

**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 Kerry Parents and Friends Association
Centre ID:	OSV-0003428
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Kerry Parents and Friends Association
Provider Nominee:	Maura Margaret Crowley
Lead inspector:	Mary Moore
Support inspector(s):	Margaret O'Regan
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 April 2016 09:00	26 April 2016 15:30
27 April 2016 08:30	27 April 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was the first inspection of the centre by the Health Information and Quality Authority (HIQA). In this centre the provider provided residential services and supports to 18 residents with a range of needs both in type and complexity; there was one vacant bedroom in one house.

Inspectors reviewed 10 of a possible 18 outcomes, one of them Outcome 1 was partially reviewed to address specific issues identified on inspection.

Inspectors met and spoke with staff including the person in charge and the nominated provider. Inspectors reviewed and discussed documentation with staff and observed staff and resident interactions. Inspectors met with 12 of the residents either in their respective homes or in the day service.

Staff spoken with had sound knowledge of each resident's needs and supports and spoke respectfully of residents when speaking to them and about them. Staff articulated a positive attitude to the regulator and regulation and saw inspection and regulation as a tool to drive improvement. It was evident that residents were comfortable in the presence of staff and were familiar with the person in charge.

Residents told inspectors that staff were nice; residents discussed their planned and favourite pastimes, goals they had achieved and those they hoped to achieve.

However, there were core significant failings identified on inspection. Some of these failings have previously been brought to the attention of the provider by HIQA in relation to other designated centres either through the process of inspection and/ or other regulatory processes such as a provider meeting. These common failings included the manner in which respite services were provided, the completion and the effectiveness of annual and unannounced reviews, fire safety measures, the maintenance and suitability of premises and governance structures including the working arrangements of the person in charge. The nominated provider confirmed that addressing some failings was dependent on securing financial resources.

Of the 10 Outcomes inspected the provider was judged to be compliant with two, substantially compliant with one, in moderate non-compliance with three and in major non-compliance with four; Governance and Management, Health and Safety in relation to the fire safety component, Use of Resources and Residents Rights Dignity and Consultation.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The statement of purpose on file with HIQA stated that respite services were provided on a planned, emergency and occasional basis in two of the four houses that comprised the designated centre. Staff spoken with on inspection confirmed this. However, inspectors saw that neither of these houses had physical capacity to accommodate respite services, that is, there was no longer a spare bedroom in either of these houses. Staff confirmed that the bedrooms of residents in receipt of residential services but in a position where they were supported by family to avail of regular structured weekend leave or a shared care arrangement were utilised to accommodate residents provided with respite services. These bedrooms were personalised and bedrooms were decorated accordingly with personal possessions, personal memorabilia including photographs, and their personal clothing. Inspectors were not satisfied that this use of residents' bedrooms for people accessing the service on a respite basis ensured compliance with regulatory requirements particularly in relation to Regulation 9 (3) Residents Rights. Inspectors were not satisfied that the provider, through this practice, ensured each resident's privacy and dignity in relation to but not limited to, his or her personal space.

Staff including the person in charge were clearly not comfortable with this practice which they confirmed happened practically every weekend. It was of concern to inspectors that the provider had been requested previously by HIQA to review and cease this practice in another of its designated centres.

Judgment:

Non Compliant - Major

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:

Each resident had two files, their main "care plan file" and the "daily file" that accompanied them to the day support service to ensure continuity of supports and recordkeeping.

The care/support plan was detailed, personalised and reflected the supports described by staff. Each plan contained a synopsis of each resident, their strengths and abilities and areas where supports were required. There was evidence that the residents and their representative as appropriate inputted into the plan. The accessibility of the plan to the resident was enhanced by the use of pictorial and photographic cues and use of plain English.

The plan incorporated the process for establishing and agreeing personal goals and objectives. This was a clear process that identified responsible persons and timeframes and actions taken to progress each goal.

There was documentary evidence that each resident had an annual review of their healthcare needs. However, there was no evidence of the collective assessment of each resident's personal, social and health care needs as frequently as required but no less frequently than on an annual basis.

