

# eDeposit Ireland

## Liosmor, Limerick

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Authors	Moore, Mary
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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Liosmor
<b>Centre ID:</b>	OSV-0002869
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Limerick
<b>Provider Nominee:</b>	Norma Bagge
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	9
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
07 February 2017 08:45	07 February 2017 18:30
08 February 2017 08:30	08 February 2017 14:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This inspection was the third inspection of the centre by The Health Information and Quality Authority (HIQA). The first inspection was undertaken in October 2014; the last inspection was in May 2016. This inspection was undertaken to follow-up on the findings of the May 2016 inspection.

How we gathered our evidence;

Prior to the inspection the inspector reviewed the information held by HIQA in relation to this service. This included the previous inspection findings and the provider's response to the action plan and notifications submitted of adverse events and incidents that had occurred in the centre.

The inspection was facilitated by frontline staff and one of the Clinical Nurse Managers (CNM1) who was deputising for the person in charge during planned leave. The inspector spoke by phone with the nominated provider representative who was not available during the inspection due to prior commitments and apologised for this. The inspector met and spoke with front-line staff on duty over the course of the two days of inspection. The inspector reviewed records including policies and procedures,

resident and staff related records, fire, and health and safety related records.

The centre was home to nine residents all of whom engaged and spoke with the inspector over the two days. The inspector observed the delivery of care and supports to residents and staff and resident interactions. It was again evident to the inspector that residents were at ease with staff and readily and regularly sought out staff and received assistance from them. There were no observed restrictions placed on residents who had ready access to the staff office; staff were seen to take their breaks with residents who chatted easily with staff.

Residents spoke of forthcoming events such as their birthdays and the planned celebrations; there was lively, respectful and appropriate engagement between residents and staff on the topic of St Valentine's Day as staff assisted residents to make cards and other tokens. Residents spoke of the attention they received from staff and how staff "looked after" them. One resident told the inspector that they did not like it when the house got noisy; one resident said that it was not nice when they did not have the opportunity to leave the house.

Description of the service;

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The statement reviewed by the inspector was updated in January 2017. The inspector found that the service provided and the supports to be provided to residents were not as described in that document due to inadequate resources.

Overall judgment of our findings;

Despite the standard of the primary care delivered to residents and the evident respect, care and warmth observed by the inspector, the inspection findings were poor; there were significant failings in core areas fundamental to safeguarding residents and ensuring that all residents received safe, quality services at all times.

Of the nine Outcomes inspected the provider was judged to be in major non-compliance with all nine Outcomes, this resulted in the provider being requested to attend a meeting in HIQA's head office in Cork on 15 February 2017.

At the time of the last inspection in May 2016 the inspector was concerned at the number and nature of incidence's of behaviors that challenged in the centre and the risk and negative impact on both residents and staff. The provider was requested to address this matter with immediate effect and put arrangements in place that adequately supported residents to manage their behaviors and protected all residents and staff from all forms of harm and abuse. However, while there was evidence of actions taken, these had clearly not resolved the matter and both staff and residents continued to be subjected to risk and harm from behaviors that challenge. The physical safety and the emotional well-being of the remaining residents in this on-going situation could not and was not protected.

Failings were identified in the systems for managing allegations of abuse including failure to notify HIQA of all allegations made.

The inspection findings did not demonstrate governance that supported staff, residents and families to raise concerns as to the quality and safety of the care and services provided or governance that demonstrated recognition of the concerns raised and responded proactively to address all of the issues that led to these concerns.

At the time of the last inspection in the context of the number of residents, the range and complexity of their needs including advancing age, medical needs, level of dependency and behaviors that challenge, the provider was informed that staffing arrangements were not always sufficient to meet those needs. However, approximately 12 weeks prior to this inspection staffing levels had been reduced further when a decision was made by the provider to allocate one staff from the centre to accompany one resident to their day care service; this resulted in two rather than three staff remaining in the designated centre from approximately 10:30hrs to 15:30hrs. There was well documented negative impact on residents particularly but not exclusively in relation to their social needs.

In the context of reduced staffing there was clear blurring of boundaries between what the provider was legally obliged to provide, that is, appropriate staff numbers to meet the assessed needs of the residents and the safe delivery of services, and what residents were requested to personally pay for such as transport and support from a private home-care provider.

Decisions made and proposed by the provider in the context of inadequate resources failed to demonstrate how they protected and promoted equity and the rights of all residents and the quality and safety of the care delivered to all residents.

Improvement was still required in the standard of documentation maintained as it was difficult and time-consuming to extract current and accurate information in relation to residents and their required care and support.

However, having triangulated the evidence the inspector was satisfied that resident's healthcare needs were adequately and appropriately met (there was a choking related risk but this is addressed as a risk management failing in this report; the required healthcare had been provided). Residents had good access to medical review and multi-disciplinary supports as appropriate to their needs. Residents were supplied with any equipment necessary for their comfort and well-being. Staff spoken with had good knowledge of residents' current needs and supports; staff were seen to be timely and respectful in their engagement with residents.

The providers initial response to the action plan was not accepted by HIQA as it did not address or demonstrate how it would address pertinent failings and matters of concern to the HIQA: in line with agreed process the provider was offered a second opportunity to submit a satisfactory response to the action plan.

Further to the receipt of the second provider's response a further meeting was convened with the provider on 25 April 2017. In summary the provider stated that while there were failings that were within its control to address, ultimately the second action plan response remained largely unchanged from the first in the

context of limited resources and the absence of funding from the statutory body, the Health Service Executive. The provider stated that decisions made (as referenced throughout this report) were the best decisions that could be made in the context of inadequate resources.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Equity was not evidenced in relation to supporting all residents to achieve a good quality of life, enjoy community inclusion and achieve their personal goals. It was not clearly demonstrated how residents rights and their promotion influenced decisions as to the management of the centre when it was clear that these decisions impacted on residents quality of life and the quality and safety of the care and services provided to them and continued to do so.

The centre was described by the provider as part of its integrated services; this was a service where programmes of activities and meaningful engagement were provided for residents both on site in the centre and off-site in locations such as the day service. Factors such as each resident's age and needs informed the programme that was developed for them. Three of the nine residents attended off-site day services Monday to Friday. There, residents participated in programmes such as arts and crafts, life skills, exercise programmes, Olympic Games participation, and socialisation.

