

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
<b>Centre ID:</b>	OSV-0004574
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Ireland
<b>Provider Nominee:</b>	Una Nagle
<b>Lead inspector:</b>	Breeda Desmond
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	3
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
31 August 2015 15:00	31 August 2015 17:30
01 September 2015 08:30	01 September 2015 19:00

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

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

**Summary of findings from this inspection**

This report sets out the findings of an announced registration inspection and it was the second inspection undertaken by the Authority of this service. This registration inspection took place over two days. As part of the inspection the inspector met with residents, house unit leader, staff members, the Provider Nominee, Sector Manager and the Person in Charge (area manager). The inspector observed practices and reviewed governance, clinical and operational documentation to inform this registration application.

The provider nominee, sector manager and person in charge displayed good

knowledge of the standards and regulatory requirements and along with staff they were found to be committed to providing quality person-centred evidence-based care for the residents.

The inspector spoke at length with family members and while they were satisfied with the care staff and their attention and kindness towards their family members, they were unhappy with the previous lack of involvement regarding decision making; this will be discussed in the report under the relevant outcomes.

Overall, the inspector found that residents' wellbeing was central to service provision in the centre. Staff were kind and respectful to residents and demonstrated good knowledge of residents and intervention necessary for those with complex divergent needs.

Staff levels appeared adequate to meet the assessed needs of residents. However, fire safety training and fire drills were insufficient to ensure safety.

This service comprised a large four-bedded bungalow within an extensive campus site. The physical environment was recently decorated and it was suitable for its stated purpose and was bright, comfortable and homely.

Policies and procedures required attention as some of the national policies were out of date and the admission policy was not comprehensive.

The inspector identified aspects of the service requiring improvement to enhance the findings of good practice on this inspection.

These improvements included:

- 1) medication documentation
- 2) updating care documents
- 3) access to allied health professionals
- 4) involvement of parents in the decision-making process
- 5) staff training
- 6) admission policy
- 7) incidents recording
- 8) directory of residents.

The action plan at the end of this report sets out the actions necessary 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 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

**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:**

The inspector observed that staff respected the privacy and dignity of residents in their interactions, care and how they addressed residents. Each resident was treated as an individual with different levels of support provided in accordance with their assessed needs, preferences and communication needs and this was observed on inspection.

Residents were assigned a key worker who acted on the behalf of individual residents and this was evidenced in their personal plans of care. Residents and their next-of-kin had access to independent advocacy services should the need arise; residents' documentation highlighted that this service was availed of by relatives. The 'Charter of Human Rights' was displayed in an accessible format.

The inspector observed that residents were consulted with informally on a daily basis, for example, choices regarding evening meals; due to residents' complex communication status, formal meetings as described in the Regulations were not feasible.

The inspector joined residents at breakfast where residents were seen to have choice and individual routines for breakfast.

Residents attended day services both on and off site campus for activation. Residents were encouraged to participate in external activities, for example going to cafes, restaurants, shopping and the cinema. Residents had access to transport which was available at all times.

The complaints procedure was displayed in both pictorial and narrative form in an

accessible format. The complaints policy was compliant with the Regulations. There was a new complaints log template in place to ensure that all the requirements set out in the Regulations could be facilitated.

**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:**

Residents were assisted and supported in their individual communication needs. Picture-enhanced communication was available and displayed throughout the centre to support non-verbal communication to relay information regarding daily activities, menu choice and staff on duty. A notice board was available outside the staff office which detailed names and pictures of staff coming on duty. There was a second notice board in the dining room that displayed menu choices and the name of the resident who decided on the day's menu. One resident had a white board outside his bedroom; he also had a small storage unit with several drawers that contained pictures which he displayed on the white board, to inform staff of his daily choices.

The centre-specific residents' guide was available in an accessible format for residents which included the ethos of the organisation.

