

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by RehabCare
<b>Centre ID:</b>	OSV-0002652
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	RehabCare
<b>Provider Nominee:</b>	Rachael Thurlby
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
04 May 2016 08:45	04 May 2016 19:00
05 May 2016 08:45	05 May 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA). The first inspection was undertaken in September 2014 and failings identified at the time of that inspection were substantially addressed.

In this centre the provider provided residential services and supports to five young adults with high support needs; three of these young adults did not communicate verbally.

The centre was located in a quiet residential area in relatively close proximity to amenities, however transport was required and transport was available daily to take residents to their respective day service. The premises was suited to its stated purpose and function.

The inspector met with staff including the person in charge, the team leader, frontline staff and the deputy regional manager. Some residents choose to interact with the inspector and some did not. The inspector reviewed the records required for the purpose of regulatory monitoring including residents support plans, health and safety and fire safety records, complaints records and staff related records including training records.

There was evidence that staff supported residents to promote and maintain health and well-being. Residents were seen to have good freedom of movement within the house and to the garden and they had ready access to staff.

On speaking with staff and on review of residents' support plans there was a strong theme of communicating effectively with residents. However, staff said that given resident's specific needs it was a challenge for staff to demonstrate how they consulted with and ensured resident participation in the organisation, planning and operation of the designated centre.

There was evidence of good practice and therapeutic supports for residents, however there was an ongoing challenge for both residents and staff in achieving balance between behaviours, activity and social inclusion and integration.

The provider did not have suitable arrangements in place to ensure that staff on duty at all times had the required skills and competencies to administer medications to residents including medication required for the emergency treatment of seizures. The inspector required the provider to take immediate action to address this failing and safeguard residents. The regional manager committed to ensure that with immediate effect there would be staff on duty at all times with the required skill and assessed competency. The provider was requested to submit a detailed formal response to the immediate action plan within three working days of the inspection. The provider responded appropriately to the immediate action plan and within the specified timeframe.

Of the full eighteen outcomes inspected the provider was judged to be in compliance with ten outcomes, in substantial compliance with one, in moderate non-compliance with six and in major non-compliance with one, Outcome 17: Workforce.

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

On speaking with staff and on review of residents' support plans there was a strong theme of communicating effectively with residents. Resident's choices and preferences, for example in their daily routines, their likes and dislikes were outlined by staff in the support plans. Staff clearly understood the role that behaviours played in residents communicating and expressing choice such as the choice not to participate in a particular activity. Daily routines, meal choices and the staff rota were all displayed in a format that was meaningful to residents choices. There was no evidence that residents' choices were not respected. However, staff said that given resident's specific needs it was a challenge for staff to demonstrate how, they consulted with and ensured resident participation in the organisation, planning and operation of the designated centre. For example, staff said that structured resident meetings did not meet residents' needs and consequently none were held. How resident consultation and participation was evidenced was also a failing identified in the provider's own review of the centre.

The provider operated a structured advocacy service for residents. However, staff confirmed that residents in the centre had not availed of the service nor had they been familiarised with it. On further discussion with the person in charge and the team leader two resident's rights related issues within the centre were identified that support from advocacy would potentially benefit both residents and staff in addressing these issues.

Staff reported that at the time of this inspection no resident was facilitated to exercise their religious beliefs. Staff agreed that this was an area that required consultation with residents and perhaps their representatives to ensure that each resident's choices and preferences were objectively established and respected.

Staff said that residents did not ordinarily vote but voting was discussed with residents as appropriate in the day service.

The complaints procedure was prominently displayed and a suggestion box was available. There was evidence that the complaints process was accessible to both residents and their representatives. The inspector saw that more substantial complaints were reported, recorded and investigated. Records were seen of the actions taken in response and the evaluation of complainant satisfaction where complaints were resolved. However, staff said that complaints of less gravity or expressions of dissatisfaction were generally dealt with through other processes such as the family communication log rather than through the local complaints log.

There were systems in place for supporting residents in the management of their personal possessions and finances. Staff maintained financial records for each resident and the inspector saw records of debits and lodgements, supporting receipts, staff signatures and records of the purpose for which the monies were used. However, staff confirmed that all residents did not have access to, did not have control over and did not always benefit from their finances and financial affairs. Staff said that action had been taken by them to address this but the matter was not resolved at the time of this inspection.

There was evidence of the limiting effect of behaviours on residents' opportunities for new experiences and personal development. This is discussed in detail in Outcome 10: General Welfare and Development but the required action is issued under this outcome.

