<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Nenagh Residential Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003420</td>
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<td>Centre county:</td>
<td>Tipperary</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>RehabCare</td>
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<tr>
<td>Provider Nominee:</td>
<td>Rachael Thurlby</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
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<tr>
<td>Number of vacancies on the date of inspection:</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.
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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>26 July 2016 09:30</td>
<td>26 July 2016 16:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td>Outcome 06: Safe and suitable premises</td>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

Background to the inspection:
This inspection was the second inspection of the centre by the Heath Information and Quality Authority (HIQA) and was undertaken following an application by the provider to vary one of its conditions of registration. The provider had applied to increase the number of residents that could live in the centre from four to five.

The previous inspection was undertaken in November 2015 to inform the decision to register the centre. Those inspection findings were satisfactory and of the full 18 Outcomes inspected the provider was judged to be in compliance with 13, in substantial compliance with two and in moderate non-compliance with the remaining three due to failings in the management of complaints, fire safety measures and medicines management practice.

How we gathered our evidence:
The inspector prior to the inspection reviewed information submitted to HIQA; this included the revised statement of purpose and function and the transition plan for the proposed new resident.
The inspection was facilitated by the person in charge and the team leader. The acting area manager was also available to staff and to the inspector. The inspector reviewed and discussed records including fire and health and safety records, records of meetings, records as they pertained to the supports provided to residents, complaint records and staff related records. The inspector reviewed the premises in the context of the proposed increase in occupancy and discussed the transition plan with the person in charge.

The inspector met and spoke briefly with three of the residents at the start of the inspection and before they left the centre for their day service. Residents welcomed the inspector in to their home; residents looked well and were content and eager to leave for the day service. There was lively and respectful banter between residents and staff in relation to the role of the inspector.

DESCRIPTION OF THE SERVICE:
In this centre residential services were provided to four adult residents. The premises was a spacious, two-storey domestic type building located in a residential area within a short commute of all local facilities. The premises were of a high standard, well-maintained, homely and welcoming in presentation.

The inspector was satisfied that the service provided was as stated in the document called the statement of purpose as while all residents required staff support there was evidence of improved outcomes for residents in areas such as daily functioning, independence and social integration.

Overall findings:
The inspector was again satisfied that the residents and the achievement of positive outcomes for them and with them was the focus of the service. This was clear on meeting with residents, speaking with staff and from records seen.

Action had been taken to address the failings identified at the time of the last inspection. Some such as in medicines management, planning and recording healthcare supports and ensuring consistent supports for residents had been addressed. Some however were not satisfactorily addressed and/or not clearly evidenced, for example facilitating residents to exercise their vote, the recording of complaints and demonstrating that the review of the support plan was multi-disciplinary.

While there were regular and consistent systems of consultation and review it was not always evidenced that the progress of agreed actions was followed up on, for example at staff and resident meetings. There had been some fluctuation to the management structure as the person in charge had been on leave. The person in charge told the inspector that this may have contributed to the lack of evidence to support actions taken and reassured the inspector that outstanding matters would be addressed.

However, overall and on balance the inspector was satisfied having triangulated evidence and records that residents were appropriately supported to keep well and enjoy full and engaging lives.
It was clear that residents were given choice and control and consulted on matters of relevance to their home.

The premises did afford sufficient private and communal space to accommodate an additional resident; it would not however, have sufficient designated facilities to accommodate two sleepover staff which was the normal staffing arrangement in the centre.

It was made clear to the person in charge that any arrangements put in place to accommodate staff sleepover duties could not impinge on the space available to residents, residents routines or their privacy and dignity, for example any use of communal space.

Of the 11 Outcomes inspected the provider was judged to be compliant with six and in substantial compliance with four. One moderate non compliance was identified in relation to evidencing the progress of actions on the management of complaints, facilitating residents to exercise their vote where they expressed an interest to, and providing reassurance to the Chief Inspector that further to any increase in occupancy, any arrangements put in place to accommodate staff sleepover duties would not impinge on the space available to residents, residents routines or their privacy and dignity.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector observed that residents were relaxed in their environment and with staff. The inspector saw from records reviewed such as support plans, daily narrative notes and records of the weekly house meetings that residents were consulted with on matters relevant to them and their home and exercised a good level of choice and control over their routines. Staffing levels ensured that residents were facilitated to make differing choices such as staying in or going out.

