

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004918
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:

05 February 2015 09:45

To:

05 February 2015 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of the centre by the Authority.

The inspector found that residents were provided with a comfortable and welcoming residence that was well maintained, adequately heated, lighted and ventilated and met their individual and collective needs.

The inspector saw that residents looked well, were engaged and relaxed in the centre and welcomed the inspector into their home. Residents had access to structured day and educational services Monday to Friday. The inspector met with residents prior to their departure to these services and on their return in the evening.

The inspection process consisted of the inspector meeting with the person in charge and the area manager and reviewing and discussing relevant documentation with them.

Overall the inspector was satisfied that there was a commitment to providing quality care and services to residents and complying with regulatory requirements. There was evidence of action taken and improvements made such as the unannounced

inspections of the centre and the planned fire safety improvement works. However, resource issues impacted on the service provided and the level of regulatory compliance evidenced.

The inspector was not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents individual and collective needs, consistent and effectively monitored. The inspector was not satisfied that the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities as set out in the regulations and to ensure the effective governance, operational management and administration of the centre including the consistent monitoring of care, services and staff. There were inadequate staffing resources available to ensure that resident's individual choices and outcomes were facilitated at all times. Improvements were required in the management of complaints.

The inspector reviewed ten of eighteen possible outcomes and judged the provider to be compliant in one, substantially complaint in two, in moderate non-compliance with five and in major non-compliance with two; governance and management and workforce.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

The complaints procedure was displayed and was available in a user friendly pictorial format for residents. However, it was not clear to the inspector who was actually responsible for the receipt and management of complaints made locally, was it the person in charge, the area manager or the chief executive officer.

The policy stated that informal complaints were to be recorded in the complaints log but no such log was maintained in the centre.

Records of a recent complaint made were requested, made available and reviewed by the inspector. While the records indicated that complaints were listened to and some action had been taken, the record did not reassure that all aspects of the particular complaint were fully investigated, particularly in relation to concerns raised in relation to the organisation of care and services, resident routines and choice, and measures in place to ensure that any resident who has made a complaint was not adversely affected by reason of having made a complaint. The complaint was not fully and promptly investigated. Based on these inspection findings particularly in relation to governance and available staffing resources, all aspects of this particular complaint required full review and investigation.

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):

This was the centre's first inspection by the Authority.

Findings:

There was a process in place for the assessment of each resident's health, personal and social care needs that was used to inform the support plan. Aspects of the plan were presented in a format that was accessible to the resident.

The process was the subject of review by the person in charge, the area manager and by the unannounced visit to the centre as arranged by the provider; all had identified deficits in the process and this would concur with the findings of this inspection. The inspector based on the sample of plans reviewed was not reassured that the plan reflected resident's changing and current needs or adequately set out the supports in place to meet the needs of each resident to keep them well and maximise their quality of life. The inspector saw;

- assessment data was undated
- where there was a clear identified need for a support plan such as in communication or physical wellbeing these were not in place
- there was no clear evidence of resident participation in the plan
- priorities were functional rather than developmental
- timeframes were not specific and there was no record as to whether priorities were still relevant, achieved or not
- the process of review was not clear
- there was a concerning recurring theme of the negative impact and constraints placed on supporting and achieving individual resident outcomes due to the low levels of available staff supports.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The inspector found the design and layout of the premises to be suited to its stated purpose and function and it met residents' individual and collective needs in a comfortable and homely manner.

On visible inspection the premises appeared to be of sound construction, well maintained and in good decorative order. The premises was adequately heated, lighted, ventilated and visibly clean.

Each resident was provided with their own bedroom; these were seen to be of sufficient space for their needs, adequate personal storage space was provided. Bedrooms were personalised and residents took great pride in showing them to the inspector.

Bedrooms were not en-suite but sufficient easily accessible sanitary facilities were provided; residents had a choice of two fully fitted bathrooms one with an assisted shower, the other with a floor level bath. A third single toilet was also available in the main entrance foyer.

Adequate communal space was provided for the number of residents accommodated and residents had a choice of two communal areas.

The kitchen/dining space was combined; the kitchen was adequately and suitably equipped and sufficient dining space was provided.

Adequate facilities were in place for the laundering of linen and personal clothing.

The external area was well maintained; seating was available but stored for the winter.

General waste was collected by a local waste collection firm and the person in charge confirmed that no clinical waste was generated.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

There was a safety statement in place and a register of risks. The register of risks reflected a recent process of centre specific risk identification and management undertaken by the person in charge; risks were assessed, controls were identified and where additional controls were required they were communicated to senior management.