**Judgment:**

Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Staff were aware of the different communication needs of residents and the individualised supports that each resident required. Staff had a good understanding of the importance of effective communication between staff and residents.

Residents' communication needs varied from full verbal ability to non-communicative by verbal means. Each resident had a support plan that outlined how each resident

communicated by verbal or non-verbal methods. The support plan highlighted each resident's receptive and expressive skills and the supports required by staff.

Augmentative strategies evidenced in the centre included visual supports such as the daily menu and the staff rota, PECS, (picture exchange communication systems) and visual planner/communication board. Staff and residents were seen to communicate using the latter on a regular basis throughout the inspection. Some residents had a history of using Lamh (a system of manual signing) and staff had completed training in its use.

Staff understood and recognised the role of behaviours in communication and some support plans included a communication dictionary that detailed behaviours, what they sought to communicate and how staff should respond.

One communication support plan seen by the inspector required updating and this is addressed in Outcome 5.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

There was evidence that staff supported residents to enjoy on-going family contact including visits home. The person in charge confirmed that family and friends were also free to visit the centre and a quiet separate private area was available for the purpose of visiting if required. Family were invited to and did attend reviews of the personal plan. Staff agreed with each family a communication agreement that set out the preferred method and frequency of communication between staff and families; a log of family contact was maintained. Each support plan contained a social roles summary that identified the importance of family and social relationships to the psychosocial well-being of each resident.

Each resident had access to structured day services and between the five residents three different services were utilised. There was evidence in each support plan that in addition staff sought to promote social inclusion and integration for each resident but a barrier to this at times was manifested behaviours. This is discussed again in Outcome 10.

**Judgment:**  
Compliant

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

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**  
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures governing admission to and discharge from the centre. There was evidence at the time of this inspection that the suitability of on-going placement was reviewed by the provider in line with resident's expressed wishes and needs.

Residents were provided with a contract for the provision of supports and services. Those seen were signed by representatives of the provider and of the resident. The contract satisfied regulatory requirements and reflected the administration of any relevant fees as reported by staff and as seen in residents financial records.

**Judgment:**  
Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**  
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Each resident had a support plan that set out strengths and abilities, where support was needed from staff and what those supports were. The plans seen were detailed and personalised and person-centred in tone and manner. However, the support plans did not meet core regulatory requirements.

The support plan was not presented in a manner that enhanced its accessibility to the resident.

Staff confirmed that annual reviews were planned and that resident's representatives were invited to attend the review. However, while support plans were dated as reviewed regularly there was no definitive evidence that the review was multidisciplinary.

There was no evidence of the comprehensive assessment of the health, personal and social care needs of each resident that informed and supported the support plan as frequently as required but no less frequent than on an annual basis. Following transition to the service one support plan was developed based on the plan that transitioned with the resident. The inspector noted numerous handwritten amendments, large sections of information struck out and ongoing reference to the discharging centre.

The process for agreeing and monitoring the progress of resident's goals and objectives was poor. Some agreed goals had no action/activity updates while others had infrequent updates. It was unclear whether the agreed goals were still relevant or not or if they had been achieved and if not why not. Timeframes and responsible persons were not always indicated.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The premises was a two-storey domestic type building that was suited to its stated purpose and function.

The premises was situated on a spacious site in a residential area within a relatively short commute of local amenities; transport was available.

Each resident was provided with their own bedroom; rooms were seen to be of a suitable size and included provision for personal storage. Resident private accommodation was provided on both the ground and first floors. At ground floor level residents had access to a universally accessible bathroom with shower, toilet and wash-hand basin. At first floor level where three residents were accommodated there were two further sanitary facilities one with shower, toilet and wash-hand basin, the other with floor-level bath, toilet and wash-hand basin. Staff said and records seen indicated that residents enjoyed the choice of either a bath or shower.

Residents had access to a main communal area that was homely in presentation and a second separate quieter area that some residents were seen to prefer.

The kitchen was adequately equipped and incorporated a dining area that offered sufficient space. From the kitchen residents had direct access to and were seen to access the rear garden and the recreational equipment situated there.

There was a separate utility area with facilities for the laundering of personal and general laundry.

There was no apparent difficulty with storage.

Clinical waste was not generated and general waste was collected by a local licensed contractor.

Overall the house was in acceptable condition but this was a busy house and there was some minor evidence of general wear and tear. The person in charge said that there was an annual maintenance budget, staff maintained a maintenance log that the person in charge or the team leader took action; there were designated maintenance contractors. The kitchen had recently been re-decorated and some appliances had been replaced.