Formal weekly house meetings were held. Minutes indicated that staff consulted with and planned the weekly menu and activities with residents. Staff recorded how they included and consulted with residents who choose not to attend the meeting. The team leader said that once a month a more substantive issue such as safeguarding was also discussed with residents. This was reflected in the minutes seen with evidence that safeguarding, fire safety, making a complaint and inspections by HIQA were discussed by staff with residents. As appropriate to resident's needs staff used social stories as an assistive communication tool in these discussions.

However, while a template was available to track and monitor any actions emanating from these meetings this was not evidenced. For example at the time of the last inspection staff confirmed that the issue of voting had not been discussed or explored with residents so as to ascertain their understanding or interest in exercising their vote. The inspector saw that this was discussed with residents (as committed to in the provider’s response to the action plan) during the meeting of 10 January 2016; it was recorded that two residents had expressed an interest in exercising their vote. However,
there was no evidence of action required or taken to progress this, for example establishing if the residents were on the electoral register.

Each resident had their own bedroom. Bedrooms and bathrooms were fitted with privacy locks. Records completed by staff were respectful in content, tone and the language used.

Staff said and there was documentary evidence that there were no risks and no restrictions on family or friends visiting the centre and family made both announced and unannounced visits. Where relevant other residents were consulted with in relation to planned visits as the house was seen as home to all residents. Ongoing contact and visits home by residents were facilitated, at times on a weekly basis.

Staff confirmed that religious observance was as per each resident’s choice.

An information booklet on how to make a complaint and what to do if the complainant was dissatisfied with the management of a complaint was available in the front hall. There was also a complaints/suggestion box in the front hall. Based on the findings of the last inspection a complaints log had been implemented. The inspector reviewed this log and saw that four separate issues were recorded by staff. The complainant, the nature of the complaint and the action taken was recorded. There was collaborative evidence particularly in resident support plans of actions to be taken to prevent a reoccurrence. However, from the complaint record itself there was no evidence of comprehensive investigation, that complainant satisfaction was established or of follow-up where necessary particularly where there was a pattern to the complaints. These inspection findings were reflected in the findings of the provider’s own review of the service undertaken on 27 May 2016.

Judgment:
Non Compliant - Moderate

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The arrangements in place to support residents were outlined in each resident’s personal plan. The information relayed to the inspector by staff at the start of the inspection concurred with the content of the personal plan.

The inspector saw that the support plan was based on an initial assessment of needs and a review of these needs on an annual basis. In addition there was documentary evidence of further regular and ongoing review of needs and supports through key-working meetings and reviews led by the team leader.

There was a clear process for supporting residents in the achievement of personal goals and objectives. The identified goals reflected a focus on personal interests, learning new skills, enhancing independence, social skills and social integration. An example of goals identified and agreed with residents included attending sporting fixtures, participating in sports, volunteering, cooking classes and going on holidays. Actions to be taken, responsible persons and timeframes were identified. There was photographic evidence of the achievement of goals.

It was clear from speaking with staff and from records seen that staff took actions that supported success rather than failure such as sourcing the location most appropriate to the resident’s needs and abilities. Residents, and as appropriate family members, participated in the planning process and these meetings were recorded. There was evidence of a collaborative approach in progressing goals between the residential and day service. The agreed goals and their progression were also reflected in the minutes of the house meetings.

Each resident attended the day service Monday to Friday and the person in charge said that the programmes participated in were matched to residents strengths, abilities and interests. The inspector saw that residents engaged in sports including football and golf, Olympic Games participation, swimming and arts and crafts.

Staff did record how they consulted with each resident and how the resident participated in the preparation and review of the plan. However, given the ability of some residents it was reasonable to conclude that the evidence of this could have been stronger.

Staff confirmed that the plan was not available to the resident in a format that was accessible and meaningful to them and this had not been progressed as recommended at the time of the last inspection.