At the time of the last inspection it had been acknowledged in the centre that a review of the programme delivered to each resident required review to ensure that their general welfare and development needs were being met. There was documentary evidence at that time of the commencement of this process which was multi-disciplinary (MDT) and an acknowledgement that an increased level of meaningful engagement and activity was needed for residents. There was a plan to review the supports that were available within the centre to see how these could be maximised to facilitate activities.

However, some residents now, as a consequence of the reduced staffing levels had less

access to internal and external activities and engagement than they had enjoyed at the time of the last inspection. One resident was admitted in early 2014 with an existing day service; a commitment was given to the resident and their family that access to a local day service would continue and that the centre would have "the staffing levels required". This commitment from the provider had not transpired and the resident now only accessed the day service one day per week and that was to receive physiotherapy.

It was clearly recorded in the resident's 2016 personal plan meeting attended by family that there was a clear need and desire for more opportunities for social involvement and engagement as the resident "loved meeting people" and had "a general interest in lots of things". This was not being achieved; the identified barriers were transport and staffing.

There was a distinct blurring of what the provider was obliged to provide to each resident and what the resident was personally responsible for funding; this was clearly evidenced on inspection. The provider had sourced the services of an external home-care provider to provide transport and support to residents for social events; residents paid for this at a cost of 25 Euros per hour; for example one "drive" and dining out for one resident lasted 6.5 hours.

Staff told the inspector and records seen indicated that this was approved under the process of requesting a personal assistant (PA). However, a core requirement of the PA scheme was;

- the identified need could not be met within existing resources
- the tasks required of the PA were not those that could be undertaken as part of the normal duties of the provider's employees.

The inspector was satisfied that neither of these criteria was met. The centre was inadequately staffed and therefore inevitably the need could not be met; the duties undertaken were part of the normal duties of employees. For example on the second day of inspection it was planned that two residents were to go with the home-care provider to a local community centre. However, due to the presence of the CNM1 in the centre, (due to the presence of the inspector) there was additional staff on duty and staff transported and accompanied three residents to the centre at no cost to the residents.

Staff maintained a log of local complaints received by them. There were 15 entries in this log since the last inspection all from residents. Two complaints were in relation to lack of access to the day service, physiotherapy, and a local community centre that residents had attended each Wednesday. Five separate complaints were from residents following incidents of behaviours of risk. As these matters and their impact were all still evident at the time of this inspection; in that context it was not evidenced how the provider's management of complaints demonstrated effectiveness and improvement measures in response to complaints as required by Regulation 34 (1) and (2). It was not evidenced what benefit there was if any for residents, in staff supporting residents to make complaints about the quality and safety of the care and services that they received when improvement was not affected by virtue of their complaints.

The provider operated a regional advocacy network; one resident was the local

advocacy representative. The inspector noted from minutes seen that the resident had not been present at the most recent advocacy meeting. Staff told the inspector that this had occurred on more than one occasion and was due to inadequate staffing.

An additional control identified by the person in charge to reduce a risk of choking was the reinstatement of the third staff member to ensure adequate staff assistance and supervision. However, at a meeting of the multi-disciplinary team in January 2017 rather than supporting the request to reinstate staff and therefore promote and protect the residents' right to remain in the centre, it was recommended that the resident be referred to the admissions, transfers and discharge committee for transfer to another centre.

**Judgment:**

Non Compliant - Major

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The findings of this inspection were largely unchanged since the last inspection. Staff said that they struggled to find the time to complete and maintain the required records to the required standard due to inadequate staffing levels. All staff said that the area of monitoring and progressing resident's personal plans, their goals and objectives had been negatively impacted on.

Staff spoken to, were familiar with each resident and their required supports; care and supports were guided by multi-disciplinary review and recommendations. However, this was not always evident or reflected in the documentation maintained and required triangulation to ensure that there were no deficits in care.

Two files were maintained for each resident, the daily file and the person centred plan (MPMP). There was duplication, contradiction and a lack of consistency noted between both files and no one clear record that outlined and guided the supports currently

required to maximise the resident's wellbeing, safety and personal development. While there were records of regular review meetings by staff the plans themselves demonstrated poor evidence of review.

Many records were still undated and it was difficult to retrieve current accurate information so as to substantiate that care implemented was as instructed.

Reviews and updates were generally but not always seen in the daily file and in the daily narrative notes and these did reflect what was seen by the inspector in practice and as reported by staff. For example a wound care plan contained historical wound care instructions that were no longer relevant. It was also difficult to track the current eating and drinking plan for a resident at risk of choking. However, the most recent hospital discharge instructions had been formally communicated to staff, staff were aware of them and they were implemented.

While there was evidence of strategies to monitor weight in narrative notes and minutes of staff meetings where a resident had demonstrated concerning weight-loss, this intervention was not evident from and there was no specific plan in either the daily file of the MPMP.

The review of the plan/supports was multidisciplinary (MDT) and this MDT input was on-going as appropriate to residents changing needs.

There was a process for establishing and agreeing resident's personal goals and objectives. Again at times the documentation process was disjointed and it was difficult to track progress. However, unlike the area of healthcare where the inspector was satisfied that the care was in place but not reflected in the records, there were clear barriers to residents achieving their personal goals and objectives. The importance of goals to residents was clearly evident with residents eagerly sharing their achievements and planned goals with the inspector.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective Services

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

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

**Findings:**

There was limited and insufficient evidence of proactive and effective measures taken in

response to the identification and assessment of risks to ensure resident safety and the quality and safety of the care and services provided to all residents.

There was evidence that further to an identified manual handling risk further input had been sought from both physiotherapy and occupational therapy; additional and alternative equipment was recommended and the night staffing arrangement was altered to two waking night staff as opposed to one waking and one sleepover staff. There was evidence that the equipment was being procured.

There were numerous risk assessments and evidence of their ongoing review by the person in charge; these risk assessments were all related to the same two identified hazards; inadequate staffing and unpredictable behaviours of risk. The identified controls did not at all times demonstrate proportionality and reasonableness in the context of residents rights or resolve the adverse impact on resident quality of life of both the risks and the control measures.

