Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	L'Arche Ireland - Cork
Name of provider:	L'Arche Ireland
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	19, 22 February 2018 and 12 March 2018
Centre ID:	OSV-0003421
Fieldwork ID:	MON-0020798

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The statement of purpose was a document intended to describe the service and facilities provided to residents, the management and staffing and the arrangements for residents' well being and safety. L'Arche Cork was a faith community that provides a service of residential and day care for adults with intellectual disabilities. At the core of L'Arche was the relationship between persons who have an intellectual disability and those who chose to support them in the community. The stated objectives of the centre were to provide a high standard of care in accordance with evidence based best practice; to enable residents to live safe, happy and fulfilled lives so that they can play their part in society as full caring human beings; and to share life and build community with our residents so that together we can change the world one heart at a time, starting with our own.
This centre consisted of three houses based in the suburbs of Cork city with the first house providing a home to five residents, the second house had four residents with a further four residents living in the third house. In relation to staff support there was a residential services coordinator and each house had a house/team leader. In total there were 15 staff (assistants) supporting the residents in the centre.

The following information outlines some additional data on this centre.

Current registration end date:	09/07/2021
Number of residents on the date of inspection:	13

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
19 February 2018	14:00hrs to 20:00hrs	Kieran Murphy	Lead
22 February 2018	08:30hrs to 15:30hrs	Kieran Murphy	Lead
12 March 2018	08:30hrs to 15:30hrs	Kieran Murphy	Lead

Views of people who use the service

Prior to the inspection two families of residents and five residents had submitted feedback in relation to the centre to the Heath Information and Quality Authority. In general this feedback was positive with one family said that they were very happy with the service provided. In the feedback from residents submitted to HIQA it was clear that residents felt safe and respected in their home.

Over the course of the three days of the inspection all 13 residents were met and any resident spoken with said they were happy living in the centre. Residents stated that they went to the cinema, out for lunch and enjoyed this. One resident said that there was lots of different things to do and another resident described how going to mass every Sunday in the local church was very important to them. The inspector was invited to attend the residents' weekly meeting in one of the houses and this appeared to be a very positive experience for all residents. Each person was afforded the opportunity to describe their week, what they had done over the weekend and what was planned for the coming week. Issues discussed included what staff were working, any upcoming appointments and any specific concerns residents may have. In one of the other houses the inspector was invited to attend a birthday party where all staff and residents shared a cake and a prayer.

Capacity and capability

While it was found that there was a governance structure in place, improvements in oversight were required. It was acknowledged by the provider that oversight from senior managers required improvement.

This was the third inspection of this centre by HIQA. Over the course of the first two days of this inspection a number of issues, detailed below, were identified. There was an interval of three weeks between day two and day three of this inspection and the provider used this opportunity to put measures in place to address the issues identified on the first two days of the inspection.

On the third day of inspection the provider submitted a governance plan to HIQA which included increased oversight from the CEO and the community director. The service undertook to include a registered nurse and the house leaders as part of the overall governance group who would meet twice monthly.

The provider had appointed a community leader whose role was to provide

oversight of the services in the region. The community leader had previously worked in health care services and was a very experienced manager. The person in charge had been appointed in 2015 and also had responsibility for one other designated centres. The person in charge was employed full time and had worked for L'Arche Services for over 20 years.

Each of the three houses had a team leader in post who supervised the care and supports being provided to residents. All three team leaders were very committed to the L'Arche Services and each had a number of years experience in supporting residents in the service.

In addition to the team leaders, staff members called "house assistants" were on duty during the inspection. These staff members lived in each of the three houses with the residents as part of the life-sharing philosophy of L'Arche services. While a number of the staff members had some experience of supporting people with an intellectual disability, some staff had limited experience. Over the first two days of the inspection a number of staff members in each of the houses was spoken with and some staff members were unclear about medicines management practices, safeguarding procedures and the supervision arrangements by the team leaders. In addition the provider undertook to review the training needs of staff.

However, on the third day of inspection all staff spoken with demonstrated their knowledge and gave clear answers about these issues.

The service acknowledged that the skill mix of staff supporting residents, particularly residents with increasing health care needs, required review and proposed to increased the nursing support being provided in one of the houses in the centre. The provider also undertook to provide "awake" night time staff in one of the houses in the centre. The provider stated that they were putting in place a plan to support residents as they got older.

It was also found that increased supervision of staff was required to ensure that residents were being adequately supported in relation to their health care needs. The provider undertook to increase the supervision of the "house assistants" in each of the three houses to ensure consistent support to residents. This included supervision by the newly appointed community leader.