At the time of the last inspection some residents were in receipt of supports from other service providers such as day services and multidisciplinary (MDT) supports. Based on records seen and staff spoken with at that time there was some reported inconsistency between services and staff expressed concern as to the impact on residents such as frequently changing day services. This matter had been addressed and staff reported positive outcomes for residents such as reduced daily travel times, reduced incidents of challenging behaviour and good participation in activity programmes.

However, while there was evidence that each support plan was the subject of regular
review and that residents had access as appropriate to their needs to multi-disciplinary supports, there was no clear evidence that the review of the support plan was multidisciplinary.

**Judgment:**  
Substantially Compliant

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**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

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**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
The premises was a spacious, two-storey domestic type building located in a residential area within a short commute of all local facilities. The premises were of a high standard, well-maintained, homely and welcoming in presentation. The inspector was satisfied that it met regulatory requirements and was suited to its stated purpose and could accommodate an additional resident.

The premises were visibly clean, comfortably heated, lighted and ventilated.

All resident private accommodation was on the first floor but the additional identified room to be used as a resident bedroom was on the ground floor. This room had functioned as a staff office/staff sleepover room. The inspector saw that this room was serviced by natural light, offered sufficient space including space for person possessions and was conveniently located to two sanitary facilities.

Rooms already occupied by residents were personalised and reflected individual resident’s interests and personalities.

Two residents’ bedrooms offered en suite sanitary facilities. In addition there was a fully equipped bathroom on both the first floor and ground floor both with bath and shower; there was an additional toilet on the ground floor.

Residents had access to one communal area but this was spacious and comfortable and allowed for differing activities.

The kitchen and dining area were combined. The kitchen was fitted to a high standard and adequately equipped. The dining area offered space for dining and some additional
recreational seating.

Adequate provision was made for storage.

Facilities were in place for the laundering of resident’s personal clothing.

Residents had access to a compact but attractive garden. The garden contained a swing seat that one resident reported enjoyment of.

There was an additional bedroom on the first floor used by staff on sleepover duty. This room was compact and the person in charge confirmed that this bedroom was not to be used to provide private resident accommodation due to its size. However, once this room on the ground floor was reassigned as a resident’s bedroom, the premises would not have sufficient designated facilities to accommodate two sleepover staff which was the current staffing arrangement in the centre.

It was made clear to the person in charge that any arrangements put in place to accommodate staff sleepover duties could not impinge on the space available to residents, residents routines or their privacy and dignity, for example any use of communal space. The person in charge confirmed that this was clearly understood.

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:
There were measures in place to promote and protect the health and safety of residents, staff and others. These measures included 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.

There was a local risk management folder; this included a suite of generic risk assessments, the risks as specifically required by Regulation 26 (1) (c) as well as risks specific to the centre and as they applied to individual residents. The risk assessments seen set out the controls in place and responsible persons for their implementation. The
inspector saw that risk assessments as they pertained to supporting individual residents reflected their needs as outlined in their support plan, were reviewed by the person in charge in May 2016 and sign by all staff working in the centre as read and understood post their review.

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.

Fire safety measures including emergency lighting and an automated fire detection system were in place. However, the inspector saw that the action that had emanated from the last inspection in relation to the clarity of designated escape routes had not been correctly understood and implemented. This was brought to the attention of the person in charge and the team leader and measures were taken to address this there and then. Prior to the conclusion of this inspection the inspector saw that this matter was addressed. The fire evacuation plan had been redrafted to indicate that three escape routes were available, proprietary signage was obtained and put in place to clearly indicate that there were three designated escape routes and that these were clear of any obstruction. The person in charge and team leader confirmed that simulated fire drills would alternate the escape route used.

Fire related records were maintained in the fire fact file. The inspector saw certificates confirming that the fire detection and fire fighting equipment and the emergency lighting were inspected and tested at the prescribed intervals and most recently in May 2016, August 2015 and June 2016 respectively. Staff maintained records of the in-house inspection of escape routes and fire safety equipment.

Training records indicated that staff were provided with fire safety training on an annual basis and most recently in September 2015. The person in charge said that she monitored staff attendance at training and both she and the team leader had attended due fire safety training in July 2016.

Each resident had a personal emergency evacuation plan (PEEP) that outlined their level of awareness and any staff assistance required; residents had also in April 2015 participated in fire safety training.