For example the requirement for residents to pay for services, change their established routines or even their proposed transfer from the service and, fundamentally the decision to divert staffing resources to another service in response to risk identified there when this decision created risk in the designated centre and impacted negatively on the remaining residents.

The completed risk assessments did not demonstrate how residents were protected by the provider from harm and abuse. The provider's risk assessment matrix allowed for three bands of risk, low (one to five), medium (six to 12) and high (15 to 25). The residual risk posed to residents from behaviours of concern and risk was rated as in the higher level of medium risk (10 to 12). There was one open high risk seen by the inspector (16) for risk of choking if adequate staff supervision was not available. However, the provider confirmed post the inspection that there were in fact two red level safety risks at the time of the inspection; the second risk was stated to be related to the lack of approval to recruit relief staff.

Accident and incident forms were poorly maintained in that the inspector found them filed in four different locations; in the resident's personal plan, in the daily file, in a resident specific folder and in a general incident folder. It was difficult to be definitive as to which if any of these was a complete record.

At the time of the last inspection in May 2016 a person with the required fire safety expertise had been requested by the provider to review the evacuation procedure in line with the dependency of the residents and the apparent safe compartments available within the building; residents were all evacuated from the building during simulated drills. Staff spoken with confirmed that a review of the fire evacuation procedures for the centre had not been reviewed and amended to progressive horizontal evacuation.

Four fire drills had been completed in 2016, the most recent in August 2016. There had been no simulated drill completed since June 2015 that tested the adequacy of evacuation with minimum staffing and maximum occupancy, that is 2:9; that exercise in June 2015 had taken 10 minutes to complete. Some escape routes were seen to be obstructed externally by items such as garden chairs and bins

There was widespread practice of holding open designated fire doors with furniture, waste bins or paper wedged between the doors and the floor.

The fire detection system had been serviced and tested at the prescribed intervals and most recently in January 2017.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

There was a pattern of allegations of abuse against staff in this centre that continued. Investigation by the provider has not upheld the allegations made and there was a body of opinion that the allegations were behaviour related. However, there was evidence that this opinion had resulted in confusion and inconsistent practice as to how these allegations were managed.

For example, minutes of a meeting dated 13 October 2016 stated that it had been agreed that a specific protocol was to be implemented for the management of these allegations by the 25 October 2016. The inspector found the agreed process and log in a working folder in the centre; it was stated on it that it was agreed for implementation. In the interests of safeguarding all residents regardless of whether they had made previous allegations that were subsequently unfounded or not, the process outlined unsafe guidance to staff and placed undue responsibility on staff to conclude whether abuse could have occurred or not.

Staff were advised that when they were in receipt of an allegation they were not to complete the formal complaints record or the formal form to the designated officer unless there was an indicator such as "evidence of harm".

Staff spoken with were not aware of any process specific to these allegations and told

the inspector that they would report all allegations through the agreed safeguarding policy and procedures. The provider nominee confirmed for the inspector that the procedure had not been implemented but was also not aware that it was available to staff in the centre, many of whom worked on a relief basis. There was no evidence available to the inspector of further MDT discussion on this process further to the meeting of October 2016 where its implementation was agreed.

Records seen indicated that staff did continue to record and report allegations made. These records however also demonstrated inconsistency as to how these allegations were managed and did not provide assurance as to how they were screened so as to be deemed unfounded; based on records seen at least three allegations had not been notified to HIQA.

In response to behaviours that challenge there was evidence of supports and actions taken including regular referral and review by psychology, psychiatry and the behaviour specialist and regular multi-disciplinary reviews. There was evidence of new interventions and protective measures introduced since the last inspection. For example the night time staffing levels had been changed to two waking staff as opposed to one waking and one sleepover, a night-time continence programme had been introduced and two staff were required to be present at all times when delivering personal care.

However, while these measures may have offered staff support from a peer they had no apparent impact on the quantity and nature of the behavioural incidents.

It was clear from records seen and from staff spoken with that the matters of concern identified at the time of the last inspection were not resolved and that staff and residents continued to be exposed to behaviours of concern and risk. Accidents and incident records seen by the inspector demonstrated that from the 2 July 2016 to the 28 January 2017 staff had been required to respond to and manage over 60 incidents of behaviours that challenge and risk. The records seen indicated that the behaviours and the risk they posed were unaltered since May 2016, were unpredictable, intense and at times prolonged for up to one hour; one incident had lasted three hours. Staff told the inspector that one recent episode had last intermittently for over 24 hours.

Based on a sample of the 60 records reviewed by the inspector the recorded behaviours included shouting, the use of offensive language and descriptors, throwing of objects, threats of and actual physical harm to staff and the purposeful blocking of staffs means of escape from these situations. On one occasion staff retreated to the opposite side of the resident's bed for their personal safety; on another recent occasion staff had to use a side exit to re-enter the building as the resident blocked the hallway.

Staff were particularly vulnerable to threat and injury when delivering personal care. Staff reported vulnerability, fear and the "psychological" impact of these ongoing serious incidents. These incidents were witnessed and or heard by all of the other residents in the house. Staff recorded that there was an ongoing requirement to at times remove the other vulnerable and dependent residents for their psychological and physical safety and that residents were visibly upset and "distressed". Risk assessments seen stated that the immediate safety of residents had to be ensured by staff.

Records seen stated that residents told staff they were afraid, that they wanted to eat their meal in their room, that they wanted staff to "take them away" from the house; residents indicated fear and insecurity and asked staff to call their family; staff described a resident as "crying and shivering". The physical safety and the emotional well-being of the remaining residents in this ongoing situation could not and was not protected.

The behaviour management guidelines reviewed on inspection by the inspector were provided to her by staff. The behaviour management guidelines were stated to be "under review" but were seen to be unaltered since the last inspection of May 2016. Reactive interventions recommended staffing still included physical intervention by staff up to and including firm physical sitting or standing restrictive holds. Based on the records seen on inspection, the inspector was assured that this was either a practical or safe recommendation. There were clear gaps and a lack of clear direction for staff in behaviour management strategies including the use of the additional private living space, the use of photographic prompts and the requirement for personal safety alarms for staff.