There was evidence of good multi-disciplinary supports for residents but it was not clear that the review of the care plan was multidisciplinary.

There was a very strong psychosocial focus to the care plan but as discussed in Outcome 11, health care needs were not integrated into the care plan.

It was not clear that the care/support plan was always reviewed and updated in response to a change in needs, for example a reported escalation in behaviours that challenged.

While there was a clear process for recording the progress of goals and objectives documentation was inconsistent across the files reviewed. It was not clear if some goals had been achieved and if not why not. Some goals had no recorded actions taken by staff to support achievement since November 2015. Some goals were once off actions such as buying a present and it was unclear how they supported the resident's ongoing personal development.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

This designated centre consisted of four separate domestic type premises in separate geographical locations. While issues arose in each house deficits were more significant in two houses which were of earlier construction.

Two premises were of more recent construction and overall met their stated purpose, were in good condition but issues arose as follows;

- there was no definitive utility space. The inspector saw laundry equipment including the tumble dryer stored and utilised in the corner of one communal room. A separate communal space was available to residents but staff did say that these particular residents did require separate personal space at times and would therefore benefit from the choice of communal space that was available. The tumble dryer was in the garage of another house.
- the floor level bath in one house was not suited to the needs of the residents who consequently were utilising the accessible shower in the en-suite of the staff office/sleepover room.
- one main entrance was not universally accessible and was not ramped. Residents did however have an alternative entrance to the rear of the house that they used.

The other two houses were of earlier construction and both were showing evident signs of age and a requirement for maintenance and upgrade. There were evident areas of damp, leaks, defective paintwork, cracks, poor or damaged plasterwork, and broken floor tiles. One resident's bedroom was accessed directly off the utility room, another bedroom while there was a short corridor leading off it was also accessed through the

kitchen and the utility room. This is discussed again in Outcome 7 in relation to fire safety requirements. Staff expressed concern at the location of another resident's bedroom as it was located at the opposite end of the house to the other bedrooms and the staff sleepover room. Staff had assessed this resident as at high risk of falling.

Generally residents' bedrooms were well presented, welcoming and personalised but there was insufficient space in one room to provide the resident with a wardrobe.

There was general lack of assistive equipment in the form of handrails and grab-rails in sanitary and circulation areas with residents reported to hold on the walls for their security. There was a further en-suite shower that staff reported was not used as it did not meet the needs of the resident.

A further observation in addition to the failings listed above by inspectors was that the premises did not have the space to facilitate the services outlined in the statement of purpose. There was no additional personal space available to facilitate the provision of respite; this has been discussed in Outcome 1.

Judgment:

Non Compliant - Moderate

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:

Inspectors saw centre specific safety statements, procedures for the identification, reporting and investigation of accidents and incidents, and for the identification of hazards and the management of risks.

Each house had a risk register that included risk assessments specific to the designated centre, individual residents and the risks as specified in Regulation 26 (1) (c) and how these were pertinent or not to each resident. Risks were supported by policies such as the centre specific procedure to be invoked in the event that a resident was missing from the centre. There was evidence that the assessor, the person in charge, escalated risks where additional controls beyond her remit were required. Some of these additional controls are relevant to these inspection findings such as the suitability of some bedrooms and controls in relation to behaviours that challenged.

The person in charge said she had reviewed the risk register in February 2016 and the risk assessments seen reflected this review. However, many of the risk assessments seen by inspectors in individual resident's files were undated. There was also some confusion as to completeness of the risk assessments and which file contained the complete suite of risk assessments as they pertained to each resident. For example inspectors saw a risk assessment for transportation in one main file that was not included in the daily file though the risk was common to any service where supports were provided.

There was inconsistent fire safety measures across the four houses so that ultimately the designated centre did not comply with the relevant Regulation and did not have all of the requisite fire precautions necessary in a dwelling in which residential care was provided for persons with a disability.

