

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by RehabCare
<b>Centre ID:</b>	OSV-0003639
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	RehabCare
<b>Provider Nominee:</b>	Rachael Thurlby
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From: 19 April 2016 09:45 To: 19 April 2016 19:00

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

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 13: Statement of Purpose
Outcome 14: Governance and Management
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). The inspection was facilitated primarily by the person in charge but all staff on duty contributed to the inspection process. Full-time residential services were provided to five residents all of whom met and engaged with the inspector when they returned in the evening from their respective day services.

Residents presented with a broad range of differing needs but the inspector noted an ease and compatibility between residents. The inspector explained the role of the inspector and of HIQA. Residents told the inspector that they were happy in the house, and that staff were "good" and "nice" to them; residents at the conclusion of the inspection hoped that the inspector had "good news" for the person in charge.

The premises was purpose built and met the current needs of residents some of whom required the assistance of a wheelchair for mobility and accessibility. Staff were clearly informed of each resident's individual abilities, requirements and supports. There was a relaxed atmosphere in the centre with staff noted to focus their time and attention on residents and their requirements.

Overall the inspection findings were positive; residents confirmed this conclusion. There was a requirement to review some fire safety measures and risk assessments to ensure that they sufficiently addressed/reduced identified risks. There were also some documentary gaps that needed to be addressed not only to enhance regulatory compliance, but also to clearly evidence the supports available to each resident, particularly in relation to progressing and achieving their desired goals and objectives.

Of the nine Outcomes inspected the provider was judged to be in compliance with three and in substantial compliance with five; one moderate non-compliance was identified in health and safety measures.

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

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Each resident had a plan that set out their abilities, where they required support from staff and what these supports were. The plans were detailed and personalised and offered sufficient guidance on the required supports. Where a resident had multidisciplinary team (MDT) review and input the MDT recommendations were reflected in the support plan. The support plan reflected each resident and their required supports as described by staff to the inspector throughout the inspection process.

There was evidence that residents inputted into the support plan. Residents spoke of their upcoming personal plan meetings/reviews with the inspector and this was an event that was obviously important to them.

There was evidence that residents were engaged in a broad range of activities including structured day services, community groups and activities, computer skills, further education, swimming, horse-riding and soccer; many sports were participated in to competition level. Having spoken with staff and the residents the inspector was satisfied that the overall objective was supporting residents to achieve positive outcomes. On the day of inspection staff supported residents to go horse-riding, attend community based groups and the local library. However, the documentation reviewed did not fully reflect this positive practice.

While the personal plan was comprehensive there was little evidence of the comprehensive assessment that informed the support plan, on an ongoing annual basis of the health, personal and social care needs of residents. One assessment seen was dated 2008.

Support plans were signed as reviewed. However, there was evidence that the support plan was not reviewed as required, to reflect any changing needs and circumstances, and that the review was not always multidisciplinary. For example a behaviour support plan did not appear to have been reviewed since 2013 and there was evidence that speech and language recommendations made in 2013 also required review.

The process for documenting the progress of the achievement of residents' goals and objectives was not robust and did not provide reassurance that staff were committed to this process. This was contrary to what the inspector observed and what staff and residents said about what they had achieved together. There was also supporting photographic evidence of the achievement of some goals. However, the inspector saw that in 2015 one resident had identified the goal of weekly swimming but this was back on the agenda for the 2016 personal plan review; swimming was not included in the resident's weekly planner. Another resident in 2015 had identified the goal of an overnight stay away; there was no evidence that this was either progressed or achieved and if not why not.

**Judgment:**  
Substantially Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**  
Effective Services

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

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

**Findings:**

The premises was purpose built, was of relatively recent construction, and located on a site within close proximity to all of the local amenities. Also on this site were another designated centre and a day resource service.

There were some maintenance issues (being dealt with) but overall the premises was attractively presented and well maintained.

