

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002663
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 15 June 2016 09:30 To: 15 June 2016 18:00

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA) and was undertaken to monitor ongoing regulatory compliance so as to inform a registration decision. The previous inspection was undertaken in October 2015. Those inspection findings were satisfactory but action was required on behalf of the provider to address failings in relation to the premises, risk identification and assessment, the submission of notifications to HIQA and the timely review of policies and procedures.

How we gathered our evidence

The inspection was facilitated by the person in charge and the team leader who was also the nominated person participating in the management of the centre (PPIM). The area manager was also available to the inspector during the inspection and attended the verbal feedback at the conclusion of the inspection. The inspector discussed the operation and management of the centre with staff and reviewed and discussed with staff, records including health and safety and fire related records,

staff records, resident related records, accident and incident and complaint records, records of reviews and the providers policies and procedures.

There were three residents in receipt of respite at the time of the inspection all of whom spoke with the inspector. Residents were eager to understand the role and purpose of HIQA and more importantly what impact HIQA and the inspection process had on the quality and safety of the services that they received. The feedback received from residents was positive; residents looked forward to their period of respite and hoped that nothing would change in the centre following the inspection. The only request made by residents spoken with and also reflected in records seen was a desire for additional and more frequent opportunities to avail of respite.

Description of the service

In this centre the provider facilitated respite on a planned rotational basis for approximately 32 residents from a wide catchment area. Respite was available for a maximum of three nights per week between Monday and Friday for six persons with a physical and/or sensory disability.

The centre was located on a site where the provider also operated other services including the day resource service and supported living accommodation. The centre was located in relative close proximity to all of the amenities of the busy local town and transport was available.

Overall findings

The inspection findings were satisfactory. The inspector was satisfied that the centre was effectively governed, the action plan from the previous inspection had been addressed by the provider and there was clear evidence the residents needs and their required supports were effectively assessed, monitored, planned for and reviewed on an ongoing basis. A high level of regulatory compliance was evidenced as of the 12 Outcomes inspected the provider was judged to be fully compliant in ten and substantially compliant in two. The failings identified were:

- the providers policy of the use of restrictive practices required review and update as it was dated 2010
- there was one gap in mandatory training.

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 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):

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

Findings:

There were organisational and local policies and procedures governing admission to and transfer and discharge from the designated centre. The inspector saw that the admission policy had been amended to include the risk for and the controls in place to ensure that residents were protected from the risk of abuse by their peers as required by Regulation 24 (1) (b).

Admission practices at the centre reflected those set out in the centre's statement of purpose. Each resident had agreed a written contract which outlined the support, care and welfare of the resident. These included details of the services provided for individual residents and the fees to be charged.

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:

The person in charge informed the inspector that the health, personal and social care and support needs of each resident were assessed prior to their initial admission and on each subsequent admission for respite. Records seen by the inspector indicated that this was correct and that these assessments had multidisciplinary input as appropriate. These assessments ensured that the centre was suitable for and could meet the needs of each resident.

Based on these assessments the inspector saw that a personal support plan was compiled for each resident. The sample of plans seen by the inspector were based on the outcomes of the assessment, detailed, person centred and respectful in the tone and the language used. In the plans seen there was a strong theme of supporting residents adequately while maintaining their independence and respecting their choices, preferences and privacy.

There was documentary evidence that the support plan was made available to the resident for their participation and agreement. There were regularly recorded reviews of the support plan that the resident signed as having participated in. In addition there was an annual review of the support plan. As appropriate to each residents needs the review of the support plan was seen to be multidisciplinary. Actions arising from the review were identified as were responsible persons and timeframes.

On each admission to the centre residents were asked by staff what their goal or priority was for their stay. Some residents continued to attend their day resource service while on respite. Residents spoken with told the inspector that they loved coming to the centre as they always had the opportunity to achieve something. For example on the day of this inspection residents went to an open day in the day resource centre, to the beautician, shopping and for a meal.

Judgment:

Compliant

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 originally consisted of two separate single storey buildings that were now connected by a link corridor. The premises was located on a well maintained and attractively landscaped site that also accommodated two supported living units and the day resource service.

The premises was not purpose built for its stated purpose and function, the provision of supports to persons with physical and sensory disabilities, but it had been modified and adapted. Therefore while elements of its design and layout were not ideal, there was no evidence that the premises did not meet the individual and collective needs of the residents or that it was not suited to its stated purpose and function.

The premises appeared to be of sound construction, it was well maintained, in good decorative order, visibly clean and welcoming in presentation.

Each resident was provided with their own bedroom for the duration of their stay. Bedrooms provided sufficient space including personal storage space. Four of the six bedrooms were fitted with ceiling mounted hoists and staff said that sufficient room and floor-space was available for the use of assistive equipment as necessary.