Residents had access to televisions, radio and music centres. There was a large flat screen television were in communal sitting room. Staff had completed communication training. Communication requirements were highlighted in personal care plans; documentation to enable and support residents in their communication needs was documented and evidenced in practice.

Residents had access to multi-disciplinary professionals such as speech and language therapy, ophthalmology, audiology, psychology and psychiatry to assist them in their communication needs.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with*

*the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

The inspector spoke at length with family members and while they were satisfied with the care staff and their attention and kindness towards their family members, they were unhappy with the previous lack of involvement regarding decision making.

They outlined that decisions regarding health and social issues were made without consultation with them as parents. There was some documented evidence that next-of-kin were consulted with in the decision-making process, however, this was not always seen in residents' documentation. This was discussed thoroughly with the person in charge, sector manager and provider nominee. They outlined a robust plan to establish effective communication with the family members and involve them in decision-making for their loved ones and this is to be welcomed. The action plan for this was input under Outcome 5 Social Care Needs.

Activity plans called an 'integrated day service plan' was devised by the day service co-ordinator for each resident. These were developed following review of residents' personal support plans and assessments and consultation with staff to facilitate activity choice meaningful to residents.

**Judgment:**

Substantially Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Written agreements with residents regarding the support, care and welfare of the resident in the designated centre that detailed services to be provided for that resident, as described in the Regulations, were in place for one resident. The family of the other residents had not returned the contracts for the provision of services.

There was a policy to support the comprehensive pre-admission application and assessment, transfer and discharge procedure, however, it did not direct the reader to the location of the admission pack/process, which formed part of the 'Provision of Information to Residents' policy. The action relating to this was included in Outcome 18 Records and Documentation.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspector reviewed a sample of assessments and personal support plans for residents. An easy read version was available for residents. In general, they were comprehensive, resident specific and well maintained. However, occasionally, valuable information was not included in the summary documents, for example, one resident had a history of absconding and this was not included even though this information was contained within the file.

Documentation identified the key worker assigned responsibility to enable residents achieve their goal with agreed timescales to review objectives and re-evaluate. Generally, support plans were signed and dated by staff, however, occasionally they were not signed or dated by the staff member completing the review.

Behavioural support plans were evidenced for those residents whose assessed needs required this support. These were annually reviewed at a minimum by the multi-disciplinary team. Assessments were submitted to the Behavioural Standards Committee for review and agreement and these reports were evidenced. There was an over-arching policy titled 'Fuller Lives Safer Live' which included several subsidiary policies to inform and support monitoring and review of behavioural support practices.

Restrictive practices were in place for three residents. There was documentation evidenced to support this including monthly reviews by the Behavioural Support



Committee in conjunction with support staff. Comprehensive records were maintained of restrictive practices, including times and residents' responses. Minutes of 'periodic service review' meetings were demonstrated which included detailed information to inform choices and care. However, they did not detail whether families were invited to these meetings for inclusion and consultation.

Residents had timely access to multi-disciplinary professionals such as speech and language therapy, dentist, audiology, general practitioner (GP), psychology, social worker and psychiatry. The sample of residents' notes reviewed evidenced regular reviews by their GP. Out-of-hours GP cover was provided. Nonetheless, one resident's was referred for occupational therapy on September 2014 but this had not been facilitated; a further referral was made for this resident for an occupation therapy assessment in May 2015 and an appointment was still awaited.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The designated centre was part of a campus located in a suburban area. It comprised a large four-bedded semi-detached bungalow which accommodated three residents and one night duty staff member. There was a secure enclosed garden to the rear of the bungalow with paving and garden furniture. There was ample parking and outdoor space for residents. A day service, large canteen, consultation rooms, horticulture centre, and training facilities were also accommodated on campus. There were walkways and a wooded area on the grounds of the campus and residents enjoyed peaceful walks there.