The provider had ensured that unannounced visits to the designated centre in relation to the quality and safety of care had been completed, with the most recent in November 2017. There was a prepared written report available in relation to issues reviewed including: social care, risk management, safeguarding, health care, medication, governance and workforce. However, this review had not identified issues that were in place over day one and day two of inspection.

The inspector reviewed a sample of staff files from each of the three houses and noted that each file contained documents as required by the Regulations.

It was a requirement that serious incidents including safeguarding issues were reported to the Chief Inspector within three working days of the incident. However, this requirement was not being complied with. The service undertook to submit all

notifications in the future.

In relation to records management in some instances residents were accompanied by their parents to doctor or specialist appointments, with staff receiving information on the visit afterwards from the parents. Inspectors noted that records of referrals to consultant specialists and subsequent results were not maintained for all residents. This practice meant that staff did not have all information relevant to the resident's health care needs and any treatment or other intervention.

A dedicated administration support was to be put in place to support the three team leaders.

Regulation 15: Staffing

The numbers and skill mix of staff required review to ensure all residents support needs were being met.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A number of staff spoken with by the inspector were unclear about the correct processes to support residents appropriately.

Judgment: Not compliant

Regulation 21: Records

All health care information in relation to residents' condition and any treatment or other intervention was not available in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider did not submit notification in relation to any serious incident including safeguarding issues were reported to the Chief Inspector within three working days of the incident.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there was a governance structure in place, improvements in oversight were required to ensure that a quality and safe service was being provided to residents.

Judgment: Not compliant

Quality and safety

Overall in relation to Quality and Safety the inspector observed that there was a positive atmosphere in each of the three houses. However, the centre was not meeting the needs of all residents in particular in relation to medicines management and in relation to each resident having access to an appropriate day service. In addition, improvement was required in relation to person centred planning in relation to assessed health care needs.

All three houses that made up this centre were based in the community and residents said that they pursued activities based on residents' wishes and preferences. Residents enjoyed their own interests such as going to the cinema, going for a meal and going to Mass each Sunday. Most residents attended either work or the L'Arche day service each weekday. The inspector was informed that there was an arrangement in place whereby not all residents could attend their day service due to an ongoing issue. This issue had been referenced by an external consultancy that had supported the service in April 2017. On the third day of the inspection the service had undertaken to source an alternative day arrangement for all residents.

In relation to health care needs, care plans had been developed as required for assessed needs. However, in some cases assessments and care plans were not always being followed by staff which had an impact on some identified health care needs. Between the second and third day of inspection the L'Arche service had undertaken a comprehensive review in relation to this issue which identified that care plans in general required to be updated.

In relation to medicines management there was a medication policy that detailed the procedures for safe medication management. Medication was dispensed by a

pharmacist in tamper proof packs. Residents' medication was stored and secured in a locked cupboard and there was a robust key holding procedure. However, over the first two days of inspection, staff did not always demonstrate an understanding of medication management and in particular what different medication was being administered for. The medication policy outlined that training on medicines management was over two days and required clinical assessments. Some staff spoken with by the inspector said the training was only one day and for three hours. The provider provider further clarification on this to say that the medicines training was over one day and the assessment of that training could be over three hours.

The inspector saw that the medicines prescription was transcribed on to the medication administration sheet. This transcription was then signed as accurate by the GP. However the medication administration record did not include the starting date of the prescription or the times of administration which was not in keeping with best practice guidelines or with the service's own policy and errors could occur. There was evidence that some residents were encouraged to take responsibility for their own medication in accordance with their wishes and preferences. However, information in relation to the prescribed medication for each resident who was self-medicating was not available in the centre as required by the L'Arche medication management policy.

The inspector saw a communication board in the kitchen of one of the houses with residents' personal information clearly on display. Also the inspector saw that person-centred language was not always being used in residents' personal files. This information had been amended by the third day of inspection.

Each resident had participated in identifying specific hazards relating to their lives. For example it was noted that one resident liked to stay at home during the day and there were specific risk assessments around this arrangement and the resident showed the inspector what they needed to do in the event of an incident. During this inspection the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site. The service undertook to submit confirmation from a suitably qualified and experienced professional in fire safety that the three houses comprising the designated centre met the appropriate fire safety requirements, particularly in relation to fire doors to prevent the spread of smoke in the event of fire.

Over the first two days of the inspection it was noted that appropriate checks were not in place for all resident financial transactions. This issue had been rectified by the third day of the inspection.