**Judgment:**

Compliant

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

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

**Theme:**

Effective Services

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

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The inspector saw both organisational and centre specific safety statements that were signed as read and understood by staff.

The safety statement included the procedures for the identification and assessment of risks and the recording, reporting and investigation of accidents, incidents and adverse events.

The inspector reviewed the local risk management folder; this included a suite of centre specific/workplace risk assessments and the risks as specifically required by Regulation 26 (1) (c). The risk assessments were dated as having been reviewed by the person in charge in July 2015.

Risks as they pertained to individual residents, their assessment and the controls required to manage or reduce risk were contained in the support plan. However, the review process of these individual risk assessments was not clear and controls identified in the assessment were not all in place. For example, two risk assessments for managing the risk of residents leaving the centre without staff stated that an alert alarm was fitted to the door. However, staff had already informed the inspector that the alarm was disabled as it was a trigger for behaviour that challenged for another resident. There was no updated risk assessment that reflected this or the requirement now to lock the main entrance and for one-to-one supervision of residents at all times as reported to the inspector.

A further risk management control identified in risk assessments was the availability in the centre of suitably trained staff in medication management. This was not always implemented and resulted in the issuing by HIQA of an immediate action plan to the provider in this regard.

The provider had a centre specific business continuity staff that set out for staff the actions to be taken in defined emergency situations; the plan included alternative accommodation for residents if required.

The inspector saw that emergency lighting and an automated fire detection system were in place. Escape routes and exits were clearly indicated, final fastenings were thumb-turn devices that allowed for timely egress. Fire action notices were prominently displayed and in a visual format that enhanced their accessibility to residents.

Fire fighting equipment was prominently positioned and there was evidence of fire doors and self-closing devices.

Fire related records were maintained in the fire fact file. The inspector saw certificates confirming that the fire detection system, fire fighting equipment and the emergency lighting were inspected and tested at the prescribed intervals and most recently in April 2016, October 2015 and January 2016 respectively. In addition staff maintained records of the in-house daily, weekly, monthly and quarterly inspection of fire safety measures.

Training records indicated that staff were provided with fire safety training on an annual basis and most recently in April 2016. Staff spoken with confirmed their attendance at training. Each resident had a personal emergency evacuation plan (PEEP) dated February 2016. All residents were stated to required staff guidance and no specific barriers to safe and timely evacuation were noted on the PEEPS.

However, while simulated fire drills were convened records of the three completed between June 2015 and February 2016 indicated that fire drills were not reflective of all possible fire scenarios. No drill had been undertaken to test full resident occupancy and minimum staffing such as that which prevailed at night-time. Staff spoken with confirmed this.

During the inspection the inspector brought to the attention of staff the routine use of equipment and labelling to be used only where infection prevention and control measures were actively required. This was addressed by staff during the inspection.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Measures were in place to protect residents from harm and abuse. These measures included organisational and national policies and procedures, designated persons, risk assessments, staff training and education.

Staff spoken with articulated a sound understanding of what constituted abuse, their obligation to protect residents and report any safeguarding concerns. Staff said that they would have no hesitation in approaching either the person in charge or the team leader and they were confident that measures would be taken as necessary to safeguard residents. There was evidence that the person in charge took measures where there was any concern raised for the safety of residents or in relation to the quality of supports provided to residents.

However, staff training records indicated that four staff had no recorded attendance at training on safeguarding vulnerable adults.

The inspector saw that measures to promote and protect each resident's privacy and dignity both in and outside of the centre were clearly outlined in residents' support plans. Staff spoke with were clear on these measures.

There were policies on positive risk enablement, positive behavioural support and the use of restrictive practices where necessary. Training records indicated that staff had attended training in responding to behaviours that challenged. Risk assessments and behaviour management guidelines that were specific to each resident were in place. The behaviour management guidelines were person-centred in their tone and language used and had a therapeutic focus. Staff spoken with while acknowledging any risk clearly interpreted behaviours as a form of communication, sought to understand and alleviate therapeutically any behaviour and its escalation. Medication prescription and administration records indicated that there was minimal reliance on medication on a regular or p.r.n (as required) basis when managing behaviours that challenged or posed risk to the resident and others.

The team leader confirmed that the recently recruited behaviour therapist had visited the centre and had reviewed with staff the existing behaviour management guidelines. The behaviour therapist was to return to the centre to assess residents and also to provide a support day to staff to enhance their knowledge and skills on the therapeutic management of behaviours.