The design and layout of the bungalow was suitable for its stated purpose and function, and appeared to meet the individual and collective needs of each resident. The lounge area inside the main entrance was spacious and contained comfortable seating. Further communal space comprised a dining room which was separate to and alongside the kitchen; an expansive sitting room with comfortable seating, flat screen television, dining suite and desk. The secure garden could be accessed through patio doors in this sitting room. Residents' bedrooms were decorated according to their choice and they had ample personal storage space. One resident had a relaxation room which contained

his music and items of interest to him. There was a seclusion room which had comfortable seating, a bean bag, cushions and items of interest to the resident.

Laundry facilities were in a secure utility room where cleaning equipment was also stored.

**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):**

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

**Findings:**

As part of the application to register this centre the provider had submitted a valid certificate of compliance regarding statutory requirements in relation to insurance, building control and fire.

There was a current safety statement and a health and safety and welfare policy which contained all the items required in the Regulations.

Fire safety upgrades were completed since the last inspection. Emergency evacuation advisory signage was displayed throughout the bungalow. There were adequate means of escape and emergency escape signs were at each exit. Inspector examined fire safety records and noted that fire safety checks were completed including routine testing of the fire alarm and emergency lighting. Certificates were in place for annual servicing of fire safety equipment and emergency lighting, and bi-annual testing of emergency lighting. However, regular fire drills and evacuations and fire safety training were not completed at suitable intervals by staff and residents to ensure their safety; fire safety training records showed that training occurred just annually.

A 'Personal Emergency Evacuation Plan' (PEEP) was completed for each resident which outlined the degree of assistance required for their safe evacuation.

Infection prevention and control measures were in place to ensure safety and a policy was in place to support best practice.

Staff were aware of their regulatory responsibilities regarding reporting incidents to the Authority and other regulatory bodies. The accident and incident log contained records which demonstrated that issues were addressed in a timely manner with the involvement of relevant professionals. Incidents involving residents and staff did not identify the resident involved, therefore, trending or analysis could not be effectively

completed to mitigate recurrences. Individual risk profiles were in place for residents, however, these were a new initiative introduced and were only partially completed; in addition, staff members completing this form had neither signed or dated it.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

There were up-to-date policies in place for protection of vulnerable adults, provision of intimate care, provision of behavioural support, and restrictive procedures as required by Regulation. Staff had completed up-to-date training in protection, restrictive practices, crises intervention protocols, seclusion protocols and practices and procedures relating to behaviours that challenge; staff interviewed demonstrated their knowledge relating to these issues. While documentation was maintained regarding chemical restraint used, it was not comprehensive. For example, the second line of a PRN (as required medication) intervention protocol was often given rather than the first line of the protocol, however, the rationale for administration of line two of the intervention protocol rather than the first line was not precisely recorded. An erasing fluid was used throughout these documents which was not in keeping with best practice.

Residents' finances were securely maintained in the secure staff office. Individual ledgers were evidenced for each resident which recorded debit and credit transactions, each with dual signatures.

**Judgment:**

Substantially Compliant

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> The sector manager and person in charge outlined the process for recording any incident that occurred in the designated centre. They demonstrated their knowledge regarding notifications as described in the Regulations, to the Authority.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 10. General Welfare and Development</b> <i>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.</i></p>
<p><b>Theme:</b> Health and Development</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> Activation day services were located both on and off site from the centre' campus. Support plans reflected the activity schedule available to residents. Good communication and engagement was observed by the inspector between staff and day services to ensure continuity of care. A detailed weekly plan of residents' activities was in place for each resident. In addition, a communication book was evidenced for each resident which included daily progress notes updated by staff in day services to inform house care staff and vice versa.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 11. Healthcare Needs</b> <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i></p>
<p><b>Theme:</b> Health and Development</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b></p>