Other than in so far as it related to the use of bed-rails, clarity was required on the use of devices that were potentially restrictive practices. Alarm devices that were in use on three resident's bedroom doors at the time of the last inspection had been removed. However, sound monitors were in use with three residents as an adjunct to the management of seizure activity and for ensuring a timely response as part of a continence management programme.

The two way devices were placed in the residents bedrooms and in the main communal area and were poorly controlled, that is they were heard to be turned on when they should not have been. There was no process for the review of the ongoing requirement for these devices (waking staff were on duty and movement sensors were also in use) and the restrictions they placed on resident privacy and dignity.

**Judgment:**

Non Compliant - Major

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

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

**Findings:**

Based on the records seen by the inspector on inspection, all allegations of abuse as

logged by staff had not been submitted to the Chief Inspector

**Judgment:**

Non Compliant - Major

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The statement of purpose reviewed by the inspector was updated in January 2017. The statement of purpose was not an accurate reflection of the services and supports provided to residents. For example the statement said residents would be supported to access day services and transport would be provided; this was not provided to all residents and residents were also assuming at times personal liability for funding both supports and transport.

The statement was inaccurate as to the grades of staff employed as the higher grade of social care had been removed.

It was unclear why, when the statement said the centre supported (and has supported) end-of-life care; there was a recommendation to transfer one resident with increased needs from their home in response to the decreased staffing levels.

As stated following the inspections in 2014 and 2016, a full review of the centre, its purpose and function, services provided, the number and the specific care needs of residents to be accommodated was required.

**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:**

These poor and concerning inspection findings (as discussed in each Outcome) were clear indicators and evidence of management systems and governance that did not ensure that all residents were at all times provided with safe and adequate supports and services based on their assessed needs.

While there was clear evidence that the majority of the failings identified by this inspection were known to the provider (they had been identified by HIQA in May 2016), actions taken by the provider consolidated the failings rather than addressing them; for example the decision to divert staffing resources from the centre to the day service and the consequent negative impact of this on the remaining residents and staff; the risk posed by behaviours of concern was unresolved.

The inspection findings did not reflect governance systems that supported staff, residents and families with effect, to raise concerns as to the quality and safety of the care and services provided or governance that demonstrated recognition of the concerns raised and responded proactively to address all of the issues that led to these concerns. For example the person in charge told the inspector that she was only notified of the decision to reduce the staffing levels 72 hours before that decision came into effect; this was reflected in a risk assessment seen; staff also confirmed this and said that there was no discussion or negotiation.

The impact of this decision was clearly identified by the person in charge and escalated to the provider in the form of risk assessments. The provider nominee confirmed to the inspector that the person in charge had been and was a strong advocate for the residents and staff and had consistently highlighted the negative impact on residents, on their safety and quality of life as a result of the diminished staffing levels and the ongoing unresolved behaviours of risk.

The CNM1 told the inspector that the person in charge in her opinion had done everything that she could possibly do. However, these inspection findings demonstrate that staff exercising their personal, professional and regulatory responsibility to raise concerns about the quality and safety of services and supports provided to residents had little if any effect or impact as evidenced by these inspection findings.

The provider had on the 26 October 2016 undertaken an unannounced review of the quality and safety of the care and services provided to residents as required by Regulation 23. However, this review was limited in its focus and had focussed on the supports provided to one specific resident and the extent to which the previous HIQA

inspection failings in this regard had been addressed.

Given these HIQA inspection findings it was not evident what impact the review and its findings had on the quality and safety of care and services provided to all residents. For example the review acknowledged that it was challenging to support the resident within the existing staff resources; that a resident did not like the house when one resident "got cross"; "concern" at the lack of evidence of follow through on MDT action plans; ongoing record management issues including the availability of multiple drafts of a core behaviour support plan.

**Judgment:**

Non Compliant - Major

**Outcome 16: Use of Resources**

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

**Theme:**

Use of Resources

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

No actions were required from the previous inspection.

**Findings:**

Based on these inspection findings the centre was not adequately resourced to ensure the delivery of care and support in accordance with the statement of purpose and as required by each resident based on their assessed needs.

There were insufficient resources to equitably support each resident achieving their individual personal plans.

**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):**

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

**Findings:**

There was consistent evidence available to the inspector that staffing numbers were not at all times sufficient to meet the assessed needs of the residents; staffing had been depleted further since the last inspection which had already identified that staffing levels were not adequate.

Staff spoken with confirmed that approximately 12 weeks ago in response to a red rated risk in another service (the day service) the need for one to one staff support for a resident from the residential service while in the day service had been identified. The required staff support was sourced from the staffing complement of the residential service resulting in a reduction of staff numbers from three to two from approximately 10:30hrs to 16:00hrs Monday to Friday. The negative impact of this on the other residents was well identified and documented by staff and the person in charge.

Staff had maintained a log of impact from the 7 November 2016 to the 9 December 2016. Negative impacts and risks for residents as recorded by staff included no access to day service, no activities, failure to attend to personal care (showers), having to wait for staff assistance (it was recorded that one resident was left sitting on a commode unattended for 30 minutes), failure to provide the observation and supervision required. Staff recorded that in addition to existing demands they regularly had to induct relief staff sent to work in the centre.

Staff spoken with confirmed that as per a record seen, on one occasion two relief staff came on duty that could neither drive the bus nor administer a rescue medicine that may have been required. Staff risk assessed and took the best action that they could in the circumstance to safeguard residents and had reported their concerns. On two occasions in December there was one staff on duty to supervise and attend to five and six residents respectfully; on one occasion this had occurred as a resident required medical review.

The residents living in the centre presented with a diverse range of complex physical and psychological needs and their ages spanned four decades. In January 2017 using a recognised assessment tool the person in charge had assessed the dependency of all of the residents as high. The inspector saw that all of the residents including those with some physical independence were dependent on staff and regularly and frequently sought out staff and staff assistance for tasks that they could not complete themselves. On the first day of inspection, given the dependency of the residents and the consequent predominance of physical care, the inspector saw that the morning routine was not complete until 11:30hrs.

Identified mitigating controls included the delegation of tasks to night staff, day service staff coming to the centre to provide activities as opposed to residents going to the day service and tendering for the provision of residents meals and additional cleaning hours to free up staff time.