Only two of the four houses were serviced by an automated fire detection system and emergency lighting. The other two houses had very limited fire detection coverage by either battery or mains connected detectors. In addition these two houses were not serviced by emergency lighting. Escape routes and final exits were not indicated in two of the four houses. Some final fastenings on exit doors could not easily be opened from the inside without the use of a key.

Fire fighting equipment was available in each house. Certificates of inspection at the prescribed intervals were seen by inspectors for the fire fighting equipment and for the fire detection systems where they were installed. However, there was no certificate of inspection and testing by a competent person of the emergency lighting.

There was no evidence of fire doors in any of the houses and rooms accessed through other rooms (inner rooms) were used as bedrooms. A fire safety survey of all of the houses had been completed in 2014 and it was confirmed for inspectors that recommended works had not been completed as they were funding dependent. The report was not available for review on inspection and the provider was requested to forward a copy to the inspectors. The provider submitted the reports as requested. The reports identified that an extensive range of upgrading works including all of the above identified failings was required in each of the four houses and that the works were to be completed within a six month timeframe of April 2016. The reports stated that the works when complete would improve detection and escape routes but not full compliance with the requirements of the fire regularisation certificates granted in January 2015. The fire safety assessor reinforced the requirement for good fire safety practice for ongoing occupancy by both staff and residents. The fire safety assessor detailed for the provider the specifics of these required fire safety practices.

Staff did undertake fire safety procedures including the weekly testing of fire detection devices and simulated fire drills. Inspectors reviewed the records of the simulated drills and there were gaps in the effectiveness of this process. For example in one house the evacuation time was longer than that recommended and took three to four minutes. The time the fire drill was convened in another house was not always recorded by staff. In another house resident's personal evacuation plans (PEEPS) indicated that three of five residents were at risk once evacuated and all three were deemed to be "one of the last to be instructed to leave the house". This control was impracticable and had not been

explored further so as to identify the measures required to ensure their safe evacuation and their safety once outside of the house. There was duplication of PEEPS with some contradictory instructions seen. For example a risk of absconding was stated on one and not the other. Staff spoken with confirmed that drills had not been convened to simulate both day and night conditions particularly in relation to staff numbers and arrangements, that is, one sleepover staff.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

There were measures in place to protect residents from harm and abuse; these included organisational policies and procedures, designated persons, risk assessments and staff training. The name of the designated person was prominently displayed as were the contact details for the national confidential recipient.

All staff spoken with during this inspection articulated understanding of what constituted abuse and their responsibility to safeguard residents including reporting any alleged or suspected abuse. Staff said that they believed management would be receptive and proactive if such a concern was made. Staff said that residents' knowledge and awareness of self-protection was supported through regular discussion at house meetings. The person in charge told inspectors that she was reassured that residents were safe in the centre as she had worked directly with the majority of staff employed. One resident pointed out the designated person as the person to go to if he had a problem. Inspectors saw that residents were comfortable with staff and that staff spoke and wrote respectfully of residents.

However, training records indicated and management confirmed that three staff recruited in early 2016 had not yet completed education and training in safeguarding.

Support plans were in place for the provision by staff of personal/intimate care support for residents. Some of these plans were functional in approach and format as opposed to how privacy, dignity and choice were facilitated. Where clear guidance and expertise specific to personal/intimate care supports had been provided to staff in February 2016 for one resident's wellbeing, this guidance was not incorporated into the intimate care plan.

Some residents did present with behaviours that were a challenge to them and to other persons. Staff had completed relevant education and training and residents had support from both psychiatry and psychology.

Inspectors saw that some residents had detailed behaviour support plans. These plans were easy to read, specific, person-centred in their tone and language and therapeutic in their approach. Plans were seen to be reviewed regularly. Staff spoken with described the interventions outlined in the plans and overall a reduction in manifested behaviours. Staff maintained behaviour records that informed reviews.

However, practice was inconsistent as other residents with reported and recorded behaviours that challenged or had the potential to harm them or others, for example physical aggression towards peers did not have similar explicit plans of support.