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed a sample of personal plans which included medical history, vaccination record, and 'Personal Communication Passport'. Care management plans were in place however these were not completed annually at a minimum, as required in the Regulations. For example, forms were dated 25/05/13 and the next review date was 01/03/15; a second form with sensory details was 13/04/13 and the next review date was 01/03/15. In addition, the document 'mental health information' was inappropriately completed as it indicated that the resident was not in receipt of mental health services even though the resident had regular reviews by the psychiatrist. Notes from the psychiatrist demonstrated that a continuous in-depth analysis was undertaken to determine precipitating factors to episodes of behaviours that challenge. This included consultation with support staff and review of incidents, PRN administration (as required medications), sleep, diet, activities and general well being. 'My Hospital Passport' contained details of each resident should the need arise and a photograph of the resident. One resident had an 'Annual Health Check', and it was reported to the inspector that the 'Annual Health Check' for the other residents was submitted to their parents for review, consultation and completion and their return was awaited.

Residents had access to allied health services as described previously and reports were demonstrated in residents' notes of assessments and reviews.

Action plans for issues identified here were included in Outcome 5 Social Care Needs.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

There was an up-to-date policy and procedures for medication management. A staff signature sheet as described in An Bord Altranais medication management guidelines 2007 and Cnáimhseachais na hÉireann was in place. Staff had recently completed their training on safe medication management.

Detailed medication care plans were in place for each resident and epilepsy care plans when relevant. These were thorough and gave comprehensive instruction to staff to inform care and welfare. There was a synopsis sheet recording medication changes as

part of each resident's medication management folder. Medication was stored securely in a locked cupboard within the secure staff office. Medication administration was observed during inspection and this was completed in line with best practice guidelines. Prescription and medication administration records in addition to PRN protocols were examined and several issues were identified that required attention:

- the dosages of the PRN administration protocol did not correlate with the prescription
- residents' prescription charts had been updated, however, the older PRN sheet had not been removed from the file, consequently, this had a huge potential for medication error
- the times for administration of medications on the prescription sheet had been changed to reflect actual administration times, however, the times had not been changed on the administration record sheets
- maximum dosages for PRNs were not always written to mitigate medication over dosage, for example, ventolin and paracetamol.
- each resident had a separate form for recording the rationale for PRN administration and the resident's response to the PRN medication, however, this was not always comprehensively completed to demonstrate why one line of the PRN protocol was administered rather than another. Actions for issues identified here were included under Outcome 18 Records and Documentation.

Return of unused or out-of-date medicines was completed in line with best practice.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

A written statement of purpose was available and this was compliant with requirements listed in Schedule 1 of the Regulations. It was also available in an accessible format for residents.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The person in charge was full-time with the necessary experience to ensure effective safe care and welfare of residents. He demonstrated good knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. He demonstrated a positive approach towards meeting the regulatory requirements and a commitment to improving quality of life and care. He was also person in charge of four other designated centres.

There was a clearly defined management structure that identified the lines of authority and accountability. The quality of care and experience of residents was monitored and developed on an on-going basis.

Annual reviews occurred and action plans were demonstrated with areas for improvement, recommended actions to be taken, persons responsible, timelines for completion and updates of progress of actions were evidenced. Bi-annual unannounced inspections occurred and reports were demonstrated to ensure oversight of quality of life issues for residents.

**Judgment:**

Compliant

**Outcome 15: Absence of the person in charge**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Suitable arrangements were in place in the absence of the person in charge whereby the sector manager deputised for the person in charge. The provider nominee was aware of the Regulatory obligations regarding notification to the Authority should the occasion arise.

**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 premises appeared to be generally well maintained both internally and externally. The bungalow had a fully equipped kitchen which was well stocked with food and other supplies; the utility room had laundry facilities and secure storage area for cleaning equipment. Current service records were in place for equipment.

**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:**

There was a unit leader with responsibility for the day-to-day running of the centre. There appeared to be adequate staff to ensure the safety and quality of life of residents. The previous inspection identified that there was an over-reliance on relief staff, and this



was now remedied, whereby additional staff were employed as core staff for the centre. There was a night superintendent on site to support night duty staff.

A sample of staff files were examined and items listed in Schedule 2 were available for those staff.