The person in charge had prepared a staffing business case supported by risk assessments. As of the 31 January 2017 the identified risks to the quality and safety of care and services provided to residents included staff failure to meet residents support needs, no access to external activities and failure to achieve personal plan objectives and, for one resident the possible failure to provide the required staff supervision needed to prevent a risk of choking. It was noted that the provider's risk assessment matrix allowed for three bands of risk, low (one to five), medium (six to 12) and high (15 to 25). All of these risks were rated in the medium to high category.

**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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Limerick
<b>Centre ID:</b>	OSV-0002869
<b>Date of Inspection:</b>	07 and 08 February 2017
<b>Date of response:</b>	11 April 2017

### Requirements

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

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

### 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:**

One resident was the local advocacy representative. The resident had not been present at the most recent advocacy meeting. Staff told the inspector that this had occurred more than once and was due to inadequate staffing.

#### 1. Action Required:

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

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

- The Brothers of Charity Services Ireland Limerick Region has an Advocacy structure in operation that ensures all residents in all designated centres are represented.
- The resident attended the last two regional advocacy meetings which were held on 23/02/17 and 16/03/2017.
- The PIC will make every effort to try and ensure that the resident is supported to attend regional advocacy meetings. This is not always possible but a clear reason will be recorded by the PIC explaining the reason for non-attendance.
- Local advocacy meetings are facilitated on a monthly basis.
- Any advocate who is unable to attend the regional advocacy meeting is forwarded a copy of the minutes.
- One of the topics that had been discussed by the Regional Advocacy Council is the impact of staffing decisions in the context of safety risks on other aspects of the service they receive. This is documented in Regional Advocacy minutes from November 2016 to February 2017.
- Residents are encouraged to make complaints individually if they are not happy with any aspect of their service. The Services acknowledges that it may not be in a position to address the complaint but that it will be recorded in a transparent manner. Where the resolution to the complaint can be found within the resources of the services then the complaint will be addressed.

HIQA did not agree the final point of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Individualised Supports and Care

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

Equity was not demonstrated in relation to supporting residents to achieve a good quality of life, enjoy community inclusion and achieve their personal goals. It was not clearly demonstrated how residents rights and their promotion influenced decisions as to the management of the centre when it was clear that these decisions impacted on residents quality of life and the quality and safety of the care and services provided to them and continued to do so.

**2. Action Required:**

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.
- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation's risk management process where addressing high level safety risks, is considered the priority.
- The complaints procedure, which includes a process for documenting all issues raised locally, supports full transparency even in situations where the provider is not in a position to adequately respond to the complaint.
- The limitations on capacity to respond are outlined in the Organisation's complaints procedure.
- The Director of Services wrote to the Regional Advocacy Council in November 2016 explaining the requirement to redirect resources at times in the context of identified safety risks which require prioritisation and acknowledging the impact that this may have on activities.
- Minutes of the Regional Advocacy Council meeting on 10/11/2017 where this was discussed are available on request. These minutes were circulated via the PIC to the designated centre on 22/11/2017 for the attention of the local advocacy facilitator.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated and the inappropriate placement of one resident. A representative from the HSE sits on the Admissions Discharge and Transfer committee where the inappropriate placement has been discussed and options explored and also through meetings with the Director of Services and the Designated Officer to discuss safeguarding concerns in the services (August 2016).
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre notwithstanding the challenges being faced in the centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being creative within the current resources.
- The Provider Nominee has requested the Service Users Money Account Technician to carry out an audit, as a matter of priority, on the use of an independent home-care resource. Where it is found that this resource has been used inappropriately by the provider the residents will be reimbursed by the provider in full and corrective action will be taken.
- Until this audit is completed the use of the independent home-care resource to

support the residents to attend day services has stopped.

- Preliminary discussions have taken place with the manager of the local Day services to determine if there are further opportunities for enhancing the activities for the residents of the designated centre linking with the day service. Formal discussions will take place between the day service and designated centre to agree what can and will be done within resources.

The qualified timescale provided has not been accepted by HIQA.

Proposed Timescale: Complete (for actions within the control of provider)

**Proposed Timescale:** 11/04/2017

**Theme:** Individualised Supports and Care

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

Some residents as a consequence of the reduced staffing levels had less access to internal and external activities and engagement than they had enjoyed at the time of the last inspection. Agreed personal plan objectives were not met.

**3. Action Required:**

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider accepts that some residents have less access to internal and external activities but this is not as a result of reduced staffing levels but rather as a result of a decision taken on how these resources would be used in the context of high level safety risks.
- A sleeping night staff has been replaced by a waking night staff following a risk assessment process in December 2016. This was done (by the redirection of a resource from another part of the service) within existing resources as per HSE directive.
- A decision was made, following a risk assessment process, to have one staff member from the designated centre accompany one resident to the day service each day. Another two residents also attend the day service.
- The ratio of staff to residents in the designated centre during the day when residents are not attending day service is 3:9. At the time of the last inspection this was 3:10. The ratio of staff to residents during day service hours is generally 2:6.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the

Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.

- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation's risk management process where addressing high level safety risks, is considered the priority.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated.
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being creative within the current resources.
- Preliminary discussions have taken place with the manager of the local Day services to determine if there are further opportunities for enhancing the activities for the residents of the designated centre linking with the day service. Formal discussions have taken place between the day service in Newcastlewest and designated centre to agree what can and will be done within resources. A follow up meeting has been scheduled in May to determine the success of this improved engagement.
- In house activities promoted such as baking, art & crafts.
- The Person in Charge and PPIM will ensure that in-house activities are maximized as much as possible within the designated centre.

**Proposed Timescale:** 31/05/2017

**Theme:** Individualised Supports and Care

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

It was not sufficiently evidenced how the providers management of complaints demonstrated effectiveness and improvement measures in response to complaints as required by Regulation 34 (1) and (2).

