Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0002671</td>
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<tr>
<td><strong>Centre county:</strong></td>
<td>Louth</td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td><strong>Registered provider:</strong></td>
<td>RehabCare</td>
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<td><strong>Provider Nominee:</strong></td>
<td>Michael O'Connor</td>
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<td><strong>Lead inspector:</strong></td>
<td>Julie Pryce</td>
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<td><strong>Support inspector(s):</strong></td>
<td>None</td>
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<td><strong>Type of inspection</strong></td>
<td>Unannounced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</td>
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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.
This unannounced inspection was carried out to monitor compliance with the regulations and standards and to inform a registration decision.

As part of the inspection, the inspector spoke to four residents. Residents said that they were happy in their home, and were eager to show their rooms to the inspector. The inspector observed that the residents appeared to be comfortable and content in their home, and that they had a good relationship with each other.

The inspector also met with staff members, observed practices and reviewed documentation such as personal plans, risk assessments, policies and procedures. Interviews were conducted with the person in charge and with staff members.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors found that the service was being provided as it was described in that document.

The centre was a residential service for adults with disabilities, and was a large, spacious, detached five bedroom house in a quiet estate close to local amenities and public transport.
Overall, inspectors found that residents had a good quality of life in the centre and the provider had arrangements to promote the rights of residents and the safety of residents.

Good practice was identified in areas such as:
- residents had detailed personal plans and were facilitated to engage in meaningful activities (Outcome 5)
- the management of risk (Outcome 7)
- staff were available to provide appropriate care and support for residents (Outcome 17)

The inspector found that some improvements were required as follows:
- guidance for staff administering ‘as required’ (PRN) medications (Outcome 12)
- the development and review of policies and procedures (Outcome 18)

The reasons for these findings are explained under each Outcome in the report and the regulations that are not being met are included in the Action Plan at the end.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
There was evidence of appropriate steps having been taken to provide a meaningful day for residents, and all residents had a personal plan in place.

Each personal plan began with a consent form signed by the resident in relation to who could have access to their personal plans, and this included permission for HIQA inspectors to view the plans.

Personal plans were well laid out with a clear index, and began with a service user profile containing the important information about each resident. There was a detailed and thorough supports summary, and in relation to a resident who had recently been admitted this was completed within three days of the admission. Where more information was required there was, in addition, a more detailed care plan, for example in the areas of mental health and medication management.

There was a clear record of regular reviews of each section, and regular reports on progress. In addition daily records were kept for each resident, which referred directly to the relevant section of the personal plan.

Person centred planning meetings were held on an annual basis, or more frequently if required. For example an extra meeting was held in relation to resident who had suffered a bereavement.

Goals were set with residents, and there was clear evidence of their choice as to which goals they would work towards. Goals were broken down into smaller steps to aid
achievement, for example, a resident who would like to take responsibility for their own medication had that goal broken down into smaller steps, and progress on each of these steps was recorded.

Personal plans were accessible to residents who could all read, and were written in language that they could understand.

The inspector was satisfied that residents were facilitated to engage in a variety of activities, both during the day and during their leisure time.

Residents attended various day services in accordance with their assessed needs, for example one resident attended a service provided specifically for elderly people. One of the residents had achieved a certificate in computer literacy.

Various activities took place in leisure time, including flower arranging and art. Some of the residents’ artwork was hung on the walls in the home. Other activities included trips to the local pub, meals out and day trips at the weekends.

**Judgment:**
Compliant

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

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

**Theme:**
Effective Services

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

**Findings:**
The inspector found that there were systems and processes in place for the management of risk and in the prevention and detection of fire, and that minor improvement was required in the storage of cleaning equipment.

All staff and residents had received fire safety training and fire drills had been conducted every three months. Records of fire drills included a description of the drill including the time taken by each individual resident to evacuate. There was a personal evacuation plan in place for each resident, with the exception of the resident who had been recently admitted. The person in charge had put this in place prior to the close of the inspection. All fire safety equipment, including emergency lighting had been tested quarterly. Daily checks were maintained of fire exits. Staff were aware of the fire evacuation plans and were able to describe the procedures involved. Residents were able to describe to the inspector what they would do in the event of an emergency.
There were structures and processes in place in relation to the management of risk. There were various risk assessments in place including individual risk assessments. For example, there were risk assessments in place in relation to independent medication management, being in the house alone or getting 'lost'. A risk assessment and management plan was in place in relation to lone working.