There was a universally accessible fully equipped shower room located between each two bedrooms. Privacy locks were fitted as was signage reminding occupants and staff to lock the door when attending to personal care. The use of shared bathrooms had been risk assessed and controls included due consideration of gender when allocating bedrooms and the removal of personal items once personal care was complete. There were two further fully equipped and accessible shower rooms available.

Communal space was available in both sections of the premises and collectively this was sufficient for the maximum number of residents to be accommodated, six.

Two rooms, one in each section, were also available to residents to meet with visitors should privacy be required.

Bedrooms were directly accessed off the main communal area. Doors however were seen to be closed at all times during this inspection, doors were fitted with automatic door closures, and there was no evidence of concerns, complaints or dissatisfaction in relation to privacy from residents. The practice and records seen by the inspector reflected an ethos of respect by staff for each resident's choice and privacy.

Based on the findings of the last inspection the provider had fitted two permanent structures/panels in each entrance lobby that restricted access to and occluded the view of the communal room and bedroom doors from persons entering the building. These panels were attractive in presentation and did enhance the privacy of the communal rooms for residents.

Dining space was provided in the link corridor. This was the main thoroughfare between the two sections but it was a bright and pleasant area that comfortably accommodated a dining table and chairs without obstructing the circulation area.

Meals were prepared daily on site by staff; the kitchen was adequately equipped for this purpose.

There was a secure laundry room in the new link section of the building which was well equipped based on the advice of an infection control resource.

Each resident had patio door access to the external patios and garden areas from their bedrooms. Pathways facilitated and promoted accessibility.

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 dated May 2015 signed as read 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 risk management folder and was satisfied that deficits identified at the time of the last inspection had been addressed. The risk management folder included a comprehensive range of centre specific and work related risk assessments and the risks as specifically required by Regulation 26 (1) (c), for example the risk of self-harm or the unexpected absence of any resident. These risks were also supported by centre specific procedures. Resident specific risk assessments were incorporated into their personal support plan. Controls to manage and or reduce risk were clearly stated and there was an evident link between resident specific risk assessments and resident's assessed needs.

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

There was a central transport department that co-ordinated the maintenance and servicing of vehicles supplied to the centre.

An automated fire detection system was in place as was emergency lighting and fire fighting equipment. Fire related records were kept in a well maintained fire fact file. The inspector saw a certificate confirming that the fire detection system was inspected and tested on a quarterly basis and most recently in June 2016 as was the emergency lighting; fire fighting equipment was serviced in April 2016. There were procedures in place for the monitoring of fire safety measures by staff on a daily and weekly basis. Records of these checks were complete and their completeness was overseen by the person in charge. Staff attended fire safety training annually to fire warden standard and most recently in February 2016.

Staff undertook simulated fire evacuation drills with residents at a frequency that reflected and captured the diverse range of residents that attended the centre for respite; the drills included a recent exercise that simulated the night-time scenario. Recommended evacuation times were seen to be achieved and each resident had a personal emergency evacuation plan. There was evidence of further good evacuation practice as an evacuation plan that was specific to the residents accommodated that week was devised weekly. Each bedroom had direct external access doors some of which facilitated bed-evacuation and these rooms were allocated to residents requiring bed evacuation in the event of fire.

Residents were seen to be provided with the equipment necessary for their comfort and wellbeing including hoists. Hoists were seen to have been inspected and tested at the prescribed legislative frequency and most recently in April 2016.

Residents support plans included resident handling risk assessments and plans that specified the staff assistance and equipment required for staff and resident safety.

The person in charge had commissioned an infection prevention and control audit of the service by a suitably qualified person in November 2015 so as to ensure that best practice standards were/would be met.

Staff spoken with confirmed that they had completed occupational health and safety training and had access to a health and safety officer who was based on site.

Judgment:
Compliant

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:

There were measures in place to protect residents from harm and abuse. These included organisational and national policies and procedures, designated persons, risk assessments, staff training and regular consultation with residents. The person in charge and the team leader confirmed for the inspector that there had been no incident of alleged, suspected or reported abuse since the last inspection. On each admission to the centre the inspector saw that staff discussed with residents the complaints and safeguarding procedures, their rights, the use of shared bathrooms so as to promote and respect privacy and dignity and how to raise a concern with staff. On discharge staff completed an evaluation with each resident to establish their satisfaction with the quality of their stay.

The inspector reviewed a sample of these evaluation forms and a record of complaints made since January 2016 and was reassured that matters complained of were not related to resident's personal well-being and safety. The feedback provided by residents spoken with was also positive. Residents said that they looked forward to coming to the centre, described the centre as home and the staff as the equivalent of family.

The name and contact number of the designated safeguarding person was clearly displayed for staff, residents and families.

