**Centre name:** A designated centre for people with disabilities operated by RehabCare  
**Centre ID:** OSV-0002653  
**Centre county:** Tipperary  
**Type of centre:** Health Act 2004 Section 39 Assistance  
**Registered provider:** RehabCare  
**Provider Nominee:** Laura Keane  
**Lead inspector:** Mary Moore  
**Support inspector(s):** Paul Dunbar  
**Type of inspection** Unannounced  
**Number of residents on the date of inspection:** 5  
**Number of vacancies on the date of inspection:** 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 25 March 2015 09:45  To: 25 March 2015 18:30

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

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<th>Outcome 05: Social Care Needs</th>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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Summary of findings from this inspection
This inspection was the first inspection of the centre by the Authority. Based on the seven outcomes inspected the inspection findings were positive with a high level of regulatory compliance evidenced. The inspector was satisfied that the service was adequately governed, staff were well informed as to regulatory requirements and committed to ongoing improvement and enhanced outcomes for residents.

The centre had capacity to accommodate six residents including an annexed apartment that was traditionally used as a service to support residents transitioning to independent living in the community. The provider has now however registered all areas of the centre as a designated centre and accepted that some gaps probably existed given the historical arrangement of the apartment. This was correct and did contribute to the non-compliance evidenced on inspection. This was clearly understood by staff as were the actions necessary to fully integrate the apartment into the designated centre in areas such as support planning and fire evacuation drills and records.

Overall the inspector was satisfied that arrangements were in place to meet residents needs and choices and that these arrangements were kept under review by the provider to ensure their sufficiency and effectiveness.

There were five residents living in the centre and the inspector observed that they
were relaxed and comfortable and enjoyed a high level of independence in a home from home environment. Each resident had access to structured day care services and staffing resources were allocated by the provider in line with residents expressed preferences and choices. Residents were aware of the work of the Authority and engaged readily with the inspector giving a positive account of their daily routines and interests.

The provider was judged to be compliant in four outcomes and substantially complaint in the remaining three. Improvement was required in the maintenance of fire safety records, person-centred planning and the consolidation of recent changes to the governance structure.
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 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
While there was some inconsistency noted, inspectors were satisfied that there was a meaningful system in place for assessing and reviewing resident’s needs, any required supports and objectives.

The inspector saw that residents’ holistic needs were assessed; where supports were not identified as required this was recorded and respected; where support from staff was required to maximise potential this was clearly outlined in the support plan. Resident’s personal goals or objectives were clearly identified as were timeframes and responsible persons. The achievement or otherwise of each goal was reviewed and recorded. There was evidence of the annual review of the personal plan involving the resident and as appropriate family members. There was a developmental and quality of life focus to the plans with objectives based on further learning, development of existing skills and meaningful engagement. While the format of the plan may not have enhanced its accessibility to each resident, having spoken with residents, inspectors were satisfied that the plans were truly person centred plans as residents confirmed their participation, their content, the agreed goals and the supports in place to facilitate their attainment. Inspectors saw and residents confirmed that they had access to structured day care services and an active programme of socialisation and social integration that reflected their personal interests and choices such as music, sport and exercise.

There was some inconsistency noted. For example while there was a reasonable rationale there was no apparent follow-through on one goal that was not progressed for one resident and the support plan in place for another resident did not fully evidence or justify to the inspector the low level of staff support required on a daily basis; the
inspector were satisfied that minimal supports were required.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The centre had measures and controls in place to ensure that the health and safety of residents, staff and visitors was promoted and protected. However, there were some minor gaps in documentation.

There was an up-to-date safety statement in the centre along with an emergency plan. There was a risk register in place which staff maintained in line with the provider's risk management policy. The risks assessed included fire, smoking, chemicals, behaviours that challenge, use of kitchen equipment etc. The centre also had measures and controls in place to address the four risks specified by the Regulations i.e. self harm; aggression and violence; unexpected absence; and accidental injury to residents, staff or visitors.

The inspector observed that fire safety measures were in place throughout the centre. There was emergency lighting, fire fighting equipment and a fire alarm. These had all been maintained in accordance with the relevant fire safety legislation. There was a prominently displayed evacuation plan and sign-posted assembly points to the front and rear of the house. However, while staff stated that each resident had a personal emergency evacuation plan, these documents were not available on the day of inspection. Staff and residents confirmed that fire drills were carried out on a regular basis. A health and safety audit completed by the provider also found that there were three fire drills in 2014. Inspectors viewed a report of one fire drill which was carried out on 27 January 2015. The report was of a night-time fire drill and there was evidence of learning for staff and residents from the drill. However, inspectors could not locate any other records of fire drills. It was also not clear if all residents had participated in the fire drills. Records of three simulated fire evacuation drills undertaken in 2014 were submitted retrospectively to the Authority by staff. These records indicated resident participation and evaluated co-operation or any area where improvement was required.