As required by residents, resident accommodation was provided on both the ground and first floor levels. Two residents' bedrooms were on the ground floor and there were two fully equipped universally accessible bathrooms on the ground floor. One of these was en-suite while the other was adjacent to the other bedroom. One of these bedrooms and bathrooms were equipped with a ceiling mounted hoist, the other was not and a floor based hoist was used. Staff confirmed that the ceiling mounted hoist was not

currently required by the current occupant. The room with the ceiling mounted hoist offered less floor-space than the other ground floor bedroom. There was no evidence available to the inspector that these arrangements were not sufficient to meet the current needs of residents.

Three further bedrooms for residents were provided at first floor level. All of the bedrooms were seen to provide sufficient space including provision for personal storage. Each bedroom was decorated to reflect the individuality of each resident.

The bedrooms at first floor level shared an en-suite bathroom facility between each two bedrooms and each entrance from each bedroom had a privacy lock fitted.

Residents had access to two communal areas. There was a kitchenette and a further fully equipped kitchen with dining area.

The utility area contained the facilities for laundering.

Residents had access to a well-maintained and pleasant rear garden with raised vegetable beds and a wooden cabin with ramped access utilised by residents if further solitude was required.

Overall the inspector was satisfied that the premises was homely and welcoming, designed and laid out to meet the needs of residents. Residents dependent on the use of a wheelchair were seen to have sufficient circulation space. There were scuff marks on doors and doorways but door widths were within recommended clearance guidelines. Door closures were fitted to all internal doors and these obviously presented accessibility challenges to these residents in particular. This is addressed below in Outcome 7 in the context of fire safety measures.

**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):**

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

**Findings:**

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

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

The inspector reviewed the local risk management folder. The folder 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 inspector reviewed a small purposeful sample of the latter and was not satisfied that all risk assessments accurately identified the nature of the risk or sufficient detail of the controls required and in place to reduce risk. More specific detail was required to demonstrate how staff ensured that residents were adequately and safely supported to maximise their independence. It was also not clear how the completion of the risk assessment identified further required controls, specifically a requirement for staff training to ensure that staff could respond appropriately in emergency situations, that is basic life support training.

Manual handling risk assessments were completed and the hoist was marked as serviced in line with statutory requirements and most recently in March 2016.

Residents had access to and were seen to use a staff call bell system.

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

The inspector saw that emergency lighting and an automated fire detection system were in place. Escape routes and exits were clearly indicated, final fastenings were thumb-turn devices. Fire action notices and diagrammatic evacuation plans were prominently displayed.

Fire fighting equipment was prominently positioned and there was evidence of fire doors (labelled).

Fire related records were maintained in the fire fact file. The inspector saw certificates confirming that the fire detection system, fire fighting equipment and the emergency lighting were inspected and tested and most recently in February 2016, January 2016 and March 2016 respectively. In addition staff maintained records of the in-house daily, weekly, monthly and quarterly inspection of fire safety measures: the person in charge monitored the completion of these. However, there was no evidence of the inspection, servicing and testing of the fire detection system between July 2015 and February 2016.

Training records indicated that staff were provided with fire safety training on an annual basis and most recently in January 2016.

Simulated fire drills were convened on a regular basis; records of eight such exercises completed between 2015 to date were seen by the inspector. Drills were convened at different times and for all of these exercises good and adequate evacuation times were recorded as achieved. Where a barrier to effective evacuation was identified staff identified any further action required including repeating the exercise. Additional support



was available from staff in the adjacent designated centre but the inspector did discuss with the person in charge the possibility of exploring the potential use of proprietary evacuation devices as an additional evacuation strategy.

Internal doors were fire doors with self closing devices. However, these obviously presented accessibility challenges to some residents particularly those with reduced upper body strength or mobile with the assistance of a wheelchair, consequently there was significant use of door-wedges by staff. In consultation with the appropriate persons this practice requires review to ensure that a reasonable balance is achieved between accessibility and fire safety requirements.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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 and national policies and procedures, designated persons, risk assessments and staff training. The names of the designated persons were prominently displayed as were the contact details for the national confidential recipient.

