

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Kingfisher 3
<b>Centre ID:</b>	OSV-0004840
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Ireland
<b>Provider Nominee:</b>	Norma Bagge
<b>Lead inspector:</b>	Margaret O'Regan
<b>Support inspector(s):</b>	Mary Moore
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
22 August 2016 10:10	22 August 2016 18:30
23 August 2016 09:00	23 August 2016 22:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 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 an unannounced inspection carried out to monitor compliance with the regulations and standards. It was the fourth inspection of the centre carried out by the Health Information and Quality Authority (HIQA).

How evidence was gathered:

As part of the inspection, the inspectors met with the six residents living in the centre. Some of the residents were able to verbally express their views regarding the service and facilities. Others expressed their views non-verbally, in the manner in which they reacted to staff, interacted with other residents, their facial expressions and their general demeanour.

Since the previous inspection, the number of residents being accommodated in the centre reduced from 10 to six. There were positive benefits from this reduction in numbers. However, inspectors formed the view that, while residents in one house were happy with their living arrangements, not all residents in the second house were appropriately accommodated. This was due to the competing needs of residents which impacted on their quality of life.

The inspectors observed how staff interacted with residents, observed the general comfort of the environment and the atmosphere within the houses. Observations varied between houses, between staff who were familiar with residents and those who were not as familiar, and varied between levels of interaction with specific residents.

Staff who had worked with this group of residents for a long time, interacted in a relaxed manner while less familiar staff were still learning the verbal and non-verbal communications of residents. This highlighted the need for appropriate staff induction and the importance of staff continuity.

The inspectors sought the views of staff in terms of what it was like to be a staff member in the service and how they viewed the quality of care provided. It was clear staff took pride in their work. The inspectors met with the person in charge who was familiar with individual resident needs and the day to day aspects of running the service.

The inspectors also met with the management team to provide feedback on the inspection findings, issue immediate action plans and address queries the management team had.

The inspectors examined documentation such as resident care plans, policies and risk management assessments and procedures.

#### Description of the service:

The provider must produce a document called the statement of purpose that explains the service they provide. The statement of purpose for this centre described the centre as one which endeavoured to provide a homely environment for the residents. Inspectors saw that the houses were homely, nicely decorated and each resident had their own bedroom.

This centre provided residential care for six adults on a full time basis. The service catered for residents with a moderate to severe intellectual disability. A number of residents also had a dual diagnosis of mental health issues.

The centre is located in the outskirts of a city. The centre comprised of two houses, located next door to each other. A number of residents availed of day services which were available in nearby day services operated by the Brothers of Charity.

#### Overall judgment of our findings:

Overall, inspectors had concerns with a number of aspects of care. These included the manner in which medication was stored (Outcome 12), the appropriateness of staff training (Outcome 17) and the inadequate learning from previous events which occurred in the centre (Outcome 7). Immediate action plans were issued on the day of inspection which required the provider to immediately address these three risk areas.

Other areas of non-compliance identified included;

- \* the maintenance of appropriate documentation
- \* the provision of adequate fire safety arrangements
- \* the follow through on appropriate health care interventions
- \* the follow through on resident safeguarding plans
- \* the provision of appropriate accommodation for residents.

The reasons for these findings are explained under each outcome in 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 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:**

The admission practices did not adequately take account of the need to protect residents from abuse by their peers. For example, on the return of a resident from another designated centre, all relevant information was not obtained. Information about incidents that occurred between the resident who was transferring and a resident in the house, was not relayed in a timely manner to all the professionals concerned in the transfer. These incidents only came to light after the transfer took place. Limited cognisance was given to the impact the transfer would have on the two residents already in the house. There was documentation to show that the transfer caused upset to both of these residents, with one regularly requiring medication to help with the upset.

In some instances, residents were supported when moving between services. For example, they were provided with significant 1:1 support, provided with day service, a comfortable environment and a pictorial time table of activities. Regular multi disciplinary team (MDT) meetings took place and training was provided to support staff in the provision of care specific to the resident's needs.

**Judgment:**

Non Compliant - Moderate

## **Outcome 05: Social Care Needs**

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

### **Theme:**

Effective Services

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

No actions were required from the previous inspection.

### **Findings:**

While assessments by health care professionals were carried out, there were inadequate arrangements in place to meet the assessed needs of each resident. For example, it was assessed that one resident needed a quiet environment but lived in a house which was noisy. The different needs of residents were such that it was not suitable for them to be living in the same house.

Assessments were not always reviewed when incidents occurred. For example, a safeguarding plan was not documented as having being reviewed following a serious incident which occurred.

Personal care plans were in place. In some instances, parts of the personal plans were reviewed annually or more frequently but it was unclear if the entire plan was reviewed. For example, safeguarding aspects of a plan were reviewed but there was no documentation to indicate whether or not a resident's goal for 2015 to go to a concert and visit a local folk park had been achieved.

It was not evident that the personal plan reviews were conducted in a manner that ensured the maximum participation of each resident, and where appropriate their representative. It was unclear if each resident's key worker was sufficiently supported to identify the resident's individual needs and choices. For example, one key worker was on several weeks leave and it was uncertain who was delegated to take on the responsibility in this staff's absence.

Staff were unsure if goals had been met. Where a goal wasn't achieved there was no documentation to indicate the barriers to its achievement. The organisation did have a system in place to document barriers to residents achieving their personal goals, and a process for escalating this. There was no indication this process was employed in this instance.

There were conflicting reports with regards to the provision of day service. Some reports indicated this service was reduced during the summer months and other reports indicated the day service did not take place as it did not suit residents' needs. Staff

generally negated the low level of day services by providing activities in house or going out with residents. Swimming, gardening and walking appeared to be the activities most enjoyed by residents. Overall, the levels of activities available had increased from previous inspections.

Improvements had taken place since the last inspection. One resident had been provided with a self contained apartment on the Brothers of Charity campus accommodation. This placement was working well. Another resident moved to another house to live with people with similar interests and capacities. This was also reported to be working well. Such moves not only benefited those who moved but also created more space for those residents that continued to live in this centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

There were inadequate procedures in place to protect and promote the health and safety of residents and staff following a recent incident involving a resident. Given the failings and risk identified the provider was issued with an immediate action plan. In addition to the issuing of the immediate action plan the provider was also requested to take further immediate action to promote the safety of staff on duty prior to the end of this inspection.