**4. 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:**

- o It is the view of the provider that there is a great benefit in supporting residents to make complaints even when the complaints cannot be resolved.
- o The benefit is in terms of ongoing advocacy.
- o The organisation's complaints procedure acknowledges limitations in terms of capacity to respond but none the less welcomes and encourages complaints.
- o Recording of complaints, even in the absence of an ability to respond, supports transparency and ensures that complainants whose complaints cannot be resolved

locally are offered the opportunity to make a formal complaint.

o Both informal and formal complaints, as well as the status of same, will be notified to the HSE on a quarterly basis in 2017 under the Service Arrangement contract.

- A review of issues raised and complaints in the designated centre has taken place by the PIC with the Head of Quality and Risk. Learning around the appropriate recording and follow up on complaints will inform the management of complaints in the designated centre in the future.

- Risk assessments have been reviewed by the PIC with the Head of Quality & Risk on the 22/02/17 and 24/02/17.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

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

**Theme:** Effective Services

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

There was duplication, contradiction and a lack of consistency noted between both files and no one clear record that outlined and guided the supports currently required to maximise the resident's wellbeing, safety and personal development. While there were records of regular review meetings by staff the plans themselves demonstrated poor evidence of review.

### **5. 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:**

- Provider Representative and Head of Quality & Risk met with the Multidisciplinary Team and the PIC on 13/02/17 to discuss the findings of the inspection as well as referencing the findings of previous internal 6 month unannounced report.
- MDT accept that their interventions are not reflected adequately in the minutes of their meeting.
- MDT team are carrying out an intensive review of the file for one resident. The learning from this review will inform a review of other residents' files by the staff and Person in Charge in the centre. File review commenced on 22/02/2017 and a report on completion was submitted to the Provider Nominee on 22/03/2017.
- Confirmed that the review of accidents and incidents for one particular resident did inform his behaviour support plan reviewed and updated in November 2016. This updated support plan was misfiled within the designated centre when the inspection took place. The plan is now correctly filed.

- PIC has also commenced file review in the centre following review of MDT on their file audit and a revised timeline has now been agreed with the PIC with regard to the updating of all files in the designated centre by 31st May 2017.
- Good practice in record keeping has been prepared by the members of the Clinical team and will be reviewed with staff by the PIC and PPIM at the next staff meeting in the designated centre.
- Spot checks by the PIC and PPIM will take place to ensure good practice is being followed with regard to record keeping.

**Proposed Timescale:** 31/05/2017

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

**Theme:** Effective Services

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

The identified risk controls did not at all times demonstrate proportionality and reasonableness in the context of residents rights or the adverse impact of the risks and the control measures on all residents quality of life.

### **6. Action Required:**

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

- The management of risks associated with safety is prioritised.
- In response to a safety related risk a decision was made to use staff differently to support a resident in his day service. This was a risk control measure.
- The impact of this measure on the quality of life of other residents was considered as evidenced by risk assessments on file regarding quality of life. Mitigations to address risk to quality of life in place at the time of inspection included:
  - o Replacement of sleeping night staff with waking night staff.
  - o Reduction of number of residents in the designated centre from 10 to 9 and a commitment not to hold the position as vacant.
  - o Vacant bedroom converted to a living space for the resident that presents with challenging behaviour.
  - o Approval for increased cleaning hours.
  - o Approval to purchase meals thus decreasing staff work load.
  - o Provision of day service slots within the residential service facilitated by the local day service.
  - o Review of work load and the use of the 2nd waking night staff to alleviate some work from day time staff.
- Review of risks carried out by the PIC with Head of Quality & Risk on 22/02/17 & 24/02/17

**Proposed Timescale:** 11/04/2017

**Theme:** Effective Services

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

Completed risk assessments did not demonstrate how residents were protected by the provider from harm and abuse.

**7. Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

- Review of risks carried out by the PIC with Head of Quality & Risk on 22/02/17 and 24/02/17
- There were two red level safety risk on file at the time of the inspection.
- The risk of choking; a follow up appointment to clarify the extent to which an intervention was effective in mitigating against the identified risk was pending at time of inspection. This medical review took place on 5th April where the service was advised that further intervention was not required.
- The risk relating to future planning in the context of lack of approval to recruit relief staff:- It did not identify an immediate safety concern but rather a situation that was likely to be unsafe if the situation remained unaddressed. In response to the identified risk approval for recruitment of care assistance and nurses was granted in December 2016. Use of agency staff as an interim measure was also approved. Reallocation of staff by manager where required mitigated against this risk in the short term. A relief social care working was hired for the designated centre prior to the inspection - while the monitoring of the risk had yet to be completed at the time of inspection this had reduced risk rating from high to moderate.
- Provider requested the Designated Officer to review all Incident & Accident reporting relating to one resident in the designated centre and to prepare a report with recommendations. This report was prepared and returned to the Provider Nominee on 31st March 2017 with agreed actions which related to meeting with staff and interviewing the resident. These actions are now completed.
- MDT completed a full review of accident and incidents relating to one resident and prepared a report for the Provider Nominee on 22nd March 2017.
- The Provider acknowledges that there are low - moderate level risks related to safety. This has been previously recognised by the provider in the immediate action plan submitted to HIQA following an inspection in May 2016. The action plan states that 'a number of safety related risks have been identified and are rated as low to moderate level risks'.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Effective Services

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

Accident and incident forms were poorly maintained; the inspector found them filed in four different locations.

**8. Action Required:**

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

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

The PIC has reviewed the filing system for accidents and incidents to ensure that in future all forms will be filed appropriately.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Effective Services

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

The fire evacuation procedures for the centre had not been reviewed and amended to progressive horizontal evacuation. Four fire drills had been completed in 2016, the most recent in August 2016. There had been no simulated drill completed since June 2015 that tested the adequacy of evacuation with minimum staffing and maximum occupancy, that is 2:9; that exercise in June 2015 had taken 10 minutes to complete.

Some escape routes were seen to be obstructed externally by items such as garden chairs and bins.

**9. 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:**

- Fire drill was carried since the HIQA inspection. It was carried out when the ratio of staff to residents was 3:9 people
- The PIC will ensure that a further fire drill will be carried out by the PPIM when the ratio of staff to resident is 2:6.
- The PIC will ensure that a night fire drill will be carried out where the staff to client ratio is 2:9 in order to test the adequacy of evacuation with minimum and maximum occupancy.
- PIC has ensured that all fire exit doors are unblocked.
- Staff have been spoken to with regards to ensuring that this practice of ensuring that

fire exits are unblocked is maintained. PIC and PPIM will monitor this on an ongoing basis.