The person in charge confirmed that no resident had a manual handling requirement but staff had training that was within mandatory requirements.

There was no fire detection system or emergency lighting in the centre; there were two smoke detectors, a fire blanket and one fire extinguisher in place. There was documentary evidence that the provider had commissioned a fire safety audit of the centre, the report was available for inspection and written confirmation that works were to commence on 9 February 2015. The scope of works to be completed included the installation of a fire detection system, emergency lighting, fire alert break glass units, additional fire fighting equipment and enhanced fire protection to the fabric of the building.

Staff had attended fire safety training and meaningful practical fire evacuation exercises were undertaken at regular intervals by staff with residents.

It was of concern to the inspector however, given the low level of fire safety precautions in place that staff did not comply with a requirement to check the existing smoke detectors on a weekly basis; records indicated that no weekly checks were completed and the most recent check was undertaken on the 28 December 2014.

There was no risk assessment or plan in place for the safe accommodation of the proposed fire safety works. A representative of the provider nominee was requested at verbal feedback to address this and provide confirmation that the required controls and monitoring of the works would be in place to safeguard resident and staff safety. This was confirmed by e-mail to the inspector from the provider as requested on the 6 February 2015.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

There was a suite of policies in place with a protective component including policies and procedures for the management of any alleged, suspected or reported abuse, the use of restrictive practices and the management of behaviours that challenged. Training

records indicated that all staff had received training on the protection of vulnerable adults. The person in charge said that some residents had the capacity for and awareness for self-care and protection whereas some residents would indicate concern through specific behavioural cues. Records seen indicated that when on duty the person in charge convened house meetings and discussed with residents the processes in place for their safety and wellbeing and how to make a complaint. Each resident had access to the advocacy service affiliated to the day service.

However, as discussed in outcome one the inspector was not reassured as to the efficiency and efficacy of the complaints management system and how this could potentially impact on the protection and safeguarding of residents.

As discussed in Outcome 14: Governance and Management the inspector was not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to resident's individual and collective needs, consistent and effectively monitored.

Residents were assessed and described by staff as having high support needs. There was one recently identified minor restrictive practice in relation to environmental safety. The person in charge had also arranged for the recent review of one resident by the behavioural therapist and the person in charge said that a therapeutic plan was required that included one-to one therapeutic staff support as necessary for the resident. There was no provision for this within the current staffing arrangements. Given the differing needs of the residents there was further evidence that the lack of staff supports impacted on individual choice and created further demands and challenges that at times led to emotional and behavioural upset for residents.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

The person in charge had sound knowledge of her legal responsibility to submit notifications as prescribed by article 31 of the regulations. However, notifications had not been submitted to the Authority in line with the requirements of the regulations. On further discussion it was agreed that the person in charge had completed the required notifications but the procedure in place whereby they were forwarded to management for return to the Authority did not facilitate the person in charge to fully exercise her legal responsibilities.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

Residents had access to their preferred general practitioner (GP) or a GP that was acceptable to them. Records seen indicated that staff facilitated residents to have timely access to medical review and treatment in response to their needs as they presented. The person in charge confirmed that all residents had a full annual medical review but that in reality it was much more frequent than this; this would concur with the records seen by the inspector. There was further documentary evidence that as appropriate to their needs residents had access to other healthcare services such as dental, optical, speech and language, behaviour therapist, social work and chiropody. There was evidence to support a health promoting ethos to care including seasonal influenza vaccination and screening and treatment for conditions such as osteoporosis.

Overall the inspector was satisfied that residents healthcare needs were monitored by staff and arrangements were put in place to meet their needs. However, it was of some concern in the absence of explicit documentation/health care plans and given the staffing arrangements how information was consistently and accurately communicated between staff to ensure that gaps and deficits did not arise. For example the inspector saw one record of recent significant weight loss with no apparent follow-up; the resident had a GP review in the intervening period but the weight loss was not referenced in the record or in the daily care record.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

There were written operational policies relating to the ordering, prescribing, storage and administration of medicines to residents.

The person in charge reported that residents enjoyed good health and this was reflected in the type and number of prescribed medications in use.

Medications were securely stored and supplied to the centre by a local pharmacy but where a resident had a preferred choice of pharmacy this was facilitated.

No resident was managing their medications independently but the person in charge had initiated a process to enhance some resident's level of involvement and participation in line with their wishes and capacity.