There was a risk management policy and procedure in place dated May 2016. Inspectors saw two separate risk registers, one kept in the centre and one retained by the person in charge. Inspectors were informed by the area manager that an incident had occurred a number of weeks previously in one house. The date of the incident was not definitive and there was no record of the incident available in the centre. The record was made available on the second day of inspection. Inspectors were told that it had been archived.

Having reviewed both an incident and accident record of this event, having spoken with staff and reviewed practice in the centre, inspectors concluded that;

- there was inadequate evidence of the investigation of the incident
- there was inadequate evidence of learning
- there was a lack of robustness in implementing measures identified as necessary to ensure the safety of staff and residents.



It was 18 days before there was any evidence of action taken to safeguard staff and residents. Inspectors found that staff spoken with were not aware that there had been an incident. Staff were not aware that further controls had been put in place for their safety i.e. a personal alarm that was linked to the other house. So while there was a risk assessment dated 21 July 2016 included in the individual risk log shown to inspectors which stated that the personal alarm must be carried by night staff at all times, this was not known by staff. Staff were not aware that a personal alarm was available to them and consequently they were not using it.

The process of risk assessment was limited, focussed on specific risks and failed to identify that this risk was relevant to other staff and other situations. For example, the identified need for night staff to have a personal alarm did not transfer to the need for day staff working on their own to also have this alarm when working with the same residents.

The risk identification process failed to identify and assess risks throughout the centre. It did not ensure the adequate ongoing monitoring of risks. For example, the provider had been previously requested to ensure that first floor windows were suitably restricted. The area manager reported the windows were restricted however, inspectors found that not all first floor windows were restricted including the windows in the bedrooms of two residents. The person in charge said that staff had disabled the restrictors.

A shelf in one staff office on which folders required by staff on a daily basis were kept was broken and unstable.

Keys used by staff were seen to be left repeatedly unattended by staff. The front door of one house was seen to be unlocked when there was a risk assessment stating that it was to be locked at all times.

Neither house was serviced by emergency lighting. In general, but also given alterations made to the use of rooms in each house there was limited provision made for fire/smoke detection with two detectors seen in each house, one each at ground and first floor level. There was a carbon monoxide monitor in each kitchen but staff were unclear if these were a combined carbon monoxide and smoke detector.

There was limited availability of fire fighting equipment with one fire blanket and one fire extinguisher located in the kitchen of each house. They were not readily visible and staff on duty were not aware of their location.

There was inconsistent evidence of the annual inspection and servicing of the fire fighting equipment. The certificate of inspection on file was dated February 2015. However, the fire fighting equipment was marked as inspected in February 2016. Records seen indicated that staff in both houses did not undertake the required inspection and testing of the fire/smoke detectors at the required weekly interval. Records seen in both houses from January 2016 indicated that the required weekly checks were not completed. The month of March had only one recorded inspection and the average was two per month.

Exits were clearly indicated. There was a break glass box with key at each door. Staff undertook regular simulated evacuation drills in both houses with residents. Overall, good and adequate evacuation times were achieved. However, the names of the residents who participated were not always identified. The evacuation time was not recorded on one occasion. A difficulty had been encountered and it had taken five minutes to evacuate one house during one recent fire drill. The reasons for this (residents did not respond) were not reflected in the Personal Emergency Evacuation Plan (PEEP) kept in the fire folder. The PEEPs seen had not been updated and were dated 2014.

There was an internal gas boiler. It was seen to be labelled as serviced on an annual basis and most recently in January 2016.

Staff were provided with a list of emergency contact numbers and procedures governing the actions to be taken in response to specific emergencies. There was a contingency plan for the provision of alternative accommodation for residents if required.

**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):**

No actions were required from the previous inspection.

**Findings:**

Measures to protect residents being harmed or suffering abuse were inadequate. Appropriate action was not taken in response to incidents occurring between residents.

On the day of this unannounced inspection there were two staff on duty in one house with three residents. There had been an incident of behaviours of concern between residents earlier that morning. One staff left the house by car to take one resident to a day service. The other staff remained in the house with two residents. The staff next door had gone out for a drive. One of two residents remaining in the house was agitated. According to staff there was no plan in place for managing this behaviour other than "run", "leave the house" and "make yourself safe".

A safeguarding plan was drawn up by the multidisciplinary team and submitted by the provider to the Health Services Executive (HSE) following incidents which had occurred. This safeguarding plan had been approved by the safeguarding team. The plan was approved with the proviso that the safeguarding actions were adhered to. However, these actions were not adhered to.

For example, the plan emphasised the importance of having regular staff, but on the day of inspection, the only two staff on day duty in the house were non regular staff. The one member of night duty staff in that house was new. The staff on duty were unaware of a personal alarm being available, unaware of incidents that had occurred a few weeks previously and had not received specific training in the management of behaviours that challenge as it pertained to the residents in that house. This was despite a multi disciplinary safeguarding plan being in place emphasising the importance of regular staff, appropriate training and personal alarm.

As reported to inspectors, the rostering of unfamiliar staff resulted from unexpected leave. It was reported to the inspectors to have been "exceptional circumstances". In view of the issues that pertained to this house inadequate consideration was given by the management team in supporting new staff in this environment and ensuring staff were aware of the protocols in place to protect residents and themselves.

Residents were not provided with adequate emotional and behavioural support to promote a positive approach to behaviour that challenges. For example, a resident who was non verbal had particular needs with regards to travelling in the seven seat vehicle. The resident was seen by the inspectors to be visibly agitated when they were positioned in the row of seats behind the driver as opposed to their preferred location in the back row.

Regular staff confirmed what the inspectors observed i.e. the resident need to travel at the back of the car. This was not only for the resident's comfort but as a safety precaution for staff who were travelling on their own with residents. The resident frequently used physical aggression to express themselves. This posed a risk when sitting behind the driver.

There were shortcomings in the documentation around the safeguarding plans. For example, the most recent safeguarding plans were not signed as having being read by staff. The plan for one resident was not updated following an incident which occurred weeks previous to the inspection. The risk assessment with regard to one resident's agitation was kept in a locked office in an adjacent house. The risk assessments in place around managing behaviours referred to behaviour support plans but staff did not articulate sufficient knowledge of these plans.