This would concur with the conclusion of the inspector that while there was evidence of good practice and therapeutic supports for residents there was an ongoing challenge for both residents and staff in achieving balance between behaviours, activity and social inclusion and integration. Staff spoken with agreed with this conclusion. This issue was addressed in Outcome 10: General Welfare and Development.

There were restrictive practices in use and the rationale for their use was the safety of the resident and others. Documentation was in place indicating what practices were identified as restrictive as per the provider's own policies and procedures and were currently under review in consultation with the behaviour therapist.

However, the inspector saw and staff confirmed that sound monitors were in use in some resident's bedrooms. There was a rationale for their use but they had not been identified as potentially restrictive and justification of their use in the context of waking staff had not been explicitly assessed.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures for the reporting, recording and investigation of accidents and incidents in the centre. This electronic system alerted the person in charge, the regional manager and relevant health and safety personnel and thereby ensured communication and follow-up. The person in charge was clear that it was his responsibility to ensure that incidents that required notification to the Chief Inspector were submitted. There was an established pattern of notifications submitted to the Chief Inspector.

**Judgment:**

Compliant

**Outcome 10. General Welfare and Development**

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

There was an understanding and commitment on behalf of staff (based on those spoken with and records seen) of supporting residents to achieve quality of life outcomes. While the process for agreeing personal goals and objectives was poor, the underlying principle or objective reflected this commitment as many of the goals seen sought to maximise resident independence, social skills, social inclusion and integration. Each resident had access to structured day services and in these services they were recorded as participating in activities and experiences such as swimming, horse riding, the sensory room and the development of practical skills. Within the centre each resident had a daily planner and this recorded activities such as local walks, shopping, eating out, home visits and table-top activities.

However, there was evidence of the limiting effect of behaviours on residents' opportunities for new experiences and personal development. There was a strong emphasis on behaviours in the support plan and other records such as the daily narrative notes and how behaviours impacted negatively on planned activities particularly where behaviours were not conducive to social integration, social participation and the resident's privacy and dignity in public. There was no evidence available to the inspector that staff were risk averse.

Some chosen activities may not have been of the residents liking and the manifested behaviours may have been the resident's means of communicating this to staff. There was no formal assessment of each residents general, welfare and development needs and potential. Staff spoken with said that it was difficult and a challenge to decide on activities that residents wanted to participate in, staff described empty periods of time and a fear that some residents had insufficient meaningful engagement.

There was evidence that in 2015 staff had sought professional review and input from an occupational therapist so as to identify activities of interest to encourage social integration and engagement. The report seen by the inspector provided detailed guidance and recommendations for staff to achieve this goal. Recommendations included a sensory room, trampoline, large sand box and other sensory based activities. Much of this was already known to staff who had recorded the strong sensory component to some of the resident's preferred activities such as the beach and water. Staff had also very recently sought input from the behaviour therapist. However, at the time of this inspection there was little evidence as to how completed assessments and recommendations were incorporated into the daily and weekly planner so as to achieve success rather than failure.

This failing is addressed and actioned in Outcome One.

**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):**  
No actions were required from the previous inspection.

**Findings:**  
There was evidence that staff supported residents to promote and maintain their health and well-being.

Residents based on records seen had timely access to their general practitioner (GP) and staff also sought advice from the GP on a regular basis. In addition and as appropriate to their needs residents were supported to access psychiatry, neurology, occupational therapy and behaviour therapy. Nursing supports were available as required through the GP practice. There was further documentary evidence that residents had regular dental and chiropody care. There were records of seasonal influenza vaccination and regular blood-profiling.

Where there was a specific need or concern identified this was reflected in the support plan and having spoken with staff the inspector was satisfied that staff implemented the required interventions such as specific dietary content or monitoring of body weight. There was a menu that offered variety and operated on a two week cycle; the narrative version was reflected daily in a pictorial format for residents.

**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):**

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

### **Findings:**

Medications were supplied to residents by a community pharmacy in either a compliance aid or the original container dependent on the format and relevant product information. Medications were seen to be supplied and labelled for individual resident use. Each resident was seen to have a current legible prescription and an administration record the entries on which corresponded to the prescription instructions.

Medications were administered in an altered format (crushed) and medical authorisation for this was indicated on the prescription. Staff described systems to enhance the safety of medication management practice including the checking of medications supplied and a daily balance count of all medications supplied.

Medications were seen to be stored securely and a refrigerator for medicines had been sourced. However, deficits identified by the inspector included;

- one medication storage facility was very untidy with two loose medicines found out of their original container
- medicine required to be used within 90 days of opening was not signed and dated by staff as to when opened

- while there was storage available for unused or unwanted medicines two open and partially used containers of the same medicine were in place for one resident
- the maximum daily dose of one p.r.n (a medicine only taken as the need arises) antipsychotic medicine was not stated
- anomalies were noted between prescriptions and residents' medication management plans indicating that the latter required review and updating.