Environmental restrictive practices were in place and had been notified to HIQA. The rationale provided for their requirement was the safety of the residents and others. Inspectors saw supporting risk assessments and restrictive practice documentation. There was evidence of multi-disciplinary meetings and consultation with both families and residents. There was evidence of resident agreement and alternatives such as one-to-one staff support. However, given the duration of one restrictive practice (March 2015 based on records seen) staff confirmed that while the risk was managed, the intervention was impacting negatively on the resident. Staff confirmed that the resident did not fully comprehend that the intervention was designed to alert staff and not to prevent freedom of movement. Therefore inadvertently, despite the efforts of staff the resident did not now voluntarily exercise freedom of movement when the intervention was in place, this was of concern to staff and to inspectors. Given this development it was not clear how the continued use of the restrictive practice in lieu of waking night staff was justified. There was evidence that a plan that offered relocation and less restriction but managed the risk while supporting the resident's right to independence and freedom of movement had been agreed. However, there was no definitive implementation date and the nominated provider confirmed that this was due to inadequate resources.

Systems described and demonstrated by staff for supporting residents to manage their personal finances reflected staff accountability. A financial ledger was maintained for each resident. There was evidence of supporting receipts, staff signatures and counter-signatures. Balances were checked at each change of shift.

Judgment:
Non Compliant - Moderate

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:

It was clear from speaking with staff that staff were attuned to and took action as appropriate to support residents in maintaining health and well-being.

Staff reported that residents had access to their choice of preferred General Practitioner (GP). Based on the records seen by inspectors there was evidence of timely and regular GP review in line with needs as they presented. In addition residents had an annual medical review. There was evidence of health promoting interventions including regular blood profiling and annual influenza vaccination. Where a resident refused or was fearful of review and treatment staff described supportive strategies such as planning ahead and clear explanation to ensure that residents were therapeutically supported to receive necessary interventions.

There was further documentary evidence that as appropriate residents were referred and had access to other required services including physiotherapy, occupational therapy, speech and language therapy, psychiatry, psychology, optical, dental care and chiropody. Nursing input was available from within the organisation. Records of referrals and reviews were maintained and staff were familiar with multi-disciplinary recommendations.

There was evidence that supports were evidence based as staff used recognised objective assessment tools such as for assessing the risk of falls.

However, residents did not have healthcare specific support plans and gaps were identified in the records of more than one resident by inspectors, for example in the recording of body weight's where this was required routinely or as a measure of well-being. There was one significant omission in communication between the day service and the designated centre; residential staff had identified this prior to this inspection. This is addressed in Outcome 5 as a failing under Regulation (4).

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

There were policies and procedures dated May 2013 governing medication management practice and overall based on these inspection findings, evidence of safe medication practice.

Medications were supplied to the centre by a community based pharmacy in compliance aids. The inspector saw that secure storage for medications including segregated storage for unused or unwanted medications was in place.

There was a prescription record to support all medications supplied and medications seen were supplied on the basis of individual resident use. Medications were seen to be clearly labelled. Prescription records were clearly written and legible. The maximum daily dosage of p.r.n medications (a medicine only taken as the need arises) was stated. The sample of medication administration records seen corresponded with the instructions of the prescription record.

Staff implemented further controls to ensure the safety of medication management systems. For example all medications supplied were checked by nursing staff to ensure their accuracy. Staff who administered medications were clear however that this did not absolve them from ensuring that they also checked accuracy at the time of administration.

Training records indicated that staff had completed safe administration of medications training and staff spoken with confirmed this.

There was a low reported incidence of medication errors and a system for their recording and review. The pharmacist had completed a medicines audit.

The inspector did however note the use of correction fluid on one prescription record and this was brought to the attention of the management team at verbal feedback.

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):

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

Findings:

The management structure consisted of the person in charge, two assistant directors of services who were the persons participating in management (PPIM) and the provider nominee, the director of services. However, due to reasons including leave and demands in other services this structure was reported to be only again consolidating itself. Governance structures and organisational demands had previously been the subject of discussion between the provider nominee and HIQA.