There was conflicting evidence with regards to how safeguarding risk was viewed by management staff. For example, it was reported that one resident was not targeting another resident yet there were two open risk assessments in relation to this targeting. The behaviours including pushing and it was documented that these impacted negatively on the resident being pushed.

**Judgment:**  
Non Compliant - Major

### **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:**

Generally, residents' health care needs were met. However, there were deficiencies in documentation. This meant it was not clear how or if all residents' identified needs were being addressed. For example, bowel record charts were incomplete for one resident despite it being identified that issues in this area of the resident's care had potential to have serious consequences. The fluid intake of one resident was restricted due to the potential of the resident drinking excessively. No record was maintained to ascertain if the resident had adequate fluids to assist with their identified health care issues.

There was evidence of residents being referred to allied health services. However, there was inadequate measures put in place following recommendations made by such professionals. For example, a psychologist report dated 10 June 2016 stated a resident's living environment was unsuitable due to the "absence of a clear separate low arousal space". The resident continued to live in the unsuitable environment and there were no imminent plans to address the matter. Medical reports for this resident also stated that the resident's environment was "the major contributing factor to (their anxious) mood".

Individual health plans were not consistently put into practice. It was noted in the annual report that one resident was on a healthy eating plan. Some staff spoke of the need to assist this resident with a healthy diet; however, no clear documented plan was in place and from what inspectors observed it was being followed in an ad hoc basis.

**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:**

Inspectors were not satisfied that arrangements in place ensured the safety of medicines management. Practice was not compliant with relevant legislation and guidance. Given the risk identified the provider was issued with an immediate action plan.

Medicines were supplied on a weekly basis to the centre by a community based pharmacy. Medicines were supplied in a compliance aid and in their original containers as necessary.

Each resident was seen to have a medicines prescription record for medicines prescribed on a regular, episodic (prescribed period) and PRN (as required) basis. Staff maintained a medicines administration record.

Inspectors saw signed and verified (by the pharmacist) records of medicines returned to the pharmacy. Records showed staff checked medicines that were returned to the pharmacy. Staff confirmed this was their practice.

However, inspectors noted and staff spoken with confirmed that, while storage was provided for medicines, the safe custody of medicines was not ensured. Inspectors saw that the key for one medicines storage cupboard was left by staff in the lock of the cupboard. At all other times the keys to both medicines cupboards were kept in an unlocked wall key-box.

There were inadequate controls in place for the secure storage of and monitoring of medicine required as an emergency measure for the management of seizure activity and kept in the transport vehicle. The medicine was seen to be unlabelled, staff confirmed that no records were maintained of its monitoring and staff spoken with did not know that the medicine was kept in the vehicle.

Medicines audits completed most recently on the 22 August 2016 stated that no medicines were transported.

Medicines including PRN benzodiazepines were found to have no resident specific prescribing and administration labels attached. The medicines management protocol clearly advised staff that if they could not read the label they were not to administer the medicine. While a staff signature sheet was maintained, on average only five staff had signed this record.

There were poor recording procedures for medicines required on a PRN basis. Staff maintained three separate records, one of which was the medicines administration sheet. However, a review of the records demonstrated inconsistencies between them and no one record that was a complete and accurate administration record.

Generally the maximum daily dosage of medicines prescribed on a p.r.n basis was stated; however, it was not stated for one night sedation recently prescribed.

Staff spoken with confirmed that they had not undertaken medicines management training and they were not aware of any scheduled training; this included training on the administration of medicine required in an emergency situation prescribed for residents in the centre for whom the staff was responsible. Inspectors were concerned at the incidence of staff medicines administration errors and the failure to evidence their investigation and actions taken to improve the safety of practice.

The person in charge had completed a risk assessment of inadequate training for staff on medicines management in the context of nine reported medicines errors. The risk was escalated to the area manager in May 2016 as per the providers risk management policy. However, at the time of inspection staff training records reviewed indicated that there were potentially 11 staff that did not have medicines management training.

Inspectors reviewed records of 11 medicines errors detected and reported by staff since November 2015. Each record was signed off as reviewed by the area manager but there was no record of remedial actions taken. The person in charge said that there was insufficient room of the form for this.

Given that the errors continued (the most recent occurred on the 19 August 2016) learning and improved practice was not evident. Given the failure to ensure the safe storage of medicines, it was of concern to inspectors that records showed two medication blister packs were "pushed open" and empty when staff went to administer them.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

The management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. For example,

- inadequate consideration was given by the management team in supporting new staff in a house which had significant health and safety issues for residents and staff
- it was 18 days before any action was taken following a safety incident was reported to management
- there was a lack of communication about the incident with relevant staff
- the deputising arrangements for the person in charge were unsatisfactory in that the deputy was unclear about the safeguarding aids available.

Inadequate facilitation was given to staff to raise concerns about the quality and safety of the care and support provided to residents. For example, staff meetings were not held as scheduled and it was unclear how staff were informed of changes to scheduled staff meetings. When meetings occurred attendance tended to be low.

The person in charge informed the inspectors she spoke with day staff about the personal alarms in place however, inspectors found several day and night staff were not aware of these alarms. The person deputising in the absence of the person in charge had limited knowledge of the alarms. The manner in which an incident involving staff safety was dealt with indicated a lack of thoroughness in minimising a re-occurrence. The matter had not been placed on the agenda of the next staff meeting.

Given the failings identified by this HIQA inspection, inspectors were not assured as to the robustness of the provider's medicines management audit process. Records of two completed audits were available to inspectors one completed in May 2016 and the most recent on the 22 August 2016. These audits had not identified;

- the failure to ensure the safe custody of medicines
- the transportation of medicines
- medicines that were unlabelled.

It was unclear to inspectors how the action proposed by the auditor in response to staff medicines administration errors (the double signing by staff) would address the risk posed by inadequate staff training as identified by the person in charge.