Regulation 12: Personal possessions

Over the first two days of the inspection it was noted that appropriate checks were

not in place as not all resident financial transactions. This issue had been rectified by the third day of the inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management procedures were implemented throughout the centre and covered the identification of risks and the measures in place to control risks.

Judgment: Compliant

Regulation 28: Fire precautions

The service undertook to submit confirmation from a suitably qualified and experienced professional in fire safety that the three houses that comprised the designated centre meet the appropriate fire safety requirements, particularly in relation to fire doors to prevent the spread of smoke in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The system in place for medicines management required improvement in relation to the transcribing of prescriptions, the training and knowledge of staff of medicines management, the correct timing of administration of medicines and the oversight of residents who may be self-medicating.

Judgment: Not compliant

Regulation 6: Health care

In some cases assessments and care plans were not always being followed by staff which had an impact on some identified health care needs.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Not all residents could attend their day service due to an ongoing issue. This issue had been referenced by an external consultancy that had supported the service in April 2017.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant

Compliance Plan for L'Arche Ireland - Cork OSV-0003421

Inspection ID: MON-0020798

Date of inspection: 19/02/2018 , 22/02/2018 and 12/03/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Having assessed the need for nursing care due to the changing needs of the residents in the designated centre a deputy house leader has been appointed who is an RNID nurse. This person will assist the community nurse in responding to the care needs of the residents in other houses. In order to further respond to the increased healthcare needs in the designated centre we are assessing the needs of the residents with regard to night-time care and will put in place suitable staffing arrangements where necessary	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to respond to regulation 16 there will be two levels of response immediate and ongoing: 1. Immediate response: a. In-house training will be enhanced on safeguarding and medication. b. Refresher courses once a quarter will be put in place by the community nurses with particular emphasis on the reasons and responses relating to medications. c. The weekly team meetings will include a review of essential information in relation to the administration of new medications or any update required for medication. d. Individual induction and support and supervision of staff will be enhanced and will be in line with any duties relating to the role. e. A deputy house leader has been appointed who is an RNID nurse f. The community nurse is currently completing additional training in diabetic management	

2. Medium term response:
    a. An assessment has been completed on the skills mix in L'Arche Cork
    b. Future recruitment will ensure an appropriate skills mix in order to ensure the needs of the residents are met
    c. Long term staff will be supported to avail of appropriate training, subject to available funding

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Health care information in relation to residents' condition and any treatment or other intervention will be available in the centre.
Parents who accompany a resident to a doctor of specialist appointment will be reminded to bring a medical report form with them to be completed by the medical professional.
House leaders will ensure that any relevant information to the health care needs of the resident is passed on to all staff who are involved in the care of that resident.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge will notify HIQA of serious incidents that occur including safeguarding incidents within 3 working days.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We will ensure that our management systems are enhanced in order to guarantee that our service is appropriate to the needs of the residents especially in light of the changing healthcare needs as residents get older. This will be achieved by the following:

- Regular visits to the houses by the Community Leader and the Person in Charge
- Monthly visits to the service by the CEO which will include meeting residents
- Weekly support and supervision by the CEO with the new Community Leader
- Quarterly support and supervision meetings with CEO, Community Leader and PIC
- Scheduled and enhanced support and supervision of all staff according to their level of responsibility
- Training for the internal auditing team in order to enhance the effectiveness of the internal auditing systems so as to identify gaps in the service such as those highlighted in this report

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Certification of the fire doors in the designated centre will be presented to the Health Information and Quality Authority

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and

pharmaceutical services:
We will ensure that the Medicines Prescription Chart and medication administration record will include the starting date of all new medication
We will ensure that the Medicines Prescription Chart and the medication administration record will include the times of administration
We will ensure that information in relation to prescribed medication for any resident who is self-medicating is available in the houses
The medication policy has been updated in order to reflect our current practice in relation to the training of staff
The community nurse will do a quarterly refresher course on the administration of medication with house teams
The weekly team meetings will include agenda items on relevant issues relating to the administration of medication

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Care plans are being updated in order to ensure that essential health care information is passed on to staff and care assistants. One to one supervision of assistants will be further enhanced in order to guarantee that the care plans are understood and implemented effectively

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The resident has been provided an alternative location within the local community to continue a day service

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/03/2018
Regulation 15(1)	The registered provider shall 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.	Substantially Compliant	Yellow	30/06/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Substantially Compliant	Yellow	30/06/2018

	continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/05/2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the	Not Compliant	Orange	31/05/2018

	resident for whom it is prescribed and to no other resident.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	31/03/2018
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/06/2018