- Fire Safety Strategy has been submitted to the HSE with an associated cost for the update of buildings that includes compartmentalisation.

The qualified timescale provided was not accepted by HIQA.

Proposed Timescale: Complete (for actions within the control of the Provider)

**Proposed Timescale:** 11/04/2017

**Theme:** Effective Services

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

There was widespread practice of holding open designated fire doors with furniture, waste bins or paper wedged between the doors and the floor.

**10. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

- Fire Safety training, which is mandatory for all staff, states that it is not acceptable practice for doors to be held open in the manner outlined in this report.
- The use of wedges will cease in the designated centre.
- Fire safety and the practice of holding doors open has been added to the staff meeting agenda on 22/02/17.
- The use of approved door openers is being pursued as a priority within the designated centre. Contractor has been identified and door closers will be installed on 19th April 2017

**Proposed Timescale:** 19/04/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Clarity was required on the use of devices that were potentially restrictive practices. There was no process for the review of the ongoing requirement for these devices (waking staff were on duty and movement sensors were also in use) and the restrictions they placed on resident privacy and dignity.

**11. Action Required:**

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

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

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

The PIC set out the rationale for the use of devices using the restrictive practice document. This document was reviewed by MDT.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Safe Services

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

The behaviour management guidelines were stated to be "under review" but were unaltered since the last inspection of May 2016.

There were clear gaps and a lack of clear direction for staff in behaviour management strategies including the use of the additional private living space, the use of photographic prompts and the requirement for personal safety alarms for staff.

While interventions may have offered staff support from a peer they had no apparent impact on the quantity and nature of the behavioural incidents.

**12. 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:**

- The Behavioural support plan had been reviewed in November by Clinical Nurse Specialist but had been misfiled at time of inspection.
- Following file review the plan is now maintained under behavioural support section in "My Profile My Plan".
- This plan is going to be reviewed and updated by the CNS in Behaviour Support following the replacement of a sleepover staff with a waking night staff in the latter part of 2016. The CNS is planning to review the revised plan with staff at a positive behavioural training session scheduled for the 19th and 20th April. The completion date has been revised in the context of the inclusion of a review of the plan by the CNS with staff.
- The PIC has outlined with PPIM and staff the importance of leaving a plan in a defined place which is familiar to all staff.
- PIC will ensure that all staff working in the designated centre have read and are familiar with the Behaviour Support plan for the resident.
- The organisation uses the MAPA (Management Of Actual and Potential Aggression) programme to inform staff of the reactive strand of Positive Behaviour Support (the other aspects of Positive Behaviour Support such as environmental accommodation etc.

are known proactive supports). MAPA's philosophy is "to provide for the best care, welfare, safety and security" of individuals at risk of engaging in verbal and/or physical assault" (Crisis Prevention Institute 2014, p.1). It teaches staff how to recognise and respond appropriately to a developing crisis at the stages beforehand i.e. anxiety and defensiveness. If these approaches are not effective or if a person quickly becomes aggressive (as in impulsivity), then MAPA's Physical Interventions which range from low, medium and high level restrictive holds are used to respond safely, proportionately and as a last resort if physically assaultive behaviour occurs.

- All of the MAPA skills have been independently risk assessed. Use of MAPA skills in the BOCSI Limerick Region are required to be documented in a Physical intervention recording Book and this is subject to annual audit by Senior Psychologists, a Clinical Nurse Specialist and the MAPA training co-ordinator. The most recent audit was conducted in March 2017. The audit confirmed that there were no incidents of physical intervention required in the Designated Centre during the period of review (July 1st 2015 – June 30th)

- Including Physical Intervention in this resident's Behaviour Support Plan appears to have been first agreed during May 2014 as a response to an incident which necessitated restraint so as to thereafter have a planned approach using endorsed skills should the need arise again. A Physical Intervention Recording Book was then put in place in both Lismore and NCW Day Service on the 20th of May 2014 to record any further use of physical intervention with the resident. There has been no further need to employ physical restraint with this resident hence the lack of records in the Physical intervention Recording Book.

- The CNS's involved in behaviour support planning since May 2014 continued to write the MAPA strategies in his behaviour support plan because the resident continued to hit out, pull at, scratch and attempt to bite his staff up to and including the time of review of his Behaviour Support Plans during December 2015, May 2016 and October 2016 . It can be seen on the plan that MAPA physical interventions are recommended only as a last resort if (and only if) first line approaches such as talking things through over a cup of tea, verbal de-escalation, moving away from him, rest, reassurance and then limit setting have been ineffective in keeping the resident and those around him safe. These first line approaches appear to be somewhat effective and therefore prevent the need for using the last resort physical restraint. However the physical intervention skills remained listed in case of serious need so staff would be clear on what to do. This is not unique to this resident.

**Proposed Timescale:** 30/04/2017

**Theme:** Safe Services

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

The physical safety and the emotional well-being of the remaining residents in the context of on-going behaviours of concern and risk could not and was not protected.

**13. 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:**

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- Review of risks carried out by PIC in consultation with the Head of Quality and risk on the 22/02/17 and 24/02/17
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.
- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation’s risk management process where addressing high level safety risks, is considered the priority.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated and the inappropriate placement of one resident.
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre notwithstanding the challenges being faced in the centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being creative within the current resources.

The qualified timescale provided was not accepted by HIQA.

Proposed Timescale: Complete (for actions with the control of the Provider)

**Proposed Timescale:** 11/04/2017

**Theme:** Safe Services

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

Records seen outlined unsafe guidance to staff and placed undue responsibility on staff to conclude whether abuse could have occurred or not. Records also demonstrated inconsistency as to how allegations of abuse were managed and did not provide assurance as to how they were screened so as to be deemed unfounded; based on records seen at least three allegations had not been notified to HIQA.

**14. Action Required:**

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers

abuse.

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

Provider requested the Designated Officer to review all Incident & Accident reporting relating to one resident in the designated centre and to prepare a report with recommendations. This report was prepared and returned to the Provider Nominee on 31st March 2017 with agreed actions which related to meeting with staff and interviewing the resident. These actions are now completed.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**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:**

All allegations of abuse had not been submitted to the Chief Inspector.