The provider is required by regulations to carry out an annual review. However, the last review carried out for this centre was over 16 months previously, on 27 April 2015.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

Based on these inspection findings, inspectors were not satisfied that staffing arrangements were managed so as to meet the assessed needs of residents and ensure that the safety of both residents and staff was protected and promoted at all times. Resident occupancy in both houses had reduced from five to three. Inspectors were told that the agreed staffing levels were two staff by day from 08:00hrs to 20:30hrs and one waking night staff in one house. In the other house the rota was one day staff from 08:00hrs to 20:30hrs and one waking night staff. The houses were adjacent to each other.

However, a review of staff rotas over a period of seven weeks in 2016 (March, April and May), inspectors saw that there was a reliance on the use of relief staff. There was evidence that staff did not always have the information and the training required to meet the needs of the residents and to ensure both their personal safety and the safety of residents. For example, staff confirmed that they did not have fire safety and medicines management training.

Staff did not know where to locate fire fighting equipment; inspectors saw that a front door was unlocked at a time when a risk assessment said that it should have been locked. Inspectors saw regular staff to exchange a resident between houses and were told that this was because relief staff on duty were not familiar with the residents "cues". Inspectors saw staff transport a resident who was required to have emergency medicine with them at all time; however, the staff had no training in administering this medicine. An immediate action plan was issued to address this matter.

In disclosing and accepting responsibility for a medicines administration error, staff stated that they were not aware of changes made as they had not worked at night in the centre for a "considerable period". As discussed in Outcome 8, inspectors saw a resident to demonstrate reluctance with staff to get into the centre vehicle. When in the vehicle the resident was restless and continued to look back. It was confirmed for inspectors that staff placed the resident in the incorrect seat.

As has been discussed in Outcome 7, it was of serious concern to inspectors that staff met with had not been made aware of a recent serious incident and the control measure introduced further to this incident for their personal safety.

While the agreed staff levels were two staff by day in one house, inspectors saw on arrival at this house and staff spoken with confirmed, that there were times when only one staff was present in the house. This occurred when one staff went out with a resident(s) and during structured staff rest breaks during which staff were at liberty to leave the house. Inspectors also saw a record of a fire drill completed on the 20 August 2016 where one staff and three residents were present in the house. This depleted



staffing level was not addressed in records seen including risk assessments.

In general, given that there was a maximum number of two staff on duty and three residents requiring support it was difficult to see how all residents were adequately and appropriately supported given that risk assessments stated that there was sufficient staff in place to provide two residents with one-to one support.

A sample of staff files were requested and made available for the purpose of inspection. This sample of staff files was compliant with regulatory requirements and contained all of the required records.

Staff training records were requested and records for sixteen staff including the person in charge were presented for inspection. Training records for five relief staff that, based on the staff rotas seen regularly worked in the centre, were not included in these records. Given that records for five staff were not available inspectors could not conclude that all staff had required mandatory training. However, staff spoken with told inspectors that they had not completed fire safety training and medicines management training.

The person in charge told inspectors that four staff required safeguarding education and training. Based on the records that were available (excluding the five staff for whom records that were not available) staff had attended training on responding to behaviours that challenged (Management of Potential and Actual Aggression), safeguarding training and fire safety training in 2014. There was no recorded attendance at medicines management training for six staff and no recorded attendance at fire safety training for two staff.

Eleven staff were recorded as having attended a specific programme delivered in May 2016 in response to specific resident needs so as to equip staff with the knowledge and skills to appropriately support residents. Five staff for whom training records were available, including the person in charge, had no recorded attendance at this training. Potentially including relief staff, 10 staff working in the centre had not attended this training.

Fire safety training for ten staff was scheduled for September 20th.

Two staff had ceased employment within the previous week. They had given two weeks' notice of their departure. The person in charge was not aware of the plan to replace these staff.

**Judgment:**  
Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

Care records were incomplete, not maintained in an ordered fashion and some were missing from a resident's file. The gaps in the documentation referred to the period around the occurrence of a serious incident involving a resident and a staff member.

Records were not readily available of a health and safety incident which occurred in the centre. The incident report was located in an archive file prior to the end of the two day inspection.

Insufficient records were available to determine if residents received adequate fluid intake and if they were supported to follow their healthy eating plan.

A number of incident report forms did not have the follow up notes section completed.

**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Margaret O'Regan  
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>	Kingfisher 3
<b>Centre ID:</b>	OSV-0004840
<b>Date of Inspection:</b>	22 August 2016
<b>Date of response:</b>	28 October 2016

#### Requirements

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

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

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

**Theme:** Effective Services

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

The admission practices did not adequately take account the need to protect residents from abuse by their peers.

<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 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

- MDT acknowledge that this individual is not optimally placed in this designated centre.
- This centre has been discussed at the Admissions Discharge and Transfer committee in order to explore the possibility of other options for this individual. At present no alternate placement is available.
- Alternative housing options have been explored and secured for 2 residents, thereby reducing the number of residents to 6. (Full capacity in this designated centre is 9)
- There is a commitment from the Provider Nominee not to increase numbers of residents to full capacity due to the complexity of support requirements for current residents. Staffing levels have remained at the funded levels.
- Given that there are no immediate alternative accommodation available for remaining residents regular review of activities, safeguarding plans and behaviour support plans is being carried out to mitigate against risks associated with this less than optimal placement.
- Where applicable residents have ongoing support from the MDT which include psychology, psychiatry, behaviour support and social work.
- Provider Nominee has commissioned a review of this service which will be led by the Head of Psychology. The report from this review is due for completion by November 30th 2016. The HIQA report and Unannounced inspection reports will be reviewed as part of this process.

**Proposed Timescale:** 30/11/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Assessments were not always reviewed when incidents occurred. For example, a safeguarding plan was not documented as having being reviewed following a serious incident which occurred.

**2. 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:**

- While the initial response by the PPIM (acting for the PIC who was on leave) was timely, it was not a robust response.
- PIC returned to work following 2 weeks leave. PIC concluded that initial response was not sufficiently robust and therefore followed up with an emergency MDT review. This took place on August 13th 2016.
- Additional controls were initiated by the PIC and include Risk Assessment for night

staff in no. 8, risk assessment for night staff in no. 7 (to support night staff in 8).