Staff training files were also reviewed and mandatory training including protection, positive behavioural support, movement and handling was up-to-date. However, fire safety training records demonstrated that staff did not complete this training in line with best practice guidelines and this action was available under Outcome 7 Health and Safety and Risk Management.

Staff had completed training regarding food preparation and hygiene pertinent to the residents in their care.

**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:**

Policies and procedures in relation to social care and welfare of residents required attention to ensure they were up-to-date and comprehensive. For example, the admissions, transfers, discharge and temporary absence of residents' policy did not contain the details of the admissions procedure. This information formed part of the 'provision of information to residents' policy, however, the former policy did not direct the reader to the location of the admissions information.

The directory of residents was available, however, information regarding admission dates to residential service and day service was inaccurate.

**Judgment:**

Substantially Compliant

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## **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:***

Breeda Desmond  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
<b>Centre ID:</b>	OSV-0004574
<b>Date of Inspection:</b>	31 August 2015
<b>Date of response:</b>	28 September 2015

### Requirements

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

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

### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Parents outlined that they were unhappy with the previous lack of involvement regarding decision making.

They outlined that decisions regarding health and social issues were made without consultation with them as parents.

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

**1. Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The personal planning system requires plans to be updated on a regular basis and for the plans to be consulted with circle of support to take place at least once a year and there has been a delay in arranging the 2015 reviews. Personal Plan review dates have now been set for all service users. These meetings will involve family, key-worker, Multi-Disciplinary Team, Service Quality Systems and PIC.

**Proposed Timescale:** 09/10/2015**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Occasionally, valuable information was not included in the summary documents, for example, one resident had a history of absconding and this was not included.

**2. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

All summary documents have now been reviewed to ensure essential and important information on service users is included. A system of cross referencing between core and summary documentation is now being introduced.

**Proposed Timescale:** 30/09/2015**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Occasionally residents' support plans were not signed or dated by the staff member completing the review.

**3. Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

All support plans have now been reviewed, signed and dated. Staff have been informed to ensure that all reviews are evident by signature and date of review.

<b>Proposed Timescale:</b> 30/06/2015
<b>Theme:</b> Effective Services  <b>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</b> One resident's was referred for occupational therapy on September 2014 but this had not been facilitated; a further referral was made for this resident for an occupation therapy assessment in May 2015 and an appointment was still awaited.  <b>4. Action Required:</b> 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.  <b>Please state the actions you have taken or are planning to take:</b> New Manager of Occupational Therapy has been appointed and service user has been urgently re-referred for services.
<b>Proposed Timescale:</b> 16/10/2015
<b>Theme:</b> Effective Services  <b>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</b> The document 'mental health information' was inappropriately completed as it indicated that the resident was not in receipt of mental health services even though the resident had regular reviews by the psychiatrist.  <b>5. Action Required:</b> Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.  <b>Please state the actions you have taken or are planning to take:</b> The medical information documentation has been amended (i) to distinguish between Consultant Psychiatrist input (ii) to include the Multi-Disciplinary Team supporting service users and generic mental health services. The service from (i) above has now been ticked to indicate the type of service that service users are in receipt of.
<b>Proposed Timescale:</b> 30/09/2015
<b>Theme:</b> Effective Services  <b>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</b>

Care management plans were in place however these were not completed annually at a minimum, as required in the Regulations. For example, forms were dated 25/05/13 and the next review date was 01/03/15; a second form with sensory details was 13/04/13 and the next review date was 01/03/15.

**6. Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

The Person in Charge (PIC) has put in place a diary system to ensure that all personal profiles and care management plans are reviewed annually or more frequently if required.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

Individual risk profiles were in place for residents, however, these were a new initiative introduced and were only partially completed; in addition, staff members completing this form had neither signed or dated it.

**7. 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:**

Staff have been informed to ensure that all reviews are evident by signature and date of review.