Residents had a holiday last year and a detailed risk assessment had been developed to mitigate any risks associated with it.

A risk register was maintained in which all risks were rated. Any red rated risks were referred immediately to either the regional manager or the clinical risk specialist, and to the health and safety officer if appropriate. A risk policy was in place which included all aspects required by the regulations, and addressed both the mitigation and the management of risks.

Accidents and incidents were recorded and addressed either with a case meeting or an action plan. Action plans had been implemented for those reports reviewed by the inspector.

The centre was visibly clean, hand hygiene facilities were available and there was a hand wash basin in the utility room.

**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
The provider had put in place systems to promote the safeguarding of residents and to protect them from the risk of abuse, although some improvements were required in the policies available to guide staff.

The inspector found that staff were knowledgeable in relation to types of abuse, recognising signs of abuse and their role in the safeguarding of residents. All staff
members had received training in the protection of vulnerable adults. However the policy on the protection of vulnerable adults had not been reviewed since January 2013, and did not reflect current national policy. The required action in relation to this issue is under Outcome 18.

There were robust systems in place relating to the safe management of residents’ finances. All transactions were recorded and signed by both a staff member and the resident. Each resident had their own bank account and were supported to manage these themselves.

While none of the residents had been identified as currently requiring behaviour support, where previous behavioural issues had arisen this had resulted in a case conference and action plan, and the implementation of this was recorded. If any further behavioural issues were to arise the centre has access to a behaviour specialist.

While there were currently no restrictive practices in place in the centre, the policy in place to guide staff if the need arose was out of date as it had last been reviewed in November 2010 and did not reflect best practice. The action relating to this issue is also under Outcome 18.

**Judgment:**
Compliant

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### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

**Findings:**
There was evidence of a nutritional diet being provided for residents, and of healthcare needs being addressed.

Snacks and drinks were readily available and choices were clearly documented in each resident’s daily notes under the heading of ‘Nutrition’. Likes and dislikes were recorded as were any dietary requirements. A weekly shop was done by the residents in which their choices were facilitated. There was often a Sunday roast, and occasional takeaway meals.

Records were kept of dietary intake, and monthly weights were taken and recorded.
Residents had access to members of the multi-disciplinary team in accordance with their assessed needs. For example community occupational therapist and speech and language therapist. Each resident had a community general practitioner (GP), and there was an out-of-hours service available. Records were kept of each appointment with the GP, either by the GP themselves or by the accompanying staff member.

There was a clear record of the actions taken in relation to a recent healthcare issue which arose unexpectedly, and follow up actions were appropriately recorded.

**Judgment:**
Compliant

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**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
There was evidence of some structures and processes in place in relation to the safe management of medications. However improvements were required in the guidance for staff in making decisions about the administration of ‘as required’ (PRN) medications and in the policy guiding practice in relation to medication management.

Each resident had a self medication assessment completed in order to assist their independence. One resident managed their medications independently, but others had chosen to continue to be supported by staff.

Medications were stored securely and stock checks were conducted regularly. Stock checked by the inspector was correct. Practice in relation to administration of medications was observed by the inspector and found to be of a high standard.

Documentation relating to the management of regular medications for residents was in place. Prescriptions for these medications contained all the information required by the regulations. However there was no guidance for staff to inform the decision making around ‘as required’ (PRN) medications, and no maximum doses indicated. This included prescriptions where more than one medication contained paracetamol.

All staff had received training in the safe administration of medications, and there was a centre specific policy in place in sufficient detail as to guide staff. Medication errors were managed by the accident and incident reporting process, and referred to the clinical risk specialist.
There was a practice in place whereby the staff transcribed prescriptions onto kardexes from which medications were administered, but there was no guidance in the medication management policy on this practice. The action relating to this issue is under Outcome 18.

**Judgment:**
Non Compliant - Moderate

### 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):
This was the centre’s first inspection by the Authority.

### Findings:
There was a clear management structure in place, and all staff were aware of this structure. However there was no annual review of the quality and safety of care and support.

Regular staff meetings were held and minutes were kept of these meetings. All required actions reviewed by the inspector had been implemented. There were also regional meetings of the community service managers.

There were some audits in place, for example a health and safety audit, a fire safety audit and an audit of finances. However, systems had not been put in place to ensure that some medication management practices were safe. There had been no audit or safety review of medication management, and the inspector was concerned that this was why the issues relating to PRN medications discussed under Outcome 12 had not been identified and addressed.