- The importance of the follow controls were reinforced with staff at staff meetings on August 24th & 25th, September 14th & 15th, October 18th & 19th.
- A system is now in place to ensure that all incidents of this nature will be dealt with in a timely manner going forward. Staff have been directed to report any incident to the PPIM when the PIC is on leave.

**Proposed Timescale:** 27/10/2016

**Theme:** Effective Services

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

It was not evident that the personal plan reviews were conducted in a manner that ensured the maximum participation of each resident, and where appropriate their representative. It was unclear if each resident's key worker was sufficiently supported in being proactive in identifying resident individual needs and choices. For example, one key worker was on several weeks leave and it was uncertain who was delegated to take on the responsibility in this staff's absence.

**3. 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:**

- Quarterly reviews of all pcps were completed in December 2015, March 2016, June 2016 and annual review was completed in September 2016
- Family members of all residents were contacted during the Information Gathering process in 2015 in line with the Services procedure.
- All families were invited to attend their family members PCP meeting and three families attended.
- This year all families will be contacted during the information gathering process, which is currently underway. This will be completed by November 30th 2016.
- Where staff are on long term leave another staff will be assigned the responsibility as keyworker for the interim period of absence.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Inadequate arrangements were in place to meet the assessed needs of each resident. For example, it was assessed that one resident needed a quiet environment but lived in a house which was noisy.

**4. Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

- MDT acknowledge issues with service user mix in this designated centre.
- This centre has been discussed at the Admissions Discharge and Transfer committee in order to explore the possibility of other options for this individual. At present no alternate placement is available.
- Alternative housing options have been explored and secured for 2 residents, thereby reducing the number of residents to 6. (Full capacity in this designated centre is 9).
- There is a commitment from the Provider Nominee not to increase numbers of residents to full capacity due to the complexity of support requirements for current residents. Staffing levels have remained at the funded levels.
- Given that there are no immediate alternatives available for remaining residents regular review of activities, safeguarding plans and behaviour support plans is being carried out to mitigate against risks associated with this less than optimal placement.
- Each resident has their own bedroom thus affording them the opportunity for quiet time.
- All residents have ongoing support from the MDT which include psychology, psychiatry, behaviour support and social work.
- Provider Nominee has commissioned a review of this service which will be led by the Head of Psychology. The report from this review is due for completion by November 30th. The HIQA report and Unannounced inspection reports will be reviewed as part of this process.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

The centre was unsuitable for the purposes of meeting the assessed needs of each resident. For example, the different needs were such that it was not suitable for them both to be living in the same house. This had been the assessment of the multi disciplinary team.

**5. Action Required:**

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

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

- MDT acknowledge issues with service user mix in this designated centre.
- This centre has been discussed at the Admissions Discharge and Transfer committee in order to explore the possibility of other options for this individual. At present no alternate placement is available.
- Alternative housing options have been explored and secured for 2 residents, thereby reducing the number of residents to 6. (Full capacity in this designated centre is 9).

- There is a commitment from the Provider Nominee not to increase numbers of residents to full capacity due to the complexity of support requirements for current residents. Staffing levels have remained at the funded levels.
- Given that there are no immediate alternatives available for remaining residents regular review of activities, safeguarding plans and behaviour support plans is being carried out to mitigate against risks associated with this less than optimal placement.
- Each resident has their own bedroom thus affording them the opportunity for quiet time.
- All residents have ongoing support from the MDT which include psychology, psychiatry, behaviour support and social work.
- Provider Nominee has commissioned a review of this service which will be led by the Head of Psychology. The report from this review is due for completion by November 30th. The HIQA report and Unannounced inspection reports will be reviewed as part of this process.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

On the return of a resident from another designated centre, all relevant information was not obtained. For example, information about incidents that occurred between the resident who was transferring and another resident in the house, was not relayed in a timely manner to all the professionals concerned in the transfer. These incidents only came to light after the transfer took place.

**6. Action Required:**

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

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

- Learning from this incident has occurred and all staff have been informed to bring all Incident report forms to the immediate attention of the PPIM when the PIC is on leave.

**Proposed Timescale:** 27/10/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The risk identification process failed to identify and assess risks throughout the centre. It did not ensure the ongoing monitoring of risks. For example, the provider had been



previously requested to ensure that first floor windows were suitably restricted. Inspectors found on this inspection that not all first floor windows were restricted including the windows in the bedrooms of two residents. The person in charge said that staff had disabled the restrictors.

A shelf in one staff office on which folders required by staff on a daily basis were kept was broken and unstable.

Keys used by staff were seen to be left repeatedly unattended by staff.

The front door of one house was seen to be unlocked when there was a risk assessment stating that it was to be locked at all times.

The process of risk assessment was limited, focussed on specific risks and failed to identify that a risk to night staff could equally apply to day staff.

### **7. Action Required:**

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

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

- PIC met with all staff to reiterate the importance of window restrictors being in place permanently on August 24th & 25th and September 14th & 15th.
- Supervision is taking place by PIC and PPIM to ensure window restrictors remain in place.
- We acknowledge that it is unacceptable that keys were left unattended. PIC met with all staff on August 24th & 25th and September 14th & 15th to reiterate the importance of all keys to be placed in the key safe.
- Supervision is taking place to ensure that keys are being locked away.
- New shelving unit has been installed.
- The process of risk assessment focuses on the assessment of foreseeable risks. This process was introduced to ensure that risk assessment does not result in undue restriction of residents. In line with HIQA guidance only risks which are of particular concern are assessed. The application of the process in this instance did not include adequately robust monitoring of controls (e.g. window restrictors) or adequate identification of significant risks (e.g. broken shelving)

**Proposed Timescale:** 27/10/2016

**Theme:** Effective Services

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

Inspectors found that staff spoken with were not aware that there had been an incident. Staff were not aware that further controls had been put in place for their safety i.e. a personal alarm that was linked to the other house. So while there was a risk assessment dated 21 July 2016 included in the individual risk log shown to

inspectors which stated that the personal alarm must be carried by night staff at all times, this was not known by staff. Staff were not aware that a personal alarm was available to them and consequently they were not using it.