Staff said that there had been no incident of alleged, suspected or reported abuse or any known concerns for the welfare and wellbeing of any of the residents. Staff described residents as having good safety awareness and said that if they did not talk directly to staff about any concerns or worries they had, staff would note changes in the residents' general demeanour. Staff took action to support residents to develop their knowledge and skills for self-care and protection. For example the local community Garda had attended the most recent residents' house meeting to discuss with them staying safe in the community.

Each resident had a personal/intimate care plan that outlined the support required from staff but also incorporated the residents right to independence, privacy, dignity and choice. Staff confirmed that personal preferences for the provision of personal care were

respected and reflected in staffing arrangements.

Some behaviour had been identified as potentially challenging to either the resident themselves or others. Behaviour management guidelines were in place that identified both potential triggers and the required staff response. The interventions required of staff to either prevent or respond to behaviours were therapeutic in their totality with no reference seen to either physical or chemical intervention. However, one behaviour management plan did not demonstrate its review since 2013. It was not clear if this behaviour still manifested as it was not referenced in either the support plan or risk assessments seen. This is addressed in Outcome 5 as a failing under Regulation 5 (6), the review of the personal plan.

The person in charge said that two potentially restrictive practices were in use, bed-rails and lap-belts. There was documentary evidence that in line with residents' needs and preferences these interventions were clinically indicated for resident safety. The inspector saw an evidence based risk assessment for the use of the bedrails and a request from the resident for the continued use of the bed-rails. The person in charge agreed however, that all of the supporting documentation as required by the provider's own restrictive practice policies and procedures was not in place.

**Judgment:**

Substantially Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Staff said that in general residents enjoyed good health supported by staff and medical review and treatment from their General Practitioner (GP). There were five residents living in the centre and each accessed a different GP of their choosing; staff described all of the GP's as facilitative and supportive.

Staff were clear that they were residents' primary support in terms of accessing the required healthcare but they communicated as appropriate with family who also provided practical support at times to residents.

Staff said and there was documentary evidence that residents' as appropriate to their needs also had access to other services including physiotherapy, speech and language therapy (SLT), occupational therapy, counselling and psychiatry. Chiropody, dental care

and optical services were accessed in the local community.

There was evidence that staff supported residents to make healthy lifestyle choices including exercise, weight-management and smoking cessation. Residents confirmed this and were clearly proud of their achievements. There was evidence of other health-promoting interventions including annual influenza vaccination and regular blood profiling.

Based on discussion with staff there was evidence to support the requirement for an updated SLT assessment. This is addressed in Outcome 5 as a failing under Regulation 5 (6).

**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:**

Medications were supplied to the centre by a community based pharmacy. Staff said that residents were known to the pharmacist as they attended the pharmacy with staff, for example when collecting medications.

Arrangements were in place for the secure storage of medication including medication no longer required. Staff implemented other measures to monitor the ongoing safety of medication management practices including the daily count of medications in stock.

Medications in stock were seen to have a current prescription and were supplied on the basis of individual resident use. All medications seen were appropriately labelled. Medications supplied in a compliance aid also had an accompanying medication identifier so that staff could identify each medication supplied. A random sample of medication administration records completed by staff corresponded with the prescription record.

Discontinued medications were signed and dated as such. Medication reviews were completed by either the GP or the psychiatrist.

Each resident had a detailed medication management plan including a protocol for the administration of p.r.n medicines (a medication only taken as the need arises).

Residents required full assistance from staff in managing their medication; this decision was informed by the completion of a detailed assessment tool that established resident capacity and willingness.

However, one prescribed medication administered to a resident outside of the centre was not included on the prescription record held by the centre. Staff were aware of this medication and the prescribed frequency and its administration were referenced in other records seen such as the support plan. However, staff could not confirm if its prescription and administration was known to persons who prescribed and/or supplied all other medications to the resident. There was also the potential for risk in the event of a prescriber not known to the resident, making additions to the medication regime based only on the information available on the prescription record.