**Proposed Timescale:** 30/09/2015

**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:**

Incidents involving residents and staff did not identify the resident involved, therefore, trending or analysis could not be effectively completed to mitigate recurrences.

**8. Action Required:**

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

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

All incidents are now recorded in our Accident and Incident Reporting System (AIRS) and trends are reviewed with Multi-Disciplinary Support Team. Details of the service users and/or staff are included and this will facilitate trending and analysis of incidents.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

Regular fire safety training was not completed at suitable intervals by staff and residents to ensure their safety.

**9. Action Required:**

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

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

All staff are required to attend mandatory Fire Prevention and Fire Safety every two years. All staff have now been trained in Fire Drills, Use of Fire Safety Equipment and Emergency Procedure for Fire Evacuation. The Social Care Leader has been trained as a Fire Warden and one other staff will also be trained as a Fire Warden on 29th September 2015. Two fire drills have been carried out in 2015 and a third to be carried out before the end of November 2015.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

Regular fire drills and evacuations were not completed at suitable intervals by staff and residents to ensure their safety.

**10. Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

As part of the Fire Prevention and Fire Safety Training, fire evacuations are conducted on an annual basis on day and night shifts or more frequent if required. Two fire evacuations have been carried out in 2015 and a third to be carried out before the end of November 2015.

**Proposed Timescale:** 30/11/2015

## **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

While documentation was maintained regarding chemical restraint used, it was not comprehensive. For example, it did not detail the rationale for administration of line two of the intervention protocol rather than the first line action.

**11. 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:**

Each service user has a Reactive Strategy which states when first and second line PRN is to be used. These Strategies will be reviewed to ensure they are clear and precise (30th September 2015). Reviews will include Multi-Disciplinary Team members and forwarded to the Behaviour Standards Committee for approval.

**Proposed Timescale:** 30/11/2015

## **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Policies and procedures in relation to social care and welfare of residents required attention to ensure they were up-to-date and comprehensive. For example, the admissions, transfers, discharge and temporary absence of residents' policy did not contain the details of the admissions procedure.

**12. Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Admissions, Discharges and Transfers Policy is currently being updated (6th October 2015) all policies and procedures issued pre 1st January 2014 will be scheduled for review in the next six months to ensure that they are reviewed within a 3 year interval.

**Proposed Timescale:** 31/05/2016

**Theme:** Use of Information



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

Prescription and medication administration records in addition to PRN protocols were examined and several issues were identified that required attention:

- the dosages of the PRN administration protocol did not correlate with the prescription
- residents' prescription charts had been updated, however, the older PRN sheet had not been removed from the file, consequently, this had a huge potential for medication error
- the times for administration of medications on the prescription sheet had been changed to reflect actual administration times, however, the times had not been changed on the administration record sheets
- maximum dosages for PRNs were not always written to mitigate medication over dosage, for example, ventolin and paracetamol.
- each resident had a separate form for recording the rationale for PRN administration and the resident's response to the PRN medication, however, this was not always comprehensively completed to demonstrate why one line of the PRN protocol was administered rather than another.

**13. Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. The PRN administration protocol is being reviewed and will be updated.
2. The old PRN sheets have now been removed and staff have been informed that when charts are re-written the old charts must be removed immediately and filed accordingly.
3. The administration record sheets will now be amended to reflect the actual administration times.
4. Maximum dosages for PRNs will be written-up by both Psychiatrist and G.P.
5. Person Centred Medication Management Policy will be discussed at staff meetings, one of the trainers will brief staff on the Services policy.

**Proposed Timescale:** 30/09/2015

**Theme:** Use of Information

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

The directory of residents was available, however, information regarding admission dates to residential service and day service was inaccurate.

**14. Action Required:**

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care

<p>and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .</p> <p><b>Please state the actions you have taken or are planning to take:</b> This document will be reviewed and the actual dates will be corrected in the document.</p>
<p><b>Proposed Timescale:</b> 06/10/2015</p>