Simulated fire drills were convened on a quarterly basis and incorporated a night time drill at least on an annual basis. The inspector saw that good and adequate evacuation times were recorded as achieved.

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 and staff training.

The person in charge confirmed that there had been no incident of alleged, suspected or reported abuse in the centre. Records seen supported that staff were attuned to resident’s concerns and worries and any altered patterns of behaviours and discussed these and any actions required to support residents.

Residents were seen to be supported through the house meetings and their person centred plan to develop their personal safety awareness and skills. Risk assessments that supported independence and safeguarding were seen in resident’s personal plans. The person in charge said that she was hoping to pilot a safeguarding programme recently used with residents in another service.

Each resident had a personal/intimate care plan, these reflected balance between risk and resident choice and independence.

Training records indicated that all staff had attended refresher training on safeguarding since the last inspection and training on responding to behaviours that challenged in 2015.

Residents did have a history of behaviours that had the potential to challenge themselves, other residents and staff. Staff reported and there was documentary evidence to support the therapeutic, evidence based management of behaviours that challenged. The provider’s policies promoted a therapeutic response and the use of restrictive interventions only as a last resort; this was evidenced in practice.

There were no reported restrictive practices; authorisation that had been in place for the use of a physical restrictive hold was signed as discontinued in November 2015. There was no evidence of the prescription and use of p.r.n (as required) medicines as an adjunct to the management of behaviours.
Behaviour management guidelines/plans were in place as appropriate and these were supported by local behaviour management protocols. The behaviour management guidelines had been reviewed by the behaviour therapist in April 2016 and were signed off as read by staff following this review.

There was evidence that at times residents did exhibit behaviours that challenged others. The response recorded was therapeutic and in line with the management plan. Residents had ongoing access as necessary to support from the multi-disciplinary team.

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

**Findings:**
Staff spoken with had a sound knowledge of resident’s healthcare requirements and improvement was noted in the incorporation of these needs into the residents support plan. All of the residents required staff and/or family support and guidance to maintain health and well-being.

Records seen indicated that staff monitored resident well-being and supported residents to access regular and timely medical review and treatment with their general practitioner (GP). As appropriate to their needs there was evidence that residents had access to other healthcare services including chiropody, dental care, psychiatry, behaviour support and specialist medical/surgical intervention as appropriate to individual needs.

There was evidence of communication and correspondence between staff and families on healthcare related matters.

There was evidence that staff encouraged and supported residents to make healthy lifestyle choices: these included managing portion sizes, food choices, exercise and diet. Staff recorded and monitored resident body weight on a monthly basis.

Overall and on balance their was consistent documentary evidence that staff supported residents to maintain their health and well-being, staff were attuned to changes and possible symptoms of illness and these were outlined in the support plan, for example how a resident may indicate pain or a recurring infection. Records of reviews and
recommendations were in place and there was evidence in practice of prescribed interventions and amended medicines regimes.

However, there was no evidence that one recent request for the monitoring of blood pressure levels had been facilitated.

**Judgment:**
Substantially 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were policies and procedures in place governing the management of medications.

No resident was self-managing their medications but each resident had been assessed as to their capacity, ability and willingness to self-administer safely. Each resident had a medication management plan that set out the rationale for and administration guidance for each prescribed medication including medications prescribed on a p.r.n (as required) basis. The plans seen reflected recent changes in prescribed medicines.

Medications were supplied to the centre by a community pharmacist in a compliance aid. Each resident had a current medication prescription record and an administration record. A staff signature sheet was maintained and staff signed for each individual medication administered. Training records indicated that staff had attended medicines management training and the team leader confirmed that he had completed recent medicines management assessor training.

Staff had systems in place for monitoring the accuracy of medications supplied and administered. These included the checking of medications when they were delivered, when they were transported such as for home leave, and routine daily checks of stock balances.

The storage of medicines had been reviewed since the last inspection and the team leader demonstrated the system in place, how access to the keys was restricted and there was nothing other than medicines stored in the secure facility.

The inspector saw that medicines were clearly labelled and supplied for individual resident use.
There were policies and procedures on the management of medication errors. Staff reported a decreased incidence of medicines management errors since the last inspection; there were two recorded errors. The person in charge said she monitored errors and took corrective action as necessary including the requirement of staff to attend refresher medicines management training.