**Judgment:**  
Substantially Compliant

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**  
Leadership, Governance and Management

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

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

**Findings:**

Prior to the inspection the inspector reviewed the statement of purpose submitted to the Chief Inspector in January 2016. The statement contained much but not all of the information specified in Regulation 3 and Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

The statement of purpose contained insufficient detail of the specific care needs that the designated centre met. There was insufficient detail of the arrangements for supporting residents to access education, training and employment. It was not clear how staff consulted with and facilitated the participation of residents. Staff and residents did hold weekly house meetings to discuss and plan the coming week but this practice was not included in the statement.

**Judgment:**  
Substantially 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:**

There was a clear management structure in place that identified roles, responsibilities, accountability and reporting relationships. The support workers reported directly to the person in charge who in turn reported to the regional manager.

The person in charge worked full-time, was suitably qualified for the role and had established experience in the supervision of supports and staff. The person in charge had three main areas of responsibility, two designated centres and the day resource centre all of which were located together on this site. The person in charge was based on-site and therefore readily accessible to residents and staff. The person in charge told the inspector that she had a temporary allocation of a further area of responsibility, another resource centre, but it had been agreed between her and the provider that this was only for a six-month period. The person in charge was mindful of her regulatory responsibilities; the person in charge readily answered any queries in relation to staffing, the operation of the designated centre, residents and their required supports.

Staff spoken with were clear on their respective roles, responsibilities and reporting relationships and had sound knowledge of each resident and their requirements. Staff described supportive and collaborative working relationships in the centre.

The person in charge reported to the regional manager and confirmed that she had ready access as required to the regional manager; formal structured regional management meetings were also convened.

The provider operated a formal on call out of hour's manager rota and support and advice was also available from the person's in charge of other designated centres in the area.

The person in charge confirmed that she completed supervisions at a minimum every quarter with staff. Staff meetings were held monthly and were scheduled to maximise staff attendance. Both the person in charge and staff spoken with confirmed that there were no outstanding issues of concern from either process in relation to the safety and quality of supports provided to residents.

The person in charge confirmed that the centre had been the subject of the annual review and unannounced visits to the centre as required by Regulation 23 (1) and (2). Reports were available for inspection and the inspector reviewed three from October 2014 and October 2015 and the most recent from the review completed in February 2016. The audit/review process was based on the Outcomes utilised by HIQA. The providers internal review process indicated a satisfactory level of compliance but documentary gaps and failings such as records not reviewed and updated. These findings would concur with these inspection findings. There was narrative evidence of the progression of required actions with improvement noted between the two most recent internal reviews.

**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):**

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

**Findings:**

There was a planned staff roster that was managed by staff themselves under the supervision of the person in charge. The inspector was satisfied that staffing levels and arrangements were informed by resident's needs and peak activity times. Night time staffing consisted on one "sleepover" staff. Staff who worked this shift confirmed that this arrangement was sufficient and there was no evidence available to the inspector to the contrary. The inspector was satisfied that the staff supports described by the person in charge and staff were as observed during this inspection.

The workforce was described as established and consistent. Staff confirmed that there was limited dependence on agency or relief staff. Relief staff, if required, was accessed from the resource centre and were staff that were known to residents.

Staff files for staff employed in this centre and in a centre previously inspected but where staff files were not available on that day, were made available for the purpose of inspection. The staff files reviewed were well presented and substantially compliant with regulatory requirements. All files seen had evidence of Garda vetting and references including a reference from the person's most recent employer. One staff file did contain the staff members photograph, however this was not in a format that was acceptable to

establishing and verifying the person's identity.