#### **8. Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

- There is an expectation that all staff should familiarise themselves with current support plans for residents for whom they work.
- Following the inspection all staff were been briefed on the current support plans for residents for whom they work. Staff have signed off that they have read the behaviour support plans.
- PIC has produced a Critical Information Handbook which will direct staff on this issue. All staff are required to sign this within an agreed timeframe in conjunction with the PIC.
- Safeguarding plans and behaviour support plans are reviewed at staff meeting and documented in meeting minutes.
- In-house Induction will be provided by the PIC for all new staff.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

There was insufficient evidence of investigation, learning and the implementation of robust measures to ensure the health and safety of staff:

- staff did not have full information on serious incidents which occurred involving residents
- records of adverse events were not readily available
- staff were not aware of all the control measures in place for their protection
- staff were left on their own contrary to risk assessment.

#### **9. 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:**

- The review of incidents and accidents which is part of the process of managing incidents and accidents will be strengthened in order to ensure a timely and comprehensive response to accidents and incidents that will ensure the health and safety of residents and staff.
- A review of accidents and incidents from 2016 that relate to the health and safety of staff will be carried out by the Area Manager and the Person in Charge as a priority in

order to ensure that adequate measures are in place to ensure the health and safety of staff and that staff are aware of these measures.

- Greater vigilance will be taken by management in the filing of records in a timely manner.
- The record that was not on file together with the missing daily notes will be reported to the Data Protection office of the Brothers of Charity Services Limerick as a possible breach. The accident report, while not on file locally, was located in storage and available for review by inspectors.
- Immediately following the unannounced inspection feedback session the staff on duty were met in order that they were briefed on controls in relation to safety for themselves and the residents. Evidence of this engagement was emailed to the inspector on 24th August 2016.
- All controls relating to staff safety will be discussed at staff meetings scheduled for 24th and 25th August 2016.
- Any staff that did not attend the staff meeting will be briefed by the Person in Charge.
- Head of HR requested to carry out a review of induction process for relief staff in community Services in order to ensure that the process is comprehensive and that relief staff have the information they require before they work in a centre.
- Risk assessments will be reviewed to reflect more clearly the staffing ratios.
- Learning from accidents and incidents will be an agenda item for future staff meetings.

**Proposed Timescale:** 26/08/2016

**Theme:** Effective Services

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

The systems in place in the centre for the assessment, management and ongoing review of risk, were inadequate. For example, the process of risk assessment was limited, focussed on specific risks and failed to identify that the risk to lone workers not only pertained to night staff as day staff were also on their own at times.

**10. Action Required:**

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

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

- A Training day to review risks of concern as identified by the PIC and Area Manager (PPIM) was facilitated by the Head of Community Services and Head of Quality and Risk on 5th October 2016. Recommendation regarding controls were provided and follow up date is scheduled for 24th November 2016.
- Risk to lone worker will be assessed and appropriate controls will be identified.
- In terms of staffing levels by day, it is common practice across community services that staff on duty may support residents to leave the designated centre thus reducing the number of both residents and staff physically present in the designated centre at certain time.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Ineffective fire safety management systems were in place. For example, staff were not aware of where fire safety equipment was stored.

**11. Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- Fire Safety Strategy has been submitted to the HSE for funding
- One waking night staff is employed in each house at night.
- The majority of staff have attended Fire Safety Training September 2016 and the remaining four staff will attend training on November 2nd and 16th.
- Location of fire equipment covered in staff meetings in August 2016 and in September 2016 and also included in critical information guide for staff.
- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Inadequate precautions had been taken against the risk of fire. There was insufficient suitable fire fighting equipment in each house.

**12. Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

- Fire Safety Strategy has been submitted to the HSE for funding
- One waking night staff are employed in each house at night.
- The majority of staff have attended Fire Safety Training September 2016 and the remaining four staff will attend training on November 2nd and 16th.
- Location of fire equipment covered in staff meetings in August 2016 and in September 2016.
- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Inadequate arrangements were in place for reviewing fire precautions. There was limited provision made for fire/smoke detection with two detectors seen in each house, one each at ground and first floor level. There was a carbon monoxide monitor in each kitchen but staff were unclear if these were a combined carbon monoxide and smoke detector. There was limited availability of fire fighting equipment with one fire blanket and one fire extinguisher located in the kitchen of each house. They were not readily visible and staff on duty were not aware of their location.

**13. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Inadequate arrangements were in place for testing fire equipment. For example, records seen in both houses from January 2016 indicated that the required weekly checks were not completed. The month of March had only one recorded inspection and the average was two per month.

**14. Action Required:**

Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Emergency lighting was not provided in either house.

**15. Action Required:**

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

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

- Fire Safety Strategy has been submitted to the HSE for funding. This will include the funding for emergency lighting.
- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Theme:** Effective Services

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

Inadequate arrangements were made for evacuating all persons in the designated centre and bringing them to safe locations. For example, the names of the residents who participated were not always identified in evacuation drills. The evacuation time was not recorded on one occasion. A difficulty had been encountered and it had taken five minutes to evacuate one house during one recent fire drill. The reasons for this (residents did not respond) were not reflected in the PEEP's (Personal Emergency Evacuation Plan) kept in the fire folder. The PEEPs seen had not been updated and were dated 2014.

**16. Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

- Personal Egress Evacuation Plans (PEEP) Forms completed in June 2016 and were in MPMP at the time of the inspection. All have now been copied and copy place in Fire Evacuation Folder.
- June 2016 PEEPS address the concerns raised by the Inspector as outlined above.
- The Fire Drill reports will include all necessary information about the fire drills as outlined above.

**Proposed Timescale:** 27/10/2016

**Theme:** Effective Services

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

Not all staff had received fire safety management training.

**17. Action Required:**

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

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

- The majority of staff have now attended Fire Safety Training which took place in September 2016. The remaining four staff will attend training on November 2nd and 16th.
- Location of fire equipment covered in staff meetings in August 2016 and in September 2016.
- Fire safety checklist will be commenced in the house and completed as per agreed schedule. PIC will monitor same and sign same on a weekly basis.

**Proposed Timescale:** 30/11/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Staff did have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. For example, staff on duty were unaware of a personal alarm being available, unaware of incidents that had occurred a few weeks previously and had not received specific training in the management of behaviours that challenge as it pertained to the residents in that house.