There was a role of social care leader; however, this was not structured in a manner that supported effective governance. The person in charge said that there were two social care leaders but they were both allocated to the same house.

The person in charge did work full-time, held suitable qualifications and was suitably experienced. However, the post of the person in charge was not full-time as the person in charge still worked as a front line social care worker and worked both sleepover and weekend duties in the capacity of social care worker in two of the four houses. The person in charge on speaking with her was fully aware of her responsibilities under the Health Act and challenges to her capacity to exercise these given her working arrangements and the size and complexity of the designated centre. Following discussion between her and the nominated provider on this matter her sleepover duties as a social care worker had been reduced from three to two. This allowed for five additional administration hours per week for the person in charge but was a very recent change so the person in charge said that the impact was not yet measureable. At a meeting convened by HIQA with the provider on 28 January 2016 in relation to another of its designated centres HIQA strongly reminded the provider of its obligations under Regulation 14 (2); that the PIC must have capacity to fulfil that post.

Staff described the person in charge as approachable and accessible. Residents were clearly familiar and comfortable with the person in charge. The provider nominee was readily available to the person in charge and in addition there were structured formal monthly management team meetings.

Staff were facilitated to voice their concerns and opinions of the quality and safety of the services and supports provided to residents through staff meetings and designated centre meetings recently introduced by the person in charge.

The annual and unannounced reviews to be completed by the provider had not been undertaken at the required frequency as outlined in Regulation 23 (1) (d) and (2). Inspectors were informed that there had been only one such review completed over four days between January and April 2016. The report of this review was available for the purpose of inspection. It was not a robust process as it did not identify some of the core failings identified by this inspection and previously identified as failings in other centres by HIQA. These failings included how respite was being provided and governance arrangements. The issue of inadequate transport was not identified by the review.

Where failings were identified as common to these inspection findings such as the maintenance of the premises and fire safety measures there was no definitive action plan or timescale. It was therefore difficult to see how this process given its infrequency and lack of specific detail informed change and brought about improvement in the quality and safety of the services and supports provided to residents.

Based on these inspection findings there was little evidence of learning transferred by the provider from previous inspections and other regulatory functions including meetings between HIQA and the provider.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

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

Findings:

Based on these inspection findings inspectors were not satisfied that the centre was sufficiently resourced to ensure the delivery of safe, quality supports and services to residents.

All staff spoken with identified the lack of readily available and sufficient transport as a barrier to supporting residents' choices and facilitating residents to live life to their full potential. There were two vehicles allocated to the four houses that constituted the designated centre. Staff described how they exchanged and shared the available transport between houses at weekends and they tried to do this in a fair and equitable

manner. There were 17 residents living in four houses in four different locations, two of these houses were in rural locations. Staff consistently articulated how the availability or not of transport decided what residents could do and what staff could decide to do with residents. Staff described a further scenario where staff had to leave one house to collect and deliver the vehicle. This meant that one staff was absent from this house for up to one hour to facilitate each journey. In addition staff raised concerns in relation to the roadworthiness of one of the two available vehicles. On the first day of inspection the vehicle was not in working order and inspectors saw that residents waited until alternative transport for them was secured. Staff spoken with said that they estimated that due to mechanical breakdown the vehicle had been unavailable on four to five occasions in the past twelve months. There was further evidence that where staff secured a taxi to facilitate an outing for residents, residents paid for this service. A significant number of residents had mobility needs either by virtue of the nature of their disability, falls risk or the ageing process.

Respite provision as insufficiently resourced.

Parts of the premises were inadequately maintained, recommended fire safety upgrading works had not been undertaken.

Plans for the relocation of one resident had not been finalised and were also reported to be resource dependent.

At verbal feedback at the end of the inspection the provider confirmed that all of these failings were resource dependent and agreed on that basis that the centre was not adequately resourced.