There had been six monthly unannounced visits on behalf of the provider as required by the regulations, and any identified actions reviewed by the inspector had been implemented. However there was no annual review of the quality and safety of care and support as required by the regulations.

The person in charge of the centre was appropriately qualified, skilled and experienced and was a regular presence in the centre. She had evidence of continuing professional
development, and was aware of her responsibilities under the regulations. In addition she had engaged in practice development with staff, for example in relation to report writing and in the development of person centred plans.

**Judgment:**
Non Compliant - Moderate

### Outcome 17: Workforce

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

**Theme:**
Responsive Workforce

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

**Findings:**
The current staffing levels and skills mix were appropriate to the needs of residents, including both healthcare needs and social needs. All staff working in the centre were familiar to the residents. While the house was unoccupied during the day when residents were out, additional staff were available if someone was unwell or chose to stay at home.

Staff engaged by the inspector were knowledgeable about the individual care needs of each resident and interactions observed by the inspector between residents and staff were appropriate to the assessed needs of the residents, and appeared to be both respectful and caring.

Staff training was up to date, and in addition to mandatory training, further courses in personal planning and epilepsy awareness had been offered.

There was system of performance management for staff including a six to eight weekly supervision meeting.

**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):
This was the centre’s first inspection by the Authority.

Findings:
Various policies reviewed by the inspector were out of date. In addition to those discussed under Outcomes 8 and 12, the policies on infection control, behaviour support, administration of medications, provision of intimate care and the management of a missing resident were also out of date.

In addition, the policy in relation to restrictive practices had not been reviewed within three years. The policy in relation to the protection of vulnerable adults did not reflect national policy and the policy in relation to medication management did not provide any guidance on the practice of staff transcribing prescriptions.

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:

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

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<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002671</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>30 March 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21 June 2016</td>
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Requirements

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

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

Outcome 12. Medication Management

**Theme:** Health and Development

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

There was insufficient guidance to ensure the safe administration of PRN medications.

1. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
1. The prescriber will advise what the maximum dosage of PRN medications is in 24 hours.
2. The resident’s medication management plan will be updated detailing what the maximum dosage is within 24 hours.
3. The pharmacy will also advise staff regarding the maximum dosage.
4. The local medication procedure will be informed by the above.
5. Staff transcribing medication onto Kardex’s has now ceased and is completed by the GP or pharmacist only.

Proposed Timescale: 30/06/2016

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:
Systems had not been put in place to ensure that medication management procedures were safe.

2. 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:
1. Manager and team leader will carry out monthly audits of medication to ensure medication is monitored.
2. Medication incidents are reviewed at team meetings and by the organisations Chief Risk Officer and the Regional Manager.
3. Should a concern arise following a review of an incident an audit by a staff member external to the service will be conducted.

Proposed Timescale: 14/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care and support.

3. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for
consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
A process to review the quality and safety of services on annual basis is currently being developed by the central Quality & Governance Directorate for deployment in all services. As part of this process a draft report for this service has been prepared. The report will be reviewed and signed off by the PIC, Regional Manager & Provider Nominee.

Proposed Timescale: 31/07/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy in relation to restrictive practices had not been reviewed within three years.

The policy in relation to the protection of vulnerable adults did not reflect national policy.

The policy in relation to medication management did not provide any guidance on the practice of staff transcribing prescriptions.

Several of the required policies were out of date.

4. 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:
The revised Restrictive Practice Policy has been drafted and currently in a short consultation phase. The revised policy will be circulated to services and come into effect by August 1st.

The practice of staff transcribing prescriptions is not provided for within organisational policy, this practice has been discontinued within the service, GPs or Pharmacist now fulfil this requirement.

Currently a new Protection of Vulnerable Adults Policy has been drafted and the organisation has appointed a National Lead for the policy implementation. The person appointed is a Social Worker by background and very experienced in the area of protection of vulnerable adults.

On the day of the inspection the most up to date versions of the organisation’s policies in respect of the following areas were not available in the service:
Subsequent to the inspection these policies have been made available in the service, discussed with staff to ensure current practice within the service is in line with organisational policy. Staff have signed off to indicate that they have read and understood them.

Review of the following policies will now commence
• Personal Care Policy (RC) V3 HSC-SEU-002, Issue Date November 2012
• Infection Control V3 HSC-OPS-001, Issue Date January 2012

In addition the organisation is undertaking a review of all Schedule 5 Policies to be completed by the end of 2016.

**Proposed Timescale:** 31/12/2016