<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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<tr>
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<td>OSV-0005375</td>
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<td>Centre county:</td>
<td>Kerry</td>
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<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Rachael Thurlby</td>
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<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
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<tr>
<td>Support inspector(s):</td>
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<tr>
<td>Type of inspection</td>
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<tr>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>10 February 2016</td>
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<tr>
<td>11 February 2016</td>
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The table below sets out the outcomes that were inspected against on this inspection.

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication                              |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs                          |
| Outcome 06: Safe and suitable premises                 |
| Outcome 07: Health and Safety and Risk Management      |
| Outcome 08: Safeguarding and Safety                    |
| Outcome 09: Notification of Incidents                   |
| Outcome 10: General Welfare and Development            |
| Outcome 11: Healthcare Needs                           |
| Outcome 12: Medication Management                      |
| Outcome 13: Statement of Purpose                       |
| Outcome 14: Governance and Management                  |
| Outcome 15: Absence of the person in charge            |
| Outcome 16: Use of Resources                           |
| Outcome 17: Workforce                                  |
| Outcome 18: Records and documentation                  |

Summary of findings from this inspection

Effectively this inspection was the first inspection of the centre but the inspection was necessary to facilitate the relocation of the service from its current location to a new premises and location; the existing service had been inspected in December 2014. The provider had made the decision to relocate the service as the current location had proved, due to matters beyond the control of the provider, to not be conducive to promoting integration and quality of life outcomes for residents.
The inspection process therefore consisted of:

- the inspection of the suitability of the new premises
- the inspection of the current service to establish the provider’s capacity for providing quality support and services and regulatory compliance as this service was transferring in its totality.

The inspector met with staff including the regional manager, the person in charge and the team leader. The inspector reviewed and discussed records including risk assessments, support plans, health related records and staff related records. The inspector was on-site for two days and observed staff/resident interactions and the delivery of supports and services to residents.

The inspection findings were positive. Staff spoken with articulated commitment to the delivery of quality supports and services to residents. Staff were clear on their regulatory roles and responsibilities and based on verbal feedback during the inspection addressed any issues that arose. Staff spoke positively of residents, their strengths and abilities and had robust measures in place to maximise independence and potential. The inspector was satisfied that the supports and routines within the centre reflected residents’ needs and articulated goals and objectives. Staff supported residents to have opportunities for new experiences and social participation and hoped to enhance this for residents following relocation of the service.

There was evidence that the service worked closely and openly with families with the common interest of positive outcomes for residents.

Of the full eighteen Outcomes inspected the provider was judged to be compliant with fifteen and in substantial compliance with the remaining three. Staff did not maintain records of all meetings held with residents and gaps were identified in the records of measures for responding to behaviours that challenged. These gaps created a risk that adequate instruction was not provided to guide staff practice, for example in the use of medications and physical crisis interventions.

The inspection findings are presented in the body of the report; the action to be taken by the provider can be found in the action plan at the end of the report.
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):
No actions were required from the previous inspection.

Findings:
Based on these inspection findings and the provider’s decision to relocate this service, the inspector was satisfied that the provider respected and promoted residents’ rights and dignity.

There was evidence that staff consulted with residents on an ongoing basis in relation to their routines, preferences and choices; these were then represented in the support plan and in the weekly planner. Further evidence of consultation with residents included the use of social stories and fortnightly key-worker meetings (these are discussed further in Outcomes 2 and 5). As appropriate this process of consultation was augmented through regular contact with family and structured family meetings.

For therapeutic purposes staff maintained a nightly sleep record; it also reflected however that while staff sought to establish a regular routine and sleep pattern, residents also had reasonable flexibility as to when they retired and when they got up.

Within the organisation residents had access to an advocacy service but also accessed independent advocacy services; contact details were displayed and staff said that advocates were invited to support residents in pertinent areas and activities such as the decision to relocate the service.

Residents’ spiritual beliefs and requirements were detailed in support plans.

There were no reported restrictions on visits to the centre and the inspector saw that staff worked with families in relation to supporting home visits.
There were policies and procedures for the management of complaints and staff maintained a log of any complaints received. The inspector reviewed this log and was satisfied that staff were open to receiving complaints, took action to resolve in so far as was possible the matters complained of and ascertained the satisfaction of the complainant with the actions taken.

The inspector reviewed the systems for the management of residents’ finances. Staff spoken with were clear on the requirement for a budgetary plan, accountability and transparency when financially supporting residents. Staff maintained a financial record of each transaction both lodgements and debits, supporting receipts and the purpose for which monies were used were available and there was evidence of two signatories for each transaction. Oversight of resident finances was incorporated into the team leader’s weekly review of the service.