Judgment:
Non Compliant - Major

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:

There was a planned roster that staff inputted directly into. Staff spoken with confirmed that agency staff were not utilised but relief staff were. Staff said that staff employed on

a relief basis worked only with the service and were allocated so as to ensure consistency of care and supports for residents. The person in charge and staff spoken with confirmed that in general staffing numbers and arrangements reflected residents' assessed needs including the requirement for one-to-one staff support. Staff who worked the night-time sleepover arrangement expressed no indication that this arrangement did not meet residents' needs (this arrangement was however referenced by inspectors in Outcome 8).

However, in one house staff confirmed that weekend staffing was reduced from two to one staff. Staff said that with home leave the occupancy of this house did fluctuate so one staff was at times sufficient but at other times not, dependent on occupancy and needs. Staff said that a limited additional staff allocation at peak activity times would benefit residents particularly in relation to facilitating individual choice. Staff said for example that with one staff on duty all residents, including residents availing of respite had to leave the house together regardless of whether this was their preference or not.

Staff files were available for the purpose of inspection. The random sample selected by the inspector was well presented and substantially compliant with regulatory requirements. However, two gaps were identified; one file did not contain a reference from the person's most recent employer, another had an unexplained gap in the person's employment history.

Electronic records of completed staff training were also made available for the purpose of inspection. All staff including relief staff were included and overall there was good staff attendance. The training content reflected both mandatory requirements and training that reflected residents' assessed needs. The inspector saw that staff had completed fire safety training, moving techniques in resident care training and responding to behaviours that challenged. Additional completed training included dysphagia, diet and nutrition, epilepsy and autism awareness, communication, first aid and food hygiene. Staff files demonstrated appropriate core qualifications such as applied social studies and healthcare support.

However, training records indicated and management confirmed that three staff recruited in early 2016 had not completed education and training in safeguarding. This was addressed in Outcome 8 as a failing of Regulation 8 (7).

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 Kerry Parents and Friends Association
Centre ID:	OSV-0003428
Date of Inspection:	26 April 2016
Date of response:	25 May 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Respite services were provided on a planned, emergency and occasional basis in two of the four houses that compromised the designated centre. The bedrooms of residents in receipt of residential services but in a position where they were supported by family to avail of regular structured weekend leave were utilised to accommodate residents availing of respite supports.

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 (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:

Respite whereby the rooms of residents are utilised by others will be discontinued.
30/06/2016

One bedroom which is a shared care place will be continued to be shared. One person avails of the bed 4 nights per week and only pays for the nights that they are in the house.

Long term Action: All respite will be provided in dedicated rooms for respite.

Proposed Timescale: 31/12/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

There was no evidence of the collective assessment of each resident's personal, social and health care needs as frequently as required but no less frequently than on an annual basis.

There was a very strong psychosocial focus to the care plan but as discussed in Outcome 11 health care needs were not integrated into the care plan.

2. Action Required:

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

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

Individual support plans on the health, personal and social care needs of the people we support will be carried out by the appropriate health care professional as required to reflect changing need and in accordance with regulation 05(1) (b).

Proposed Timescale: 30/07/2016

Theme: Effective Services

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

It was not clear that the care/support plan was reviewed and updated in response to a change in needs, for example a reported escalation in behaviours that challenged.

3. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

A review of current paperwork and recording practices will be carried out to ensure that they review and assess the effectiveness of each plan and take into account changes in circumstances and new developments. Auditing of current Personal plans will highlight areas where there is noncompliance with record keeping. Review of current record keeping guidelines will be carried out.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

There was evidence of good multi-disciplinary supports for residents but it was not clear that the review of the care 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:

All multidisciplinary personnel involved in the care of the person we support will be invited to review meetings.

Proposed Timescale: 25/05/2016

Theme: Effective Services

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

It was not clear if some goals had been achieved and if not why not. Some goals had no recorded actions taken by staff to support achievement since November 2015. Some goals were once off actions such as buying a present and it was unclear how they supported the resident's ongoing personal development.