The inspector did not see explicit assessments used to assess resident's capacity or otherwise to manage their own medications. The person in charge said that they were under review at the time of inspection.

There were systems in place for the reporting and review of medicine related errors. There were recorded medication administration errors. These had been reviewed by the person in charge and the inspector saw that the descriptor used in the review and confirmed to the inspector to describe the errors made by staff was complacency. The person in charge and the team leader told the inspector that all errors were addressed with staff either through the staff supervision process or at staff meetings. However, it was not clear to the inspector that there was sufficient learning and improved safety in practice as a further medication administration error by staff was recorded in the days prior to this inspection.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

A revised statement of purpose was submitted to HIQA prior to this inspection. It contained all of the information required by Regulation 3 and Schedule 1.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

There was a clearly defined management structure in the designated centre that comprised of the team leader, the person in charge and the regional manager.

The person in charge worked full-time and was person in charge for this and another designated centre. The person in charge said that his presence was generally divided equitably between both centres. The person in charge was suitable qualified and experienced for the post and held both relevant nursing and management qualifications. The person in charge was clear on his regulatory responsibility and accountability.

On a day to day basis the team leader had responsibility for the operational management of the centre. For example the preparation and maintenance of the staff rota, the completion of staff supervisions and the oversight of residents' support plans. The team leader worked full-time and told the inspector that in addition to the roles of person in charge and team leader governance of the centre was supported by the formal identification of a shift-coordinator daily and at weekends.

There was a rota detailing the on-call, out-of-hour's manager available to staff. Formal management meetings were convened between the person in charge and the regional manager. Further opportunities for discussion, learning and peer support were facilitated through recently introduced team leader meetings.

Staff meetings were convened in the centre and there was a planned schedule of meetings for 2016. The person in charge and the team leader both said that any issues or concerns were addressed with staff through either collective staff meetings or individual staff supervisions.

Systems were in place for the completion of the unannounced visit to the centre and the annual review so as to determine the safety and quality of care and supports provided to residents and as required by Regulation 23 (2) (a) and (b) and Regulation 23 (1) (d). The inspector reviewed the report and action plan of the unannounced visit to the centre undertaken in March 2016. Findings reflected some of these inspection findings for example in relation to the review of resident's support plans, restrictive practices ,

access to advocacy and how residents were consulted with and participated in the organisation of the centre.

However, based on the failing identified in Outcome 17: Workforce and the fact that an immediate action plan was issued by HIQA, the inspector was not satisfied that the management systems were sufficient to ensure that the supports provided to residents were at all times safe, appropriate, consistently and effectively monitored.

**Judgment:**

Non Compliant - Moderate

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Arrangements were in place for the management of the centre in the absence of the person in charge. The team leader was the nominated PPIM (person participating in the management of the centre) and was fully aware of the responsibilities of the role. The team leader confirmed that in the absence of the person in charge support was available to her from within the wider organisation.

**Judgment:**

Compliant

**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:**

The provision of resources to ensure the effective delivery of services and supports to residents was discussed at verbal feedback at the end of the inspection. The regional manager confirmed commitment to the provision of resources so as to address any regulatory failings and to support residents in achieving their individual potential.

**Judgment:**

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):**

No actions were required from the previous inspection.

**Findings:**

The person in charge, the team leader and staff spoken with all confirmed that there had been significant turnover of staff in the centre. At the time of this inspection however there was evidence that action had been taken to address this. Replacement staff had been recruited in the last quarter of 2015 and further staff were awaiting final completion of recruitment procedures prior to commencing employment. There was some ongoing reliance on relief and agency staff in the interim but staff said and the rota indicated that this was managed so as to ensure consistency of personnel and supports for residents.

The team leader maintained a planned and actual staff rota. This reflected the staffing supports and arrangements reported to the inspector and as based on resident's assessed needs; that is one to one staff support. Night-time staffing consisted of one sleepover staff and one "waking" staff.