The person in charge carried out monthly checks of hazards within the centre. The reports identified any issues which needed addressing and also logged maintenance requests. There were weekly and monthly checks of fire safety precautions which included visual inspections of the fire panel, fire escapes, fire doors, extinguishers,
The centre maintained an incident/accident log which was made available to inspectors. The log contained records of falls and minor injuries. Inspectors were satisfied that there was learning from these incidents and that they were discussed at staff meetings.

**Judgment:**
Substantially Compliant

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**Outcome 08: Safeguarding and Safety**

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

**Theme:**
Safe Services

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

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

**Findings:**

There was evidence to support that adequate measures were in place to protect and safeguard residents.

There was a suite of policies with a protective component available to staff including the management of any alleged, reported or suspected abuse; the management of behaviours that challenged and the use of restrictive practices. Training records indicated that all staff had current education and training on protection and responding to behaviours that challenged.

Staff spoken with had a clear understanding of what may constitute abuse, their reporting obligations and the reporting pathway. There was documentary evidence of further recently implemented measures to assist residents in developing knowledge, awareness and skills for self-care and protection. The inspector saw that staff discussed with residents their charter of rights and the promotion of and respect for each resident’s privacy and dignity within the house. Two residents had recently commenced a formal well-being programme. Inspectors saw that residents were relaxed and engaged positively with staff and that residents were encouraged to be as independent as possible in their daily routines.

There were no reported restrictive practices and this concurred with the observations of inspectors and records reviewed. There were therapeutic plans in place for the management and de-escalation of behaviours that had the potential to impact negatively on the individual resident or other residents. Interventions identified in the plan were psychosocial as opposed to chemical or physical restriction. Where restrictions or
There were parameters necessary for resident safety (such as staff accompaniment or reporting to staff) there were risk assessments in place to support their requirement.

**Judgment:**
Compliant

### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

#### Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

**Findings:**
There was evidence to support that residents on an individual basis was supported to achieve and enjoy the best possible health.

Staff said and records seen confirmed that each resident retained the services of their preferred General Practitioner (GP) and were facilitated by staff to access these services as needed. Clear records were maintained of each referral, review, prescribed and recommended treatments; these were subsequently seen to be integrated into the person plan. Where there were particular identified health problems or concerns there was a plan in place to meet identified needs and maintain well being; staff spoken with were familiar with these plans. For example the inspector saw that staff maintained dietary intake records and regularly monitored body weight.

In addition there was further documentary evidence that residents had access to other health care services as appropriate to their needs including dental services, dietician, ophthalmology, psychiatry and the acute hospital services. There was further evidence of regular blood profiling, the administration of influenza vaccination and participation with consent in national screening programmes. Staff spoken with articulated a clear understanding of educating and promoting health and well-being while respecting a resident’s right to refuse treatment.

**Judgment:**
Compliant

### Outcome 12. Medication Management

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

**Theme:**
Health and Development

#### Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

**Findings:**
There were measures in place to ensure safe medication management practice.

There were policies and procedures available to staff, staff had signed as having read and understood the policies and all staff had received medication management training. Each service user had a current medication management plan. The plans were well maintained, contained the medication prescription record and the administration record, clear guidance for staff on the administration of medication prescribed on a PRN basis (medication that is not scheduled or required on a regular basis) and a formal assessment of each resident's capacity and willingness to manage their own medications. No resident was self-administering their medication but the rationale for this was clearly outlined in the assessment. The medication management plan was seen to concur with the resident's individual personal plan.

Medications were securely stored with evidence that security deficits had been identified and rectified by the provider following the provider's own annual review. Staff completed and maintained stock balance checks of all prescribed medications and there were procedures and records for the return to the pharmacy of any unwanted or unused medications. Medical records seen supported that oversight was kept of prescribed medications by the relevant General Practitioner (GP) and other health professionals such as psychiatry. There was evidence to support that medications assessed as no longer required by the resident were discontinued.

The maximum daily dosage of PRN medications was clearly stated.

Staff confirmed that they facilitated each resident to have direct access to the pharmacy and pharmacist.

There was a transparent system in place for the identification, recording, reporting, investigation and learning from any medication related incidents.

**Judgment:**
Compliant

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**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

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**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
There was evidence of an effective management system that sought to promote the quality and safety of care and services provided to residents.

The person in charge was on leave but staff were aware of and confirmed the arrangements in place for the management of the centre in her absence. Staff described the person in charge as accessible and available to staff and residents and while not based in the centre the person in charge was reported by staff to have a regular pattern of attendance in the centre. Based on these inspection findings there was no evidence to indicate that the person in charge was not adequately engaged in the governance and operational management of the centre.

Staff confirmed that there was an on call out of hour’s manager available within the wider organisation and this rota was readily available to staff.