Staff training records were maintained. These records did not provide adequate evidence that training had been provided. Gaps in staff attendance at training were indicated, however there was further evidence that the training had actually been provided. For example gaps were identified in staff attendance at fire training but a further record in the fire fact file recorded the attendance of staff at training in January 2016. Likewise gaps were recorded at staff attendance at medication management training but staff spoken with confirmed that they had completed training. The inspector having spoken to the person in charge and staff was satisfied that staff training was monitored by the person in charge to ensure that staff completed all mandatory training in fire safety, protection and safeguarding, moving techniques in resident care and responding to behaviours that challenged. There was a planned training schedule for 2016 with mandatory refresher training scheduled. Staff files provided further evidence of relevant or transferable education completed by staff to Further Education and Training and Awards Council (FETAC) Level 5.

**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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by RehabCare
<b>Centre ID:</b>	OSV-0003639
<b>Date of Inspection:</b>	19 April 2016
<b>Date of response:</b>	10 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 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 little evidence of the comprehensive assessment that informed the support plan, on an ongoing annual basis of the health, personal and social care needs of residents. One assessment seen was dated 2008.

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



**1. Action Required:**

Under Regulation 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:**

Each service user will have an annual needs assessment and medical assessment, as required, reflecting current needs and circumstances.

**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 that the support plan was not reviewed as required, to reflect any changing needs and circumstances, and that the review was not always multidisciplinary. For example a behaviour support plan did not appear to have been reviewed since 2013 and there was evidence that speech and language recommendations made in 2013 also required review.

**2. 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:**

All individual support plans will be reviewed and amended as necessary.  
A new referral will be submitted for speech and language review for one individual.

**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:**

The process for documenting the progress of the achievement of residents' goals and objectives was not robust and did not provide reassurance that staff were committed to this process.

**3. 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:**

Service users person personal plans will be reviewed and updated, and any actions and goals will be planned and evidenced with defined timeframes identified.

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

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

**Theme:** Effective Services

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

More specific detail was required in some risk assessments to demonstrate how staff ensured that residents were adequately and safely supported to maximise their independence. It was also not clear how the completion of the risk assessment identified further required controls, specifically a requirement for staff training to ensure that staff could respond appropriately in emergency situations, that is basic life support training.

**4. Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

Review unsupervised time risk assessment for one service user and amend control measures as necessary, any changes will be reflected in the relevant support plan.

All staff booked on occupational first aid training on 9 May 2016.

**Proposed Timescale:** 20/05/2016

**Theme:** Effective Services

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

There was no evidence of the inspection, servicing and testing of the fire detection system between July 2015 and February 2016.

There was significant use of door-wedges by staff. This practice required review to ensure that a reasonable balance was achieved between accessibility and fire safety requirements.

**5. Action Required:**

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

Acoustic fire door closures will be purchased for doors in the living areas, risk assessment will be amended accordingly.

The quarterly inspection for the second quarter 2016 was booked on 25 April 2016 and copies of all documentation for inspections and servicing for 2015 were requested from the company.

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

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

The person in charge said that two potentially restrictive practices were in use, bed-rails and lap-belts. The person in charge agreed however, that all of the supporting documentation as required by the provider's own policies and procedures was not in place.

**6. Action Required:**

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

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

Restrictive practice documentation in relation bed rails and lap belt for one service user will be reviewed in conjunction with appropriate multidisciplinary supports. All necessary documentation will be completed.

**Proposed Timescale:** 31/05/2016

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

One prescribed medication administered to a resident outside of the centre was not included on the prescription record held by the centre.

**7. Action Required:**

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

**Please state the actions you have taken or are planning to take:**  
Psychiatrist to include once weekly medication on one service users kardex.

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

### **Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement contained much but not all of the information specified in Regulation 3 and Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

#### **8. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Statement of purpose and function to be reviewed and amended to reflect specific supports required by current services users, supports around education, training and employment and how services users are consulted and facilitated in regard to choice and decision making.

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

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

One staff file did contain the staff members photograph, however this was not in a format that was acceptable to establishing and verifying the person's identity.

Staff training records were maintained, however, these records did not provide adequate evidence that training had been provided.

#### **9. 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:**

One staff member's photographic ID updated and included in the individual's file on 03 May 2016.

Training records will be reviewed and updated.

**Proposed Timescale:** 31/05/2016