5. Action Required:

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

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

Guidelines on Goals and goal setting to be developed and circulated. Audits on PCP's and goals will highlight areas where there is noncompliance with record keeping practices, this will inform action plan which will be implemented.

Proposed Timescale: 30/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There was general lack of assistive equipment in the form of handrails and grab-rails in sanitary and circulation areas with residents reported to hold on the walls for their security. There was a bath and a further en-suite shower that staff reported were not used as they did not meet the needs of the residents.

Staff based on assessed risks had concerns as to the location of some bedrooms.

There was no definitive utility space. The inspector saw laundry equipment including the tumble dryer stored and utilised in the corner of one communal room.

There was no additional personal space available to facilitate the provision of respite services.

6. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

Assessments of the needs re assistive equipment will be undertaken and all equipment required will be installed.

The tumble dryer will be relocated outside the communal area.

Respite will cease in the house identified.

There are costed plans drawn up and submitted to the HSE for funding to upgrade and redesign the houses to meet the needs of the people we support. This will include the provision of a utility room and alternative bedroom space.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

Two houses were of earlier construction and both were showing evident signs of age and a requirement for maintenance and upgrade. There were evident areas of damp, leaks, defective paintwork, cracks, poor or damaged plasterwork, and broken floor tiles.

7. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

A priority maintenance list will be developed for the designated centre and work completed accordingly. The more extensive work is planned and is to be completed by the end of the year.

Proposed Timescale: 31/12/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Many of the risk assessments seen by inspectors in individual resident's files were undated. There was also some confusion as to completeness of the risk assessments and which file contained the complete suite of risk assessments as they pertained to each resident.

8. Action Required:

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

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

All risk assessments have been transferred to the new Xyea Software System, to ensure that they will be completed thoroughly and accessed in the one common place. The system will be managed locally and will signal for review dates. The system is still in the introduction stage and we are working closely with the system provider to ensure it meets the needs of the Organisation especially in relation to senior management being alerted to additional controls needed for risks rated at 15 or higher.

Proposed Timescale: 30/05/2016

Theme: Effective Services

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

As outlined in detail in the body of this report there was inconsistent fire safety measures across the four houses so that ultimately the designated centre did not comply with the relevant Regulation and did not have all of the requisite fire precautions necessary in a dwelling in which residential care is provided for people with a disability.

9. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

The plan that has been developed by our fire consultant and previously submitted to HIQA outlining the proposed fire safety improvements will be completed.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

Inspectors reviewed the records of the simulated fire drills and there were gaps in the effectiveness of this process. For example in one house the evacuation time was longer than that recommended and took three to four minutes. The time the fire drill was convened in another house was not always recorded by staff. In another house resident's personal evacuation plans (PEEPS) indicated that three of five residents were at risk once evacuated and all three were deemed to be "one of the last to be instructed to leave the house". This control was impracticable and had not been explored further so as to identify the measures required to ensure their safe evacuation and their safety once outside of the house. There was duplicated of PEEPS with some contradictory instructions seen. For example a risk of absconding was stated on one and not the other. Staff spoken with confirmed that drills had not been convened to simulate both day and night conditions particularly in relation to staff numbers and arrangements, that is, one sleepover staff.

10. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

All the PEEPs have been reviewed and updated to ensure that adequate arrangements are in place for evacuating all the people we support safely.

The times of fire drills are now recorded and fire drills will take place at various times of the day to simulate both day and night conditions.

All personal risks have been dated and a full suite of risks are kept in Health and Safety folder and all staff have been reminded of this.

Proposed Timescale: 30/05/2016

Theme: Effective Services

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

There was no certificate of inspection and testing by a competent person of the emergency lighting.

11. Action Required:

Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

Contractor will be contacted to carry out this inspection and provide certification.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

The fire safety assessor reinforced the requirement for good fire safety practice for ongoing occupancy by both staff and residents. The fire safety assessor detailed for the provider the specifics of these required fire safety practices.

12. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

All the areas highlighted in the report by our fire assessor for good fire safety practices are being implemented in the designated centre.

Proposed Timescale: 20/05/2016

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:

It was not clear how the use of the restrictive practice in lieu of waking night staff was justified. There was evidence that a plan that offered relocation and less restriction but managed the risk while supporting the resident's right to independence and freedom had been agreed. However, here was no definitive implementation date and the nominated provider confirmed that this was due to inadequate resources.

13. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

A business plan has been sent to HSE Disability Services for the additional funding required to move the resident to his new accommodation on 10/03/2016.

The Chairperson of our Board of Management has made contact with the HSE Area Manager to escalate this funding issue within the HSE.

The HSE Area Manager has agreed to meet with us before the end of June, at this meeting we will highlight again the urgent need for this funding.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

Practice was inconsistent as other residents with reported and recorded behaviours that challenged or had the potential to harm them or others including physical aggression towards peers did not have similar explicit plans of support.

14. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A comprehensive behaviour support plan will be developed for the resident identified.

Proposed Timescale: 31/07/2016

Theme: Safe Services

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

Training records indicated and management confirmed that three staff recruited in early 2016 had not completed education and training in safeguarding.

15. Action Required:

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

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

All outstanding staff have been trained in Safeguarding Vulnerable Adults.

Proposed Timescale: 03/05/2016

Theme: Safe Services

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

Intimate care support plans were functional in approach and format as opposed to how privacy, dignity and choice were facilitated. Where clear guidance and expertise specific to personal/intimate care supports had been provided to staff in February 2016 for one resident's wellbeing, this guidance was not incorporated into the intimate care plan.

16. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

Guidelines for intimate and personal care were circulated. New more detailed intimate care forms circulated and to be implemented immediately. Audit on intimate and personal care to monitor compliance with intimate care practices.

The guidance as specified has been incorporated into the persons intimate care plan.

Proposed Timescale: 13/05/2016

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:

The role of the person in charge was not full-time as the person in charge still worked as a front line social care worker and worked both sleepover and weekend duties in two of the four houses.

17. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The position of the Person in Charge will be reviewed quarterly to ensure that she has sufficient time to manage the designated centre in accordance to regulation 14(2).

Proposed Timescale: 25/05/2016

Theme: Leadership, Governance and Management

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

The annual and unannounced reviews to be completed by the provider had not been undertaken at the required frequency as outlined in Regulation 23 (1) (d) and (2). Inspectors were informed that there had been only one such review completed.

It was not a robust process as it did not identify some of the core failings identified by this inspection and previously identified as failings to the provider by HIQA. Where failings were identified as common to these inspection findings such as the maintenance of the premises and fire safety measures there was no definitive action plan or timescale.

18. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

An announced inspection will be carried out taken into account all the areas as identified as being required.

Proposed Timescale: 31/08/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

Staff spoken with specifically identified transport and respite provision as insufficiently resourced. In addition parts of the premises were inadequately maintained, recommended fire safety upgrading works had not been undertaken and plans for the relocation of one resident had not been finalised and were also resource dependent.

19. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

We will ensure that transport will be available to each house. When our own buses are not available we will source and fund taxis/wheelchair taxis as appropriate.

Maintenance, Fire Safety work and respite have actions under the other headings in the Action Plan.

Proposed Timescale: 25/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

One staff file did not contain a reference from the person's most recent employer, another had an unexplained gap in the person's employment history.

20. Action Required:

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

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

A satisfactory reference has been requested from the person's most recent employer.

The gap in the person's employment history has been explained satisfactorily and documented in her file.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Weekend staffing was reduced from two to one staff in one house. Staff said that with home leave the occupancy of this house did fluctuate so one staff was at times sufficient but at other times not, dependent on occupancy and needs.

21. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

As the respite in this house will be discontinued the occupancy should not fluctuate and the staffing should be sufficient to the needs of the people we support.

Proposed Timescale: 30/06/2016