**15. Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Provider requested the Designated Officer to review all Incident & Accident reporting relating to one resident in the designated centre and to prepare a report with recommendations. This report was prepared and returned to the Provider Nominee on 31st March 2017 with agreed actions which related to meeting with staff and interviewing the resident. These actions are now completed.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose was not an accurate reflection of the supports and services provided to residents.

**16. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Review of Statement of Purpose and Function of the designated centre has been carried out.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

## **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

Staff exercising their personal, professional and regulatory responsibility to raise concerns about the quality and safety of services and supports provided to residents had little if any effect or impact.

**17. 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:**

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider does not agree with the conclusion that Staff had little if any impact when they exercised their personal, professional and regulatory responsibility to raise concerns about the quality and safety of services and supports provided to residents.
- Numerous actions have been taken in response to concerns raised by staff.
- In response to a safety related risk a decision was made to use staff differently to support a resident in his day service. This was a risk control measure.
- The impact of this measure on the quality of life of other residents was considered as evidenced by risk assessments on file regarding quality of life. Mitigations to address risk to quality of life in place at the time of inspection included:
  - o Replacement of sleeping night staff with waking night staff.
  - o Reduction of number of residents in the designated centre from 10 to 9 and a commitment not to hold the position as vacant.
  - o Vacant bedroom converted to a living space for the resident that presents with challenging behaviour.
  - o Approval for increased cleaning hours.

- o Approval to purchase meals thus decreasing staff work load.
- o Provision of day service slots within the residential service facilitated by the local day service.
- o Review of work load and the use of the 2nd waking night staff to alleviate some work from day time staff.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Leadership, Governance and Management

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

Governance and Management systems in place did not ensure that all residents were at all times provided with safe and adequate supports and services based on their assessed needs.

**18. 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:**

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider nominee concurs with the view that the centre is not adequately resourced. This was communicated to the Inspector as part of the feedback session.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.
- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation's risk management process where addressing high level safety risks is considered the priority.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated and the inappropriate placement of one resident.
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being

creative within the current resources.

- Preliminary discussions have taken place with the manager of the local Day services to determine if there are further opportunities for enhancing the activities for the residents of the Designated Centre linking with the day service.
- Formal discussions have taken place between the day service in Newcastlewest and designated centre to agree what can and will be done within resources. A follow up meeting has been scheduled in May to determine the success of this improved engagement
- In house activities promoted such as baking, art & crafts.
- The Person in Charge and PPIM will ensure that in-house activities are maximized as much as possible within the designated centre.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

**Theme:** Leadership, Governance and Management

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

The review was limited in its focus. It was not evident what impact the review and its findings had on the quality and safety of care and services provided to all residents.

**19. 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:**

A 6 month unannounced visit to the Designated Centre took place on 26/10/2016.

The review focused on the extent to which findings from the May HIQA inspection were progressed.

6 month unannounced visit reports are indicative rather than comprehensive.

There is an expectation that recommendations made and learning from the 6 month unannounced inspection process in the designated centre is generalised to other areas of the designated centre.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

The centre was not adequately resourced to ensure the delivery of care and support in accordance with the statement of purpose and as required by each resident based on their assessed needs.

### **20. Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider nominee concurs with the view that the centre is not adequately resourced. This was communicated to the Inspector as part of the feedback session.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.
- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation's risk management process where addressing high level safety risks, is considered the priority.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated and the inappropriate placement of one resident.
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being creative within the current resources.
- Preliminary discussions have taken place with the manager of the local Day services to determine if there are further opportunities for enhancing the activities for the residents of the Designated Centre linking with the day service. Formal discussions have taken place between the day service in Newcastlewest and designated centre to agree what can and will be done within resources. A follow up meeting has been scheduled in May to determine the success of this improved engagement.
- In house activities promoted such as baking, art & crafts.
- The Person in Charge and PPIM will ensure that in-house activities are maximized as

much as possible within the designated centre.

Proposed Timescale: Complete

**Proposed Timescale:** 11/04/2017

## **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Staffing numbers were not at all times sufficient to meet the assessed needs of the residents; staffing had been depleted further since the last inspection which had already identified that staffing levels were not adequate.

#### **21. 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:**

HIQA did not agree elements of this action plan with the provider despite affording the provider two opportunities to submit a satisfactory response. However, in the interests of transparency HIQA has taken the decision to publish the providers response in part as follows;

- The Provider nominee concurs with the view that the centre is not adequately resourced. This was communicated to the Inspector as part of the feedback session.
- The Provider confirms that it is committed to ensuring the designated centre is operated in line with the regulations cognisant of the overall resources allocated to the Brothers of Charity Services Ireland Limerick Region and the clear direction from the HSE (funder) to operate within these resources.
- This requires the Provider Nominee to make the decisions based on resources available rather than making the decision that they would like to make.
- Decision making is informed by the organisation's risk management process where addressing high level safety risks, is considered the priority.
- Given the serious nature of this report a copy of the report was sent to the HSE and a request for an urgent meeting was made to discuss the designated centre in the context of the resources allocated and the inappropriate placement of one resident.
- At the Service Arrangement with the HSE on 22nd February 2017 the HSE confirmed that it did not have any additional resources to allocate to this designated centre.
- The Provider Nominee wrote to the HSE following non acceptance by HIQA of the initial Action Plan to request funding for this designated centre. The HSE has confirmed that there is no extra financial resource available and recommends working and being creative within the current resources.
- Preliminary discussions have taken place with the manager of the local Day services to

determine if there are further opportunities for enhancing the activities for the residents of the Designated Centre linking with the day service. Formal discussions will take place between the day service and designated centre to agree what can and will be done within resources.

- Formal discussions have taken place between the day service in Newcastlewest and designated centre to agree what can and will be done within resources. A follow up meeting has been scheduled in May to determine the success of this improved engagement.
- In house activities promoted such as baking, art & crafts.
- The Person in Charge and PPIM will ensure that in-house activities are maximized as much as possible within the designated centre.

Proposed Timescale: Complete

**Proposed Timescale: 11/04/2017**