Residents had a personal/intimate care support plan that outlined the limit of the supports required from staff, for example just preparing the room and allowing the resident to undertake personal care in private.

However, at the commencement of the inspection the person in charge said that one recently recruited staff member had not had formal education on safeguarding, the review of the training records reflected this. The person in charge said that the staff member had read the safeguarding policy and procedure and had also read the training material used by the training department while awaiting training. The inspector was advised that safeguarding training was scheduled for the 18th July 2016.

There were no reported behaviours that challenged or posed a risk; staff had however completed the required training.

Staff had identified practices that were potentially restrictive including the use of bedrails, lap-belts and chairs that reclined. Having spoken with staff and reviewed the supporting documentation the inspector was satisfied that practice was evidence and risk based and there was a clear rationale for the interventions, the safety and comfort of the resident. For example staff understood that while a resident may request the use of a reclining chair it was potentially restrictive as the resident could not exit the chair

without staff assistance. There was evidence that the use of bedrails was assessed to ensure their requirement and safe use with each resident. There was evidence of the use of alternatives including impact reducing floor mats.

Judgment:
Substantially Compliant

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):

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

Findings:

The person in charge was clear that it was her responsibility to ensure that notification of incidents and events were submitted to HIQA as required by Regulation 31, for example any serious injury to a resident.

There were policies and procedures for the identification, recording, reporting and investigation of accidents and incidents that occurred in the centre; electronic and hard copies were maintained. Based on the records seen by the inspector, the inspector was satisfied that any required notifications had been submitted to HIQA.

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:

Residents ordinarily lived at home and were resident only in the centre for the duration of their respite stay; therefore residents and/or their families were primarily responsible

for the management of healthcare related issues. However, there was clear evidence available to the inspector that staff had systems in place to ensure that residents were adequately and appropriately supported to maintain their health and wellbeing while in the centre.

Prior to admission and on each subsequent admission to the centre the inspector saw that staff collated and updated all relevant healthcare related information. Staff said that residents retained access to their own general practitioner (GP) who staff contacted for advice should any query or concern arise. Staff were also seen to have contacted the out-of-hours medical service and made referrals as necessary to the local acute hospital facility which was conveniently located to the centre. Staff said that if a resident had a scheduled appointment during their respite stay this was facilitated with staff support.

Based on the assessed needs of residents staff had healthcare specific support plans in place for residents. Those seen by the inspector were detailed and provided clear guidance for staff on the required supports for example for the management of diabetes or seizure activity. It was evident from records seen that staff supports sought to strike a reasonable and safe balance between resident independence, choice and maintenance of general well-being.

Where a resident's needs altered or increased it was clear from staff spoken with and records seen that a planned multi-disciplinary approach was taken to ensure that further admissions were planned, additional supports were identified as were actions required to ensure that the centre could safely meet residents needs. For example staff had recently undertaken education and training in PEG feeding (a procedure where nutrition, fluids and/or medications can be put directly into the stomach when it is not possible to do so by mouth) and were aware of and had discussed as a team the recent safety alert issued by HIQA on this procedure.

Nursing input as required was accessed from the local community.

There were policies and procedures on the management of illness that developed while on respite. It was a requirement stipulated in the statement of purpose and function that residents had to be physically well on admission and may be discharged in the event of illness. The inspector review the policy and procedure in this regard as was satisfied that there was a clear decision making framework for such events to ensure that discharges if necessary were planned and safe and that the required supports were in place for the resident if they were to return home.

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):

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

Findings:

There were organisational and local policies and procedures underpinning the management of medicines; staff clearly described these procedures.

The procedures for the management of medicines varied and reflected whether residents independently managed their own medicines or were supported by staff. Staff said that the majority of residents independently managed their own medicines when at home and were facilitated to continue to do this while availing of respite. The inspector was satisfied that whether residents were independent or supported there were safe medicines management systems in place.

The inspector saw that medicines were securely stored. Medicines were supplied to the centre in either their original containers or in a compliance aid and were clearly labelled by the issuing pharmacist. Each resident had a prescription record that was reviewed and amended as necessary on each admission. Where staff supported residents they recorded the medication that they administered and this record reflected the instructions of the prescription.

Staff implemented systems for ensuring the safety of medicines management. These included the reconciliation of the prescription with the medicines supplied on each admission, monitoring resident capacity to manage their own medicines and putting supports in place as necessary without limiting resident independence. Any unused or unwanted medicines were returned to the pharmacy following each respite stay. Records were maintained of all medicines management activities.

The person in charge and the team leader independently confirmed that based on the findings of the last inspection the pharmacist had provided education of the use of prescribed medicine used to prevent harmful blood clots from forming or growing larger. Staff spoke of the learning and improved practice following this such as their enhanced knowledge of risks, interactions and adverse effects.