**18. Action Required:**

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

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

- There is an expectation that all staff should familiarise themselves with current support plans for residents for whom they work.
- Following the inspection all staff were briefed on the current support plans for residents for whom they work. Staff have signed off that they have read the behaviour support plans.
- PIC has produced a Critical Information Handbook which will direct staff on this issue.

All staff are required to sign this within an agreed timeframe in conjunction with the PIC.

- All behaviour support plans and safeguarding plans are discussed at staff meeting and documented in meeting minutes. In-house Induction will be provided by the PIC for all new staff.
- MAPA training for one staff completed in September 2016, all other staff have up to date MAPA training.
- Refresher of Protection of Vulnerable Adults training for remaining 4 staff is scheduled for December 12th 2016.

**Proposed Timescale:** 12/12/2016

**Theme:** Safe Services

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

Residents were not protected from all forms of abuse due to the incompatible mix of residents in the house and the lack of adherence to the safeguarding plan.

**19. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

- MDT acknowledge issues with the mix of service users in this designated centre.
- This centre has been discussed at the Admissions Discharge and Transfer committee in order to explore the possibility of other options for this individual. At present no alternate placement is available.
- Alternative housing options have been explored and secured for 2 residents, thereby reducing the number of residents to 6. (Full capacity in this designated centre is 9).
- There is a commitment from the Provider Nominee not to increase numbers of residents to full capacity due to the complexity of support requirements for current residents. Staffing levels have remained at the funded levels.
- Given that there are no immediate alternatives available for remaining residents regular reviews of activities, safeguarding plans and behaviour support plans are be carried out to mitigate against risks associated with this less than optimal placement.
- All residents have ongoing support from the MDT which include psychology, psychiatry, behaviour support and social work.
- Provider Nominee has commissioned a review of this service which will be led by the Head of Psychology. The report from this review is due for completion by November 30th. The HIQA report and Unannounced inspection reports will be reviewed as part of this process.

**Proposed Timescale:** 30/11/2016



**Theme:** Safe Services

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

Staff had not received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. While the rostering of unfamiliar staff resulted from unexpected leave and was reported to be "exceptional circumstances"; in view of the issues that pertained to this house inadequate consideration was given by the management team in supporting new staff in this environment and ensuring staff were aware of the protocols in place to protect residents and staff.

**20. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

- Staff attended Protection of Vulnerable adults training in September and October.
- Refresher of Protection of Vulnerable Adults training for remaining 4 staff is scheduled for December 12th 2016.
- All new staff will receive in-house induction from the PIC.
- Where possible two new staff will not be placed on duty together.
- If this should arise in exceptional circumstances the staff will be met by the PIC or PPIM in the designated centre to review key information contained in the Critical Information Handbook.

**Proposed Timescale:** 12/12/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Individual health plans were not consistently put into practice. It was noted in the annual report that one resident was on a healthy eating plan. Some staff spoke of the need to assist this resident with a healthy diet; however, no clear documented plan was in place and from what inspectors observed it was being followed in an ad hoc basis.

**21. Action Required:**

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

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

- Care plan has been put in place.
- All staff in the designated centre are aware of this plan. This has been signed off by staff.

**Proposed Timescale:** 27/10/2016

**Theme:** Health and Development

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

Inadequate records were available to indicate if a resident with special dietary requirements combined with specific restrictions received an adequate daily fluid intake.

**22. Action Required:**

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

- Fluid intake chart completed on a daily basis. PIC checks this on a fortnightly basis.

**Proposed Timescale:** 27/10/2016

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

Appropriate and suitable practices to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident were not in place. For example, records showed two medication blister packs were "pushed open" and empty when staff went to administer them.

**23. 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:**

- Staff have attended Medication Training in September and October.
- Remaining two staff who require Medication Management Training will attend training on December 11th 2016.
- New medication storage press installed
- Medication error identified was reviewed by psychiatrist.
- Medication Audit completed 22nd August 2016, same will be repeated this quarter as per policy. Area Manager will be supported by the Head of Community Services for this audit to provide guidance and training.

**Proposed Timescale:** 11/12/2016

**Theme:** Health and Development

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

There was a failure to ensure all medicines were securely stored and access to medicines was restricted at all times.

**24. Action Required:**

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

- Staff on duty on the evening of the inspection were advised to ensure that the drug press was kept locked per medication policy.
- Staff on duty on the day following the inspection were advised to ensure that the drugs press was kept locked as per medication policy.
- The importance of locking of the drug press, which is a requirement of the medication policy, was an item on the agenda at the staff meeting on 24th August at 8pm and 25th August at 11am.
- Increase vigilance by management to ensure that the drug press is locked as part of supervision of the designated centre.
- Safety alert has been issued to management by the Director of Services in respect of advising staff of the importance of ensuring that the medication press is locked.
- Provider nominee visited both houses on 25th August and checked to see that drugs presses were locked. In both instances the drugs press was locked.
- Memo will be issued by the Person in Charge by 26th August 2016 to keep all drug press locked and secure keys in key box.
- New medication press for both houses has been sourced and will be installed by 1st September 2016. These presses will be double locked presses.
- A new key box for each house was ordered on 24th August and will be installed on 25th August. These key boxes are key coded and all keys will be locked inside.

**Proposed Timescale:** 26/08/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. For example,

- inadequate consideration was given by the management team in supporting new staff in a house which had significant health and safety issues for residents and staff
- it was 18 days before any action was taken following a safety incident was reported to management

- there was a lack of communication about the incident with relevant staff
- the deputising arrangements for the person in charge were unsatisfactory in that the deputy was unclear about the safeguarding aids available

## **25. Action Required:**

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

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

- We acknowledge delay in initiating robust response to this incident and undertake that all incidents of this nature will be dealt with in a timely manner going forward.
- Learning from this incident has occurred and all staff have been informed to bring all Incident report forms to the immediate attention of the PPIM when the PIC is on leave.
- While the initial response by the PPIM was timely, it was not a robust response.
- PIC returned to work following 2 weeks leave. PIC concluded that initial response was not sufficiently robust and therefore followed up with MDT review on August 13th 2016.
- Additional controls were initiated by the PIC and include Risk Assessment for night staff in no. 8, risk assessment for night staff in no. 7 (to support night staff in 8), The need to follow controls were reinforced with staff at staff meetings on August 24th & 25th, September 14th & 15th, October 18th & 19th.
- All staff should familiarise themselves with current support plans for residents for whom they work.
- PIC has produced a Critical Information Handbook which will direct staff on this issue. All staff are required to sign this within an agreed timeframe in conjunction with the PIC.
- All incidents are discussed at staff meeting and documented in meeting minutes.
- In-house Induction will be provided by the PIC for all new staff.