However, staffing arrangements did not always ensure that staff on duty at all times had all of the knowledge and skills required to meet resident's assessed needs. There was considerable lack of clarity in the centre in relation to the content of the medication administration module. Initially it was reported to the inspector that all staff did not have training in the administration of Buccal Midazolam, a medicine prescribed for some residents to manage seizure activity and requiring administration within a specified timeframe and as per an explicit protocol. It was clarified sometime later that staff did have training but could not administer the emergency medicine as they had not been practically assessed to establish competency in its administration as required by the

provider's own medication administration policy. The person in charge and the team leader said that the staff rota was managed to ensure in so far as possible staff with the required skill and competency were on duty. However, staff spoken with confirmed that shortly before this inspection staff were on duty at night that had not been assessed as competent to administer any medications to residents. Staff confirmed that staff came to the centre from another centre to administer a routine medicine. Staff confirmed that if necessary (this was possible based on the needs of the current residents) they would not have been able to (as they had not been assessed) administer Buccal Midazolam and would instead have contacted the emergency services. Given these failings and the consequent risk to resident well-being and safety HIQA issued an immediate action plan as immediate action was required to ensure that with immediate effect there were staff on duty at all times in the centre with the required skill and assessed competency to administer all prescribed medications and specifically Buccal Midazolam.

Adequate arrangements were not in place for monitoring staff education and training to ensure that learning needs were met so that staff could adequately and appropriately support residents. The failing above highlighted the lack of timeliness in both providing training to staff following employment and in assessing staff learning and competency in a timely manner following training to ensure that staff could meet resident's assessed needs. Based on the training records available to the inspector three staff had not been assessed as competent to administer any medications; these records did not include agency staff.

Staff files were available for the purpose of establishing compliance with regulatory requirements. The random sample reviewed by the inspector was well presented and contained most of the required information. However, it was not possible to establish in one staff file the date employment in the centre commenced and another file did not contain documentary evidence of relevant training and qualifications.

**Judgment:**  
Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**  
Use of Information

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

No actions were required from the previous inspection.

**Findings:**

Overall the inspector was satisfied that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place and available for inspection.

There was documentary evidence that the provider had appropriate insurance in place.

The residents guide contained the required information and was presented in a user friendly format.

However, while a directory of resident was maintained, it did not contain all of the information specified in Schedule 3.

The provider had reviewed and updated many of its policies and procedures, however the most recent version of the provider's medication management policy was not the version in use; this was rectified prior to the conclusion of this inspection.

Training records were maintained for staff. However, records for all staff were not maintained in the centre and records were not presented in a manner that facilitated easy retrieval in a timely manner of the required information for all staff working in the centre.

**Judgment:**

Substantially Compliant

**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

## Action Plan

### Provider's response to inspection report<sup>1</sup>

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002652
Date of Inspection:	04 May 2016
Date of response:	09 June 2016

### Requirements

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

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

### Outcome 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:**

Given resident's specific needs it was a challenge for staff to demonstrate how, they consulted with and ensured resident participation in the organisation, planning and operation of the designated centre.

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

**1. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

In order to determine the effectiveness of house meetings with this service users group service user house meetings will be introduced on a trial basis in an accessible format for all service users.

More regular consultation with families will be introduced, this will be done by phone contact, face to face meetings as required this will be distinct from the service user annual review.

Where appropriate Staff will support service users using alternative means of communication such visual prompts and social stories to enable the team to consult more effectively with service users.

**Proposed Timescale:** 01/07/2016

**Theme:** Individualised Supports and Care

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

Staff confirmed that residents in the centre had not availed of the advocacy service nor had they been familiarised with it.

**2. Action Required:**

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:**

Internal and external advocate is available for consultation. Information posters with photo of internal advocate and contact details to be displayed in the service.

Social story in relation detailing advocacy supports to developed and explained to service users.

Internal advocate has been invited to the service to consult with team, date to be confirmed.

External advocate will be requested to advocate on behalf of service user with a specific requirement (details below)

**Proposed Timescale:** 01/07/2016

**Theme:** Individualised Supports and Care

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

Religious/spiritual observance required consultation with residents and perhaps their representatives to ensure that each resident's choices and preferences were objectively established and respected.

**3. Action Required:**

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

Consult with families and service users in relation to service user preferences and supports required.

A social story will be developed to give choice to the service users regarding attending religious ceremonies.

Support Plans to be updated and supports required in this area will be recorded in individual support plans.

**Proposed Timescale:** 13/06/2016

**Theme:** Individualised Supports and Care

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

All residents did not have access to, did not have control over and did not always benefit from their finances and financial affairs.

**4. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Support plans provide details on the support service users require to manage their finances held in the service, each plan is updated to reflect any changes in the financial support requirements of the individual.

An external advocacy officer will be requested to advocate for service users whose finances are currently managed by their family.