Training records indicated and staff spoken with confirmed that all staff were trained and assessed as competent to administer other specific medicines such as those required as an emergency intervention in the management of seizure activity. Residents were seen to have medicines management plans specific to the administration of these medicines.

There was a system for identifying, recording, investigating and learning from any medicines related errors.

Judgment:
Compliant

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 and function was submitted to HIQA prior to the inspection. The statement contained all of the required information and the inspector was satisfied post the inspection that it was an accurate reflection of the centre and the service and support provided to residents.

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):
No actions were required from the previous inspection.

Findings:
There was a clear management structure consisting of the team leader, the person in charge and the regional manager. Staff were clear on their respective roles,

responsibilities and reporting relationships. Based on these inspection findings the inspector was satisfied that the management structure effectively monitored and ensured the adequacy, quality and safety of the services and supports provided to residents.

The person in charge was suitably qualified and experienced and worked full-time. This was the only designated centre that the person in charge was responsible for. The person in charge was responsible for a community based service but was confident that she had the capacity and the supports to effectively manage all of the services within her remit. These inspection findings would support this and there was clear evidence that the person in charge was engaged in the governance, operational management and administration of the service on a regular and consistent basis.

On a day to day basis the person in charge was supported by the team leader. The team leader was appointed to this role in December 2015, was suitably qualified for the role and had previously worked as a front-line support worker. The team leader was clear on her role and duties, readily answered queries and retrieved any requested information. Both the person in charge and the team leader had a sound knowledge of each resident and their required supports and articulated a positive attitude to regulation.

The person in charge told the inspector that she had ready access to the regional manager, her line manager as required and they also met formally once a week. The team leader confirmed that she had ready access to the person in charge. The person in charge said that either she herself or the team leader were in the centre when it was operational and they always met each Friday for a formal review of the service.

Centre based team meetings were held every six to eight weeks and the agenda for these were open to staff. This ensured that staff had an opportunity to raise and discuss any issues they may have had as to the quality and safety of the services that they delivered.

The provider operated a formal system of supervision for all grades of staff.

The provider had arrangements for the annual review and the unannounced visits to the centre as required by Regulation 23 (1) (d) and (2). The report from the most recent unannounced review undertaken on the 13 June 2016 was issued in a timely manner and was available for review by the inspector. This report indicated that a satisfactory level of compliance was evidenced and this would concur with the findings of this HIQA inspection.

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:

Based on the information available to the inspector there was evidence that staffing numbers and arrangements were based on the number of and the needs of the residents accommodated during each period of respite. For example the person in charge said that some resident's needs were adequately met by a sleepover staffing arrangement where as at times, dependent on need this reverted to one sleepover and one waking staff member. Staffing numbers increased as resident occupancy numbers increased. The person in charge was clear that all supports were based on assessed needs as it was important to maintain resident ability and independence for when they were discharged home.

Relief staff were employed but these staff worked only in the provider's local services and were therefore familiar with the service and the residents. Residents spoken with confirmed the continuity of staff and how this was important to them, to have staff that were so familiar with them and their needs.

Staff files were available for the purpose of inspection. Those reviewed were well presented and contained all of the information required by Schedule 2.

Staff training records for all staff including staff working on a relief basis were maintained. Staff attendance at training was monitored and the person in charge and the team leader were aware of a gap in staff training and told the inspector that the required training was scheduled. Apart from this gap the training records indicated that staff had attended mandatory training within the specified timeframes. Further training completed reflected the needs of the residents and the services provided and included medication management, occupational first aid, hand hygiene and infection prevention and control, the management of diabetes, understanding acquired brain injury, epilepsy awareness and responding to mental health crisis. In addition the staff files seen contained documentary evidence of relevant core qualifications including social care and disability studies.

Judgment:

Compliant

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):

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

Findings:

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. All records seen were well maintained and required information was retrieved with ease by the inspector.

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

The inspector reviewed the suite of policies 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). All of the required policies were in place and their review date indicated that the majority had been reviewed within the past three years as required by Regulation 4 (3). However, there was no evidence that one policy the policy on the use of restrictive practice had been reviewed since 2010.

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002663
Date of Inspection:	15 June 2016
Date of response:	1 July 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 08: Safeguarding and Safety

Theme: Safe Services

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

At the time of the inspection one staff member had not attended safeguarding training.

1. 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

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

response to abuse.

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

Staff member is scheduled to complete Safeguarding Vulnerable Training on 18th July 2016.

Proposed Timescale: 18/07/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

There was no evidence that one policy the policy on the use of restrictive practice had been reviewed since 2010.

2. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

This policy has been formally reviewed, re written in new template and is being reviewed by three nominated persons from our multidisciplinary team. It is due to issue in July 2016.

Proposed Timescale: 30/07/2016