However, the inspector noted that the maximum daily dosage of medicines administered on a p.r.n (as required) basis was not stated.

The inspector also found that all medicines discontinued or rewritten by the prescriber were not signed and dated as discontinued and staff had followed the instructions of the older prescription. This had not led to a medicines error; the prescription though rewritten was unaltered.

**Judgment:**
Substantially Compliant

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**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 with the application to vary the condition of registration.

The statement contained all of the required information, reflected the proposed increase in resident occupancy and the inspector was satisfied that it was an accurate description of the centre and the services provided.

**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 in place consisting of the team leader, the person in charge and the acting regional manager. All spoken with were clear on their respective roles, responsibilities and reporting relationships and regulatory requirements. All persons participating in the management of the service demonstrated accountability for the service and the residents, a commitment to regulatory compliance and positive outcomes for residents.

The person in charge worked full-time and was responsible for three services; this and another designated centre and the day service. The person in charge had established experience in this role since 2008 and was confident that she had the capacity and supports to ensure the effective governance of all three centres. Inspection findings to date would overall and on balance support this. The overall governance structures were recently enhanced by the appointment of a team leader to the other designated centre. The person in charge held relevant qualifications in social care, behaviour support and health services management.

The person in charge was based in the day service; all residents attended the day service each day and had direct access to the person in charge. The person in charge said that she also called to the house on a daily basis and as necessary.

On a day to day basis the operational management of the centre was co-ordinated by the team leader. The team leader worked evening and weekend shifts when residents and staff were both present. The team leader confirmed that the person in charge was always accessible and supportive, provided clear direction and had systems in place to ensure the quality and consistency of the supports provided to residents.

The person in charge said that she had access as required to the acting regional manager and that the nominated provider continued to provide practical guidance to staff.

Staff confirmed that there was an on call out of hour’s manager available within the wider organisation and the rota was readily available to staff.
There were processes in place through the monthly staff meetings and the formal staff supervision system that facilitated staff to raise their observations and concerns. The inspector reviewed a sample of staff meeting records and saw that they were well attended and there was constructive discussion and review of residents, their changing needs and any other matters such as any accidents and incidents.

There was evidence from records seen that on an ongoing basis the quality and safety of the care and services provided to residents was monitored through consultation with residents, the review of support plans, staff meetings and the monitoring of incidents and accidents. Arrangements were also in place for the completion of the annual review and the unannounced visits to the centre as required by Regulation 23 (1) and (2). This process involved consultation with residents and representatives.

Reports were available for inspection and the inspector reviewed the report from the most recent unannounced provider review undertaken on 27 May 2016. This unannounced review measured compliance with ten of the Outcomes utilised by HIQA and overall indicated a high level of compliance with the requirements of the audit process. Where deficits were identified these were predominately of a documentary nature and the failure to evidence actions taken as opposed to deficits in the quality and safety of care and supports to residents and this would concur with the findings of this HIQA inspection.

**Judgment:**
Compliant

**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:**
The provider was aware of and had exercised its responsibility to notify the Chief Inspector of any planned absence of the person in charge and of the arrangements in place for the management of the centre in her absence.

As discussed above in Outcome 14 the person in charge and the management of the centre was supported by the team leader.
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:
There was a planned and actual staff rota that was managed by the team leader. The person in charge told the inspector that there was no planned increase in staffing numbers once the number of residents increased from four to five and that this was based on an assessment of needs, required and available supports. However, the person in charge confirmed that staffing arrangements would be managed during the period of transition so that four staff were present in the house when all residents were present and night-time staffing would convert to one waking and one sleepover staff. This was possible from the existing staff cohort but the person in charge confirmed that if following transition a need for additional staff was identified this would be put in place.

The occupancy of the house did fluctuate due to residents going home, at times on a weekly basis. The inspector reviewed the staff rota and saw that staff numbers and arrangements reflected what the inspector was told; there was a minimum of three staff and at times four staff on duty when residents were present in the house. The use of relief staff was planned and managed so as to ensure that deficits were managed but in a way that minimised change and ensured consistency for residents.