**Proposed Timescale:** 13/06/2016

**Theme:** Individualised Supports and Care

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

There was evidence of the limiting effect of behaviours on residents' opportunities for new experiences and personal development. There was a strong emphasis on behaviours in the support plan and other records such as the daily narrative notes and how behaviours impacted negatively on planned activities particularly where behaviours were not conducive to social integration, social participation and the resident's privacy and dignity in public.

Staff spoken with said that it was difficult and a challenge to decide on activities that residents wanted to participate in, staff described empty periods of time and a fear that some residents had insufficient meaningful engagement.

**5. 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:**

A referral has been sent to the organisation's behavioural therapist for one service user. The remaining four residents will also be referred before June 30th with a view to identifying strategies that can be used to support behaviours in a manner that will facilitate residents to engage in planned and new social activities.

Original report received from Occupational Therapist did not provide the service with sufficient detail on the individual needs of the two residents referred, hence further more detailed reports have been requested from the Occupational Therapist with additional recommendations specific to each individual. On receipt of report recommendations to be reviewed and implemented as appropriate.

Recommendations and strategies recommended from the input of both the behaviour therapist and occupational therapist (for two residents) will be used to guide staff practice and support service users.

**Proposed Timescale:** 30/08/2016

**Theme:** Individualised Supports and Care

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

Complaints of less gravity or expressions of dissatisfaction were generally dealt with through other processes such as the family communication log rather than through the local complaints log.

**6. Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

All expressions of dissatisfaction will be recorded in line with organisational policy for the handling and resolution of complaints.

**Proposed Timescale:** 30/05/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

There was no evidence of the comprehensive assessment of the health, personal and social care needs of each resident that informed and supported the support plan as frequently as required but no less frequent than on an annual basis.

**7. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A needs assessment will be carried out and reviewed on at least an annual basis for all service users.

All changes in the support needs will be detailed in the support plans, support plans will reflect service user's current service arrangements and support needs.

**Proposed Timescale:** 01/07/2016

**Theme:** Effective Services

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

The support plan was not presented in a manner that enhanced its accessibility to the resident.

**8. Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

An accessible format to be developed in order for service users to view their support plans.

**Proposed Timescale:** 01/07/2016

**Theme:** Effective Services

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

While support plans were dated as reviewed regularly there was no definitive evidence that the review was multidisciplinary.

**9. Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

All stakeholders to be invited to an individual annual review for each service user.

Where service users are facilitated to access the support of professionals such as GP this is recorded in the health records section of the service user files and support plans are updated accordingly with any changes to support needs.

**Proposed Timescale:** 30/05/2016

**Theme:** Effective Services

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

The process for agreeing and monitoring the progress of resident's goals and objectives was poor. Some agreed goals had no action/activity updates while others had infrequent updates. It was unclear whether the agreed goals were still relevant or not or if they had been achieved and if not why not. Timeframes and responsible persons were not always indicated.

**10. Action Required:**

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

All action plans to be reviewed and recorded in line with organisational templates.

All actions to have responsible person noted with action date.

Action Plans to be maintained and updated to ensure they are reflective of the practice within the service on an ongoing basis.

**Proposed Timescale:** 20/06/2016

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

**Theme:** Effective Services

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

The review process for resident specific risk assessments was not clear and controls identified in the assessment were not all in place.

**11. Action Required:**

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

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

Business continuity plan in place.

Risk management framework folder in place.

Safety statement in place.

All risk assessments to be reviewed by PIC.

**Proposed Timescale:** 01/07/2016

**Theme:** Effective Services

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

Fire drills were not reflective of all possible fire scenarios. No drill had been undertaken to test full resident occupancy and minimum staffing such as that which prevailed at night-time.

**12. 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 drills to be completed utilising different scenarios including with at time of full occupancy and minimum staffing levels.

**Proposed Timescale:** 30/06/2016

## Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Sound monitors were in use in some resident's bedrooms. There was a rationale for their use but they had not been identified as potentially restrictive and justification of their use in the context of waking staff had not been explicitly assessed.

**13. 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:**

Restrictive practices to be discussed in restricted practices committee, restrictive practice will be implemented and documented in line with organisational policy.

**Proposed Timescale:** 01/07/2016

Theme: Safe Services

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

Staff training records indicated that four staff had no recorded attendance at training on safeguarding vulnerable adults.

**14. Action Required:**

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

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

Staff who required training at time of inspection completed safeguarding training on the 31st May and 7th June 2016.

**Proposed Timescale:** 07/06/2016

## Outcome 12. Medication Management

Theme: Health and Development

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

The inspector did not see explicit assessments used to assess resident's capacity to manage their own medications. The person in charge said that they were under review at the time of inspection.

