/2017 requesting follow up on this matter. The DOS will continue to liaise with the relevant representative of the legal authority.
• The safeguarding plan for this service user remains in place. There have been no further issues of concern since 2015.

Proposed Timescale: 24/07/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate oversight in relation to medicines management to ensure that practices were safe and residents received medicines as prescribed.

The training provided was insufficient to equip staff with adequate knowledge and skills to administer medicines as prescribed.

It could not be demonstrated that medicines were administered as prescribed due to the documentation practices in the centre.

An ambiguous prescription was not clarified in a timely manner

3. Action Required:
Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
• Medication Management Policy is currently under review and recommendations made by the inspector will be used to inform changes to our procedure.
• Medication Management Training is currently under review in light of the required review to the Policy. Training will then be revised and recommendations made by the inspector will be used to inform changes to our training.
• Monthly audits carried out by the Area Manager will continue in the centre.
• The ambiguous prescription has since been clarified.

Proposed Timescale: Points 3 & 4 above are completed. Points 1 & 2 above will be completed by 30/09/2017

Proposed Timescale: 30/09/2017