An annual review of the quality and safety of the care and services had been completed by the provider in November 2014; the review was based on the eighteen outcomes utilised by the Authority. A report and action plan issued from the review and both were made available to inspectors. Timescales and responsible persons were identified and inspectors saw that some required actions were completed.

The regional manager for the service confirmed that the provider has put in place arrangements for the unannounced visits to designated centres as required by article 23 (2) of the regulations.

The provider ordinarily undertook a survey with service users nationally on an annual basis; in addition staff had consulted with and sought feedback from residents locally. The format utilised was accessible and based on the sample reviewed by inspectors the feedback from residents was positive. Weekly house meetings were also convened with residents; the scope of the agenda had been expanded based on the findings of the annual review.
As discussed in outcome 18 there was a formal system in place for supervising and supporting staff on an ongoing basis. Inspectors saw minutes of regularly convened staff meetings where staff were kept informed and actively facilitated to exercise their views on the operation of the centre.

Staff confirmed that in response to the increasing needs of residents and as a support to staff an additional resource of six “team leader” hours per week had been introduced to the service. Staff welcomed this supportive initiative and spoke positively of its impact on both the operational management of the centre and the support it afforded to staff in meeting regulatory requirements such as the maintenance of documentation and the updating of support plans. However, the resource introduced to augment the existing structure had not been formalised into the management structure and/or reporting relationships.

**Judgment:**
Substantially Compliant
Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector was satisfied that the centre had sufficient staffing levels to meet the needs of the current residents. There were three full-time staff on a rotating shift pattern in the centre. The staff began their shift at 4 pm and went on sleepover duty at midnight. Their shift recommenced at 8 am and then finished at 10 am when the residents left the centre to attend their day services/activities. In addition, in response to the increasing needs of residents there was a part-time staff member whose hours were allocated by the person in charge based on differing needs in the centre from week to week. For example, staff informed the inspector that if there were activities that some residents wished to partake in when others did not, then the part-time staff were on duty to facilitate the residents' choices. There was a planned and actual rota which reflected the shift pattern described to inspectors by staff.

Staff were seen interacting with residents in a warm and friendly manner. There was a comfortable familiarity between staff and residents and staff had been working in the centre for several years.

Staff files were not viewed as part of this inspection as the inspection was unannounced; the files were held by the provider in a central location and not readily available. The providers adherence to robust recruitment practices has been evidenced on previous inspections and staff were advised that staff files would be required on the next inspection. Staff said that they received three appraisals by management during their first year of employment with the provider as part of their probation. Upon completing their probation staff had monthly one-to-one supervision meetings with the person in charge in order to discuss any issues relating to their work and the operation of the centre. Managers from other centres would sometimes be present at the supervision meetings as a quality assurance measure. A record of such supervision meetings was provided for the purpose of inspection.

There were monthly staff meetings in the centre chaired by the person in charge. The minutes of these meetings were available for inspection; a variety of topics were discussed e.g. regulation, training, service user needs, health and safety etc. All staff were facilitated on the rota to attend these meetings.
All staff had received mandatory training in fire safety, abuse, manual handling and behaviours that challenge. Staff also received training in person-centred planning, report writing, health and safety, medication administration etc. The person in charge maintained a training matrix which recorded when a staff member had received training and when they were due for refresher training. The inspector was satisfied that staff were familiar with the various policies in place in the centre and were also aware of the regulations and standards applicable to designated centres. There were currently no volunteers in the centre.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<th>Centre name:</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0002653</td>
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<tr>
<td>Date of Inspection:</td>
<td>25 March 2015</td>
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<tr>
<td>Date of response:</td>
<td>28 April 2015</td>
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Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no apparent follow-through on one goal that was not progressed for one resident; the support plan in place for another resident did not fully evidence or justify to inspectors the low level of staff support required on a daily basis.

Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
The goal that was not progressed will be transferred to an action for 2015 and will be completed before 31.05.15.

Support plan mentioned above will be reviewed and updated by 10.04.15.

**Proposed Timescale:** 10/04/2015

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**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:
While staff and residents confirmed that fire drills took place at regular intervals, there was no documentary evidence to support this. While staff stated that each resident had a personal emergency evacuation drill they were not available on the day of inspection.

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

**Please state the actions you have taken or are planning to take:**
Documentation in relation to fire drills from 2014 now available in fire fact file in the service. Personal emergency evacuation plans in place for all service users in the service. Completed on the 01.04.15.

**Proposed Timescale:** 01/04/2015

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The resource introduced to augment the existing governance structure had not been formalised into the management structure and/or reporting relationships.

**Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.
Please state the actions you have taken or are planning to take:
The governance structure including a 5hr Team leader have been formalised into the management structure and the relevant documentation have been review and updated on 01.04.15.

**Proposed Timescale:** 01/04/2015