However, staff confirmed that the issue of voting had not been discussed or explored with residents so as to ascertain their understanding or interest in exercising their vote.

Staff said that residents as they wished met daily with the team leader to discuss any issues or concerns that they had and that meetings with residents to agree the weekly planner were held each Monday morning, staff did not however maintain records of these meetings.

**Judgment:**
Substantially Compliant

**Outcome 02: Communication**
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

**Theme:**
Individualised Supports and Care

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

**Findings:**
The inspector saw detailed support plans that identified both strengths and where additional supports were required to facilitate effective communication for and with residents; staff spoken with conveyed to the inspector what was identified in the support plan.

The support plan reflected a broad understanding of communication and addressed not only verbal communication but also comprehension, literacy and the role of exhibited behaviours in communication. Strategies identified in the support plan to assist communication were evidenced in practice and included the use of visual schedules and...
planners and a white board that was updated daily by staff. A further technique used by staff was the use of “social stories”, a tool for teaching social skills and learning from specific situations, events or activities. Staff described the positive use of social stories to communicate to residents what to expect and how to act in particular situations and said that residents would also request “talk-time”.

Staff understood the requirement for allowing sufficient time, the importance of tone of voice and sentence structure.

As discussed below in Outcome 3 there was evidence of honest and open communication between staff and families.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
It was evident that staff recognised the importance of and supported residents to maintain and develop positive family and social relationships. There was evidence that the centre was organised in consultation with both residents and their representatives and that this was an open and transparent process where differences may arise but there was a mutual commitment to positive outcomes for residents.

Maintaining family contact was an agreed goal in support plans and the inspector saw that this was supported by staff through both home visits and visits to the centre. Staff maintained a log of family contact, there was daily contact between families, residents and staff and formal family meetings were implemented in late 2015.

As discussed in Outcome 10 while challenges did exist staff were striving to achieve social integration and relationships with peers for residents.

Judgment:
Compliant
Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were policies and procedures in place governing admission to the centre.

The inspector saw a detailed contract for the provision of supports and services to residents signed as agreed with a representative of the provider. The contract detailed the fees to be charged for the services provided and what services were not included in the fees and were the personal responsibility of residents. The fees outlined in the contract reflected residents’ personal financial records. There was evidence of ongoing discussion with resident representatives on the provided supports and applicable fees.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
The arrangements for meeting each resident’s assessed needs were set out in the personal support plan. The support plan was presented in a respectful person-centred manner, focussed on strengths and ability and reflected the provider’s commitment to achieving with and for, positive outcomes for residents. This plan was based on an assessment of both strengths and where staff supports were required in domains that
included health and wellbeing, maximising independence and social inclusion. As appropriate family were invited to and inputted into the review of the support plan.

Each resident had a key-worker and resident participation in the plan was facilitated through fortnightly meetings with the key-worker. The inspector also saw that staff had maximised resident participation in their plan through the completion of an ELP discovery tool (essential lifestyle planning); a tool that allowed the resident to communicate to staff their strengths, what and who was important to them, what they wanted to achieve and the supports they required for this. From each assessment the specific supports required by the resident were identified as were the resident's desired goals and objectives. Each goal had an action plan that identified responsible persons, timeframes and tracked the progress of its achievement. These action plans were detailed and identified both what had worked and what had not worked; learning was then integrated into the support plan to support future success rather than failure.

Overall the inspector was satisfied that there was congruence between the findings of the ELP tool, the support plan, identified goals and objectives, what staff said, other inspection outcomes such as residents rights, communication and health and safety and what the inspector observed in practice.

There was a transition plan in place to support residents’ relocation to the new centre. Staff were seen to support the plan and the resident through the use of a visual plan and a social story as referred to in Outcome 2.

Resident participation in the plan was clear, how the accessibility of the plan for the resident could be enhanced further was discussed by way of recommendation at verbal feedback.

**Judgment:**
Compliant

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**Outcome 06: Safe and suitable premises**

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

**Theme:**
Effective Services

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

**Findings:**
It was evident that the provider had invested in the refurbishment of the premises to enhance its suitability to its proposed stated purpose and function; following
refurbishment the premises had been fully redecorated.

Each resident was to be provided with their own bedroom; though compact there was no evidence that they did not offer sufficient space to meet the needs of the proposed residents.

Bedrooms were not en suite but in close proximity to the bedrooms there was a spacious universally accessible bathroom with shower, toilet and wash-hand basin. There was a further separate room with toilet and wash-hand basin. These facilities was sufficient for the proposed maximum number of residents to be accommodated, two.

The kitchen offered sufficient space, was adequately equipped and incorporated the dining area. There was an annexed area with facilities for the laundering of residents’ personal clothing.

The premises was located on a spacious site that afforded security. Some further external