Staff files were available for the purpose of inspection. The inspector reviewed a random sample and found that one file did not contain photographic evidence of the person’s identity or documentary evidence of relevant qualifications and training.

Records were maintained of each staff member’s attendance at training; the person in charge said that she monitored attendance. These records indicated that staff had attended mandatory training in fire safety, safeguarding, manual handling and responding to behaviours that challenged. Staff had also completed training in first aid, medicines management, health and safety, person centred planning, food safety, risk management, augmentative communication techniques and supporting persons with mental health problems.
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 report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Nenagh Residential Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003420</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>26 July 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02 September 2016</td>
</tr>
</tbody>
</table>

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:
It was recorded that two residents had expressed an interest in exercising their vote. However, there was no evidence of action required or taken to progress this, for example establishing if the residents were on the electoral register.

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1 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) (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:**
It is confirmed that two service users who choose to vote are on the electoral register, at the next opportunity to exercise their right to vote they will be supported to do so.

The other two service users are currently not registered on electoral register. This is will now be discussed with the service users and their families, and they will be supported accordingly.

**Proposed Timescale:** 30/09/2016
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises would not have sufficient designated facilities to accommodate two sleepover staff which was the current staffing arrangement in the centre. Any arrangements put in place to accommodate staff sleepover duties must not impinge on the space available to residents, residents routines or their privacy and dignity, for example any use of communal space.

2. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
The service will have one night duty and one sleep over staff. Statement of Purpose of Function will be changed to reflect this change.

**Proposed Timescale:** 15/09/2016
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From the complaint record itself there was no evidence of comprehensive investigation, that complainant satisfaction was established or of follow-up where necessary particularly where there was a pattern to the complaints.

3. **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:**
The service will commence the recording of complaints on an online system with immediate effect, which includes a prompt to ensure the complainant is consulted with to establish if they are satisfied with the outcome.

Family review meetings will be scheduled, which will include discussion of the complaints in question.

**Proposed Timescale:** 31/10/2016

**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 clear evidence that the review of the support plan was multidisciplinary.

4. **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:**
Each resident has an annual review meeting, where applicable those professionals providing MDT input will be invited.

On an ongoing basis changes to supports are advised by members of an MDT the resident’s support plans are updated.

**Proposed Timescale:** 31/10/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The plan was not available to the resident in a format that was accessible and meaningful to them and this had not been progressed as recommended at the time of the last inspection.

5. **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:
Alternative format for support plans will be developed for residents who require it and do have the literacy skills to read the current format.

**Proposed Timescale:** 31/10/2016

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did record how they consulted with each resident and how the resident participated in the preparation and review of the plan. However, given the ability of some residents it was reasonable to conclude that the evidence of this could have been stronger.

6. **Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
A meeting will held with service users every six months to formally review their Support Plan, a record of this meeting will be maintained and the plan signed by service users as appropriate.

**Proposed Timescale:** 30/09/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that one recent request for the monitoring of blood pressure levels had been facilitated.

7. **Action Required:**
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
The resident has now been supported to visit the GP and blood pressure has been monitored.

**Proposed Timescale:** 08/08/2016
<table>
<thead>
<tr>
<th>Outcome 12. Medication Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The maximum daily dosage of medicines administered on a p.r.n (as required) basis was not stated.</td>
</tr>
<tr>
<td>All medicines discontinued or rewritten by the prescriber were not signed and dated as discontinued and staff had followed the instructions of the older prescription.</td>
</tr>
<tr>
<td><strong>8. Action Required:</strong></td>
</tr>
<tr>
<td>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 as prescribed to the resident for whom it is prescribed and to no other resident.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>Kardex was updated to include the maximum dosage of PRN medication.</td>
</tr>
<tr>
<td>All old Kardex’s have been removed from the current file, only current Kardex are held in files in line with organisational process and policy.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 26/07/2016</td>
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</table>

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<thead>
<tr>
<th>Outcome 17: Workforce</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Responsive Workforce</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>One staff file did not contain photographic evidence of the person’s identity or documentary evidence of relevant qualifications and training.</td>
</tr>
<tr>
<td><strong>9. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>Staff file has been up dated with ID, qualifications and training records.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 26/08/2016</td>
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</tbody>
</table>