The person in charge confirmed that there were no medications requiring administration in an altered format (crushed) and each medication seen was labelled and supplied for individual resident use.

There were procedures and records for the receipt and return of medications to and from the pharmacy and a segregated area for the storage of such medications. There was no evidence of excess stock.

Each resident had a current dated and signed (completed by the GP) prescription record and an administration record. However, the inspector noted that while the prescription record had an alphabetical code for each prescribed medication this was not used when recording administration. Staff recorded that the "blister pack" was administered rather than each individual medication and this would not concur with best practice guidance. The current medication management policy did not adequately address or provide clear guidance on this issue.

The current medication policy stated that all non-nursing staff were to receive training on an annual basis but training records indicated and the person in charge confirmed that staff had not received medication administration training since 2010. This is addressed under Outcome 17: Workforce.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

The inspector was not satisfied that management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents individual and collective needs, consistent and effectively monitored. The inspector was not satisfied that the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities as set out in the regulations and to ensure the effective governance, operational management and administration of the centre including the consistent monitoring of care, services and staff.

The person in charge was appointed to her post in September 2014; she is person in charge for this one designated centre but the provider plans to extend the centre to two houses and ten residents. The inspector found the person in charge to be suitably qualified; she had established relevant experience within the organisation. This was the first management position held by the person in charge but the inspector was satisfied that she demonstrated knowledge, accountability and responsibility, had a sound understanding of the requirements of her role and regulatory requirements and was committed to ongoing review and improvement.

The person in charge worked full-time; however the post of person in charge was not full-time. The person in charge has clearly defined legal responsibilities for 50% of the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the regulations therefore require that the post of person in charge is full-time. However as required by the provider, 23% of her rostered hours were as a member of the frontline staff in the centre; 50% of her remaining hours were spent as manager on call for ten designated centres leaving 30 hours per fortnight for her duties as person in charge of the centre. In addition the person in charge and area manager reported that following a weekend of on call duties the rota resulted in the person in charge not on duty from Sunday to the following Friday. The person in charge was not based in the centre but on the main campus ten miles from the centre. The role of on-call manager was reported to have included replacing staff and providing one-to-one accompaniment to residents from other centres.

There were systems in place for the monitoring and review of the safety and quality of the care and services provided to residents but it was not evident that actions identified by the provider as necessary were taken to remedy identified deficits and bring about improvement. As required by article 23(2) the provider had made arrangements for the unannounced inspection of the centre on a six monthly basis. The reports were available for inspection and indicated that good practice was evidenced but also deficits such as the inadequacy of staffing resources and the impact of this. There was no clear plan as to what actions were to be taken to address these deficits.

The area manager confirmed that a process was in place to undertake an annual review of the quality and safety of care and support in the centre involving consultation with residents and relatives as required by article 23(d)(e)and (f); the process was to be complete by 31 April 2015.

Judgment:

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):

This was the centre's first inspection by the Authority.

Findings:

Residents in the centre presented with differing challenges and needs; the inspector was not satisfied that the available staffing resource was appropriate to the individual and collective needs of the residents. There was sufficient evidence to support this finding in records reviewed and in discussion with the person in charge and the area manager.

Ordinarily there was only one staff member allocated to the centre at any one time; five additional staffing support hours were allocated each Saturday from 10:00 hrs to 15:00hrs. The one staff member had full responsibility for all six residents, their physical and psychosocial needs, their recreational needs including transportation and all housekeeping duties including the preparation and cooking of meals, laundry and environmental hygiene, and the maintenance of all records and documentation pertinent to all of these duties.

There was documentary evidence that the available supports were inadequate to meet resident's individual and collective needs in the form of completed risk assessments; in residents' person centred plans; in complaints records and in the providers own unannounced inspection of the centre in June 2014. The report of that inspection reported that staff support was "quite low" and additional staff supports were required particularly in meeting person centred planning outcomes; the timescale for this action to be completed was August 2014. It was evident that the deficit presented further demands and challenges to both residents and staff. For example the inspector saw that one resident had requested relocation to another centre; staff reported to the person in charge that they did not have time to undertake routine fire safety checks; the inspector saw that residents were seated at the main dining table for a considerable and unnecessary period of time prior to receiving their evening meal.

The person in charge reported that staffing arrangements dictated that all care and routines had to be completed before 09:00hrs Monday to Friday and there was documentary evidence that this impacted negatively on residents choices and requests in relation to their daily routines such as a request to get up at a later time.

The roster was prepared and maintained centrally. There was no roster maintained in

the centre, showing staff on duty during the day and night.