**Proposed Timescale:** 27/10/2016

**Theme:** Leadership, Governance and Management

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

Inadequate facilitation was given to staff to raise concerns about the quality and safety of the care and support provided to residents. For example, staff meetings were not held as scheduled and it was unclear how staff were informed of changes to scheduled meetings. The manner in which an incident involving staff safety was dealt with indicated a lack of thoroughness when staff raised concerns about safety issues.

## **26. Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

- There have been eight documented staff meetings held in the designated centre since January 2016. All staff are sent a text message by the PIC if staff meetings need to be

rescheduled.

- Since this inspection staff meetings were held on August 24th & 25th, September 14th & 15th, October 18th & 19th.
- Staff minutes are available in the designated centre for all staff
- The requirement to attend staff meetings has been communicated to all staff and is being monitored.
- PIC office is in the designated centre and staff are encouraged to raise their concerns with the PIC in addition to planned meetings.
- We acknowledge delay in initiating robust response to this incident and undertake that all incidents of this nature will be dealt with in a timely manner going forward.
- Learning from this incident has occurred and all staff have been informed to bring all Incident report forms to the immediate attention of the PPIM when the PIC is on leave.

**Proposed Timescale:** 27/10/2016

**Theme:** Leadership, Governance and Management

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

Given the failings identified by this HIQA inspection, inspectors were not assured as to the robustness of the provider's medicines management audit process. Records of two completed audits were available to inspectors one completed in May 2016 and the most recent on the 22 August 2016. These audits had not identified;

- the failure to ensure the safe custody of medicines
- the transportation of medicines
- medicines that were unlabelled.

It was unclear to inspectors how the action proposed by the auditor in response to staff medicines administration errors (the double signing by staff) would address the risk posed by inadequate staff training as identified by the person in charge

**27. Action Required:**

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

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

- Staff attending medication training in September and October 2016.
- Remaining two staff who require Medication Management Training will attend training on December 11th 2016. New medication storage press installed
- Medication Audit completed 22nd August 2016, same will be repeated this quarter as per policy. Area Manager will be supported by the HOCS for this audit to provide guidance and training.

**Proposed Timescale:** 11/12/2016

**Theme:** Leadership, Governance and Management

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

The provider is required by regulations to carry out an annual review. However, the last review carried out for this centre was over 16 months previously, on 27 April 2015

**28. Action Required:**

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

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

- Annual review for 2015 was carried out in April 2015
- Six monthly unannounced visit took place on March 3rd 2016.
- Annual review for 2016 was completed and submitted by the PIC to the Provider Nominee, Head of community Services and Head of Quality and Risk on September 18th 2016.

**Proposed Timescale:** 27/10/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Two staff had ceased employment within the previous week. They had given two weeks notice of their departure. The person in charge was not aware of the plan to replace these staff.

**29. Action Required:**

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

- Recruitment process for additional relief staff underway, interviews completed. Garda vetting & reference checks underway.
- Planned and actual roster maintained in the designated centre.

**Proposed Timescale:** 31/12/2016

**Theme:** Responsive Workforce

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

Residents did not receive continuity of care and support, particularly in circumstances

where staff were employed on a less than full-time basis. This was in tandem with identified resident safeguarding needs to have continuity of staff.

**30. Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

- Agreed relief staff for the Kingfisher management area as far as possible.
- All staff employed in the designated centre will be shadowed by the PIC or regular staff.
- PIC office is in the designated centre
- All staff supported to familiarise themselves with current support plans for residents for whom they work. PIC has produced a Critical Information Handbook which will direct staff on this issue. All staff are required to sign this within an agreed timeframe in conjunction with the PIC.
- All safeguarding and behaviour support plans are discussed at staff meeting and documented in meeting minutes.
- In-house Induction will be provided by the PIC for all new staff.

**Proposed Timescale:** 27/10/2016

**Theme:** Responsive Workforce

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

Staff had inappropriate medication management training; in particular training in the management of prescribed emergency medication.

**31. Action Required:**

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

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

- New and updated medication training has been agreed by Community Services management in August 2016.
- Training for Area Managers and Persons in Charge has been prioritized and both PIC and AM of this designated have attending this training.
- Future dates for training for front line staff are currently being agreed as a priority.
- Medication management was an agenda items at staff meetings on 24th and 25th August and will remain an agenda item.
- Medication audits by the Area Manager will continue.
- Buccolam training was provided to the majority of the staff in this designated centred following the feedback from the HIQA inspection. This training was provided on 24th August and 25th August by a nurse. The training for the remaining staff (5) will be provided as a priority.

- Medication training will be reviewed to include training on buccolam.

**Proposed Timescale:** 26/08/2016

**Theme:** Responsive Workforce

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

Staff did not have access to appropriate training, including refresher training, as part of a continuous professional development programme. For example, some staff did not have fire safety training or adult protection training.

**32. Action Required:**

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

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

- Staff attended medication training in September and October 2016
- Remaining two staff who require Medication Management Training will attend training on December 11th 2016.
- The majority of staff have attended Fire Safety Training September 2016 and the remaining four staff will attend training on November 2nd and 16th.
- MAPA training for one staff completed in September 2016, all other staff have up to date MAPA training.
- Staff attended Protection of Vulnerable Adults training in September and October 2016.
- Refresher of Protection of Vulnerable Adults training for remaining 4 staff is scheduled for December 12th 2016.

**Proposed Timescale:** 12/12/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Records were not available for inspection in relation to each resident as specified in Schedule 3. These included all nursing or medical care provided to the resident, including a record of the resident's condition and any treatment or other intervention.

**33. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.



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

- Freedom of Information Officer informed about possible breach of data protection legislation due to missing daily notes.
- Fluid intake chart implemented. This will be checked and signed by PIC on a fortnightly basis.

**Proposed Timescale:** 27/10/2016