**15. Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Review of self administration assessments will be completed.

**Proposed Timescale:** 13/06/2016

**Theme:** Health and Development

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

- one medication storage facility was very untidy with two loose medicines found out of their original container
- medicine required to be used within 90 days of opening was not signed and dated by staff as to when opened
- while there was storage available for unused or unwanted medicines two open and partially used containers of the same medicine were in place for one resident
- the maximum daily dose of one p.r.n (a medicine only taken as the need arises) antipsychotic medicine was not stated
- anomalies were noted between prescriptions and residents' medication management plans indicating that the latter required review and updating.

There were systems in place for the reporting and review of medicine related errors. However, it was not clear to the inspector that there was sufficient learning and improved safety in practice as a further medication administration error by staff was recorded in the days prior to this inspection.

**16. Action Required:**

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

Medication errors discussed with regional manager, PIC, team leader and staff on 18th May 2016.

Medication errors to be investigated as per policy and learning outcomes to be discussed in staff meetings.

**Proposed Timescale:** 13/06/2016

## Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

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

Based on the failings identified in Outcome 17: Workforce and the fact that an immediate action plan was issued by HIQA, the inspector was not satisfied that the management systems were sufficient to ensure that the supports provided to residents were at all times safe, appropriate, consistently and effectively monitored.

**17. 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:**

PIC addressed issue regarding non-communication of changes in training at the regional managers meeting. A summary of training is being completed and will be sent to all centres.

Appropriate numbers of trained staff to be on duty at all times to meet the needs of the service users.

**Proposed Timescale:** 13/06/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

It was not possible to establish in one staff file the date employment in the centre commenced and another file did not contain documentary evidence of relevant training and qualifications.

**18. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Training and qualification documents have been requested for outstanding staff member.

Signed contract obtained from outstanding staff member for file.

**Proposed Timescale:** 01/07/2016

**Theme:** Responsive Workforce

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

Staffing arrangements did not always ensure that staff on duty at all times had all of the knowledge and skills required to meet residents assessed needs. Staff did have training but could not administer if necessary the emergency medicine as they had not been practically assessed to establish competency in its administration as required by the provider's own medication administration policy. Shortly before this inspection staff were on duty at night that had not been assessed as competent to administer any medications to residents.

**19. 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:**

Appropriate numbers of trained staff to be on duty at all times to meet the needs of the service users.

**Proposed Timescale:** 05/05/2016

**Theme:** Responsive Workforce

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

There was considerable lack of clarity in the centre in relation to the content of the medication administration module; training had not been provided in a timely manner following recruitment and employment and following training the practical assessment required by the provider's medication policy had not been completed.

Adequate arrangements were not in place for monitoring staff education and training to ensure that learning needs were met so that staff could adequately and appropriately support residents.

**20. Action Required:**

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

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

Providers Response to the Immediate Action Plan.

- 31 medication training dates are scheduled for 2016, with a further 10-15 dates that can be added as required.
- Medication training sessions are available on a monthly basis. Any further sessions required will be planned dependant on the needs of the services and the recruitment of new staff.

- The four new staff for Drombanna that are currently having pre-employment checks completed have been booked to attend training on the 31st May 2016.
  - Further training has taken place to increase the amount of available trained medication administration assessors. A database of all trainers is now available. This is to ensure that assessment of staff competency will take place at the first opportunity.
  - A summary sheet of the content of the safe administration of medication training is being prepared and will be sent to all centres by the 16th May 2016.
- 
- On an annual basis for existing staff and on recruitment of new staff the PIC will liaise with the internal training department to assign staff members to scheduled training programmes (including refresher training) ensuring training is attended by staff in a timely manner and within appropriate timeframes.
  - Medication administration assessors have been trained and a database is available of all trainers, the PIC has access this database to allocate assessors to staff within the service as required.
  - A content summary of the medication training to be sent to all services.

**Proposed Timescale:** 13/06/2016

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The directory of residents did not contain all of the required information.

**21. Action Required:**

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:**

Directory of residents with all required information completed.

**Proposed Timescale:** 30/05/2016

**Theme:** Use of Information

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

Training records for all staff were not maintained in the centre and records were not presented in a manner that facilitated easy retrieval of the required information in a timely manner for all staff working in the centre.

**22. Action Required:**

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:**

Training department advised of issue with format/presentation of staff training records. The single page format for an individual staff member that was made available to the inspector on the day of the inspection was found to be adequate, training department advised of this.

**Proposed Timescale:** 30/05/2016