There was a planned annual programme of staff training. The records of staff training seen by the inspector indicated that mandatory training including fire safety, manual handling, and the protection of vulnerable adults was completed by all staff, staff had also received or it was planned that they were to receive training in the management of behaviours that challenged. A deficit was identified in medication management training.

There was no formal system in place for the supervision and development of staff and the staffing and governance arrangements were not conducive to this as staff worked in a solitary and unsupervised manner.

Staff files were not available on site, were not requested or inspected. The provider nominee was informed that they would be required for review at the next scheduled inspection.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
Centre ID:	OSV-0004918
Date of Inspection:	05 February 2015
Date of response:	27 February 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

A recent complaint was not fully and promptly investigated

Action Required:

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

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

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

- Protective measures were put in place.
- Acting Head of Community Services has taken the following actions :
- Met with area manager to discuss delay in processing complaint in order to ensure this does not happen again.
- Met with Social worker and designated person to discuss how complaint was handled and how decision by DP was reached. The matter was not a DP issue but related to poor practice that needed to be addressed by the manager.
- Management will review procedures/protocols to support staff such as orientation to new places of work.
- Met with staff to discuss what happened on the evening and how resident was affected. Code of Practice was discussed with staff. Staff given a copy of Code of Practice and will be given Code of Practice training in April
- Social Worker reported on outcome of complaint to resident who stated she is happy with outcome.
- A new procedure for tracking complaints by PIC is being introduced so that there will in future be a weekly check on the status of all complaints in designated centres.

Proposed Timescale: 30/04/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The record did not reassure as to what measures were in place to ensure that any resident who has made a complaint was not adversely affected by reason of having made a complaint.

Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

- Protective measures were put in place.
- All staff have received training on national policy for The Welfare and Protection of Vulnerable Adults. This is mandatory training and refresher training is provided in accordance with guidelines.
- New complaints procedure being rolled out in the designated centre and Policy on the Handling of Complaints is at present under review and will be implemented when passed.
- Code of Practice 'in house' training will be given to all staff.
- The Service User policy on The Management of Bullying will be discussed with residents of the designated centre.

Proposed Timescale: 31/03/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in**

the following respect:

The policy stated that informal complaints were to be recorded in the complaints log but no such log was maintained in the centre.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

- A book to log all complaints is now placed in each house. This book is an interim measure until the Complaints Policy that is at present under review is passed by Policy Review Group and the HSE.
- Revised complaints logs will be printed after Complaints Policy is passed. A log will then be placed in designated centre.
- Area manager will discuss with designated centre staff and PIC the importance of logging all complaints from residents and others and tracking any complaints made and informing complainant of outcome.

Proposed Timescale: 31/03/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

There was a concerning recurring theme of the negative impact and constraints placed on supporting and achieving individual resident outcomes due to the low levels of available staff supports.

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:

- A staffing proposal was submitted to Senior Manager on 23.01.2015 for increased support staff hours.
- Risk assessments completed on 4 residents to identify support needs.
- Day Services staff who starts duty in the house Monday to Friday will have her role reviewed so that service offered will be more person centred.
- Day Services staff will receive training so that residents can benefit from her presence in a more individual way to meet their wishes e.g. Medication administration and intimate care training.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Residents' plans did not reflect residents changing and current needs or adequately set out the supports in place to meet the needs of each resident to keep them well and maximise their quality of life.

Action Required:

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

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

- Relevant care plans are being developed in consultation with other members of multi-disciplinary team and GP as required
- Day Services staff who starts duty in the house Monday to Friday will have her role reviewed so that service offered will be more person centred.
- Day Services staff will receive training so that residents can benefit from her presence in a more individual way to meet their wishes e.g. Medication administration and intimate care training.

Proposed Timescale: 31/03/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Given the low level of fire safety precautions in place it was of concern that staff did not comply with a requirement to check the existing smoke detectors on a weekly basis

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:

- Frontline staff on duty have been instructed to check smoke detectors weekly.
- New smoke detection system has been installed and work was completed during week ending 20.02.2015

Proposed Timescale: 25/02/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

A therapeutic plan was required that included one-to one therapeutic staff support as necessary for the resident. There was no provision for this within the current staffing

arrangements.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

- Staffing proposal was submitted to Senior Manager on 23.01.2015 for increased support staff hours. This will be reviewed to reflect outcome of risk assessment.
- Risk assessment will be completed on the resident to identify individual support needs

Proposed Timescale: 31/03/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Notifications had not been submitted to the Authority in line with the requirements of the regulations

Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

- Quarterly return for designated centre was returned on 10.02.2015
- PIC has been advised of the requirement to return all notifications in complete form by due date.

Proposed Timescale: 10/02/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

It was of some concern in the absence of explicit documentation/health care plans and given the staffing arrangements how information was consistently and accurately communicated between staff to ensure that gaps and deficits did not arise.

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:

- PIC met GP to arrange that diagnostic and relevant information is given to staff.

Information from GP will help to inform relevant care plans.

- Staff informed by PIC that all appointments should be noted in house diary.
- All staff have been instructed to complete Appointment Form after visit to GP, consultant, dentist, physiotherapist, dietician, etc. with appointment information and outcome including follow up appointments or recommendations.
- Appointment form is filed in My Profile/My Plan for reading by other staff and PIC

Proposed Timescale: 25/02/2015

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:

Staff recorded that the "blister pack" was administered rather than each individual medication and this would not concur with best practice guidance. The current medication management policy did not adequately address or provide clear guidance on this issue.

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 administer medication according to policy on Administration and Management of Medication
- Administration and Management of Medication Policy was reviewed, updated and passed for use in February 2015.
- Policy includes having a photograph of the resident in the Kardex/drugs administration folder
- Instructions on administration are listed by dispensing pharmacy on blister pack labels
- Training (suitable to non nursing staff as no nurses are employed in the designated centre) on the administration of drugs will be organised for all staff of the designated centre.
- Residents are encouraged to use community pharmacies of choice.

Proposed Timescale: 30/04/2015

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:

Not ensuring that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents individual and collective needs, consistent and effectively monitored.

Not ensuring that the working arrangements required of the person in charge by the provider would facilitate and support her to fulfil her legal responsibilities as set out in the regulations and to ensure the effective governance, operational management and administration of the centre including the consistent monitoring of care, services and staff.

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:

- There is a clearly defined management structure in place in respect of this designated Centre.
- The roles and responsibilities of the PIC (Community Residential Team Leader) are currently been reviewed and agreed.
- The roles and responsibilities of other management grades are also being reviewed and agreed.
- A review of the on call arrangement is taking place to make sure that system is working.
- Increased supervision for the PIC.

Proposed Timescale: 31/03/2015

Theme: Leadership, Governance and Management

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

It was not evident that actions identified by the provider as necessary were taken to remedy identified deficits and bring about improvement.

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:

- There have been 2 six monthly unannounced inspections in this designated centre.
- The recommendations from each of these inspections will be reviewed and where recommendations have not been followed action will be taken.

Proposed Timescale: 31/03/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

the following respect:

There was documentary evidence that the available supports were inadequate to meet resident's individual and collective needs in the form of completed risk assessments; in residents' personal centred plans; in complaints records and in the providers own unannounced inspection of the centre in June 2014.

Action Required:

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

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

- Staffing proposal was submitted to Senior Manager on 23.01.2015 for increased support staff hours. This will be reviewed to reflect outcome of risk assessment
- Individual risk assessments are to be carried out for individuals.
- When completed risk assessments will inform staffing needs of the designated centre.
- The final proposal will be escalated to the Director of Services for approval with a supporting business case.

Proposed Timescale: 31/03/2015

Theme: Responsive Workforce

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

There was no roster maintained in the centre, showing staff on duty during the day and night.

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:

- Administrative staff who is responsible for rostering has been spoken to and advised that monthly roster for the following month must be issued for designated centre by 15th of each month.
- Changes to roster must be sent out as soon as any staff change is confirmed.

Proposed Timescale: 25/02/2015

Theme: Responsive Workforce

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

A deficit was identified in medication management training.

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:

- Training (suitable to non nursing staff as no nurses are employed in the designated centre) on the administration of drugs will be organised for all staff of the designated centre

Proposed Timescale: 30/04/2015**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no formal system in place for the supervision and development of staff and the staffing and governance arrangements were not conducive to this as staff worked in a solitary and unsupervised manner.

Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

- A national policy on Staff Support and Supervision is being developed by Brothers of Charity Ireland. This policy will be implemented in the designated centre when passed.
- Managers will continue to visit designated centres on a regular basis to meet staff and to provide support and supervision for all staff working in the centre.
- Monthly staff meetings will take place and will be documented.
- Checklist that is completed by Person in Charge is used to support staff in performance of duties. This process will be extended during 2015.

Proposed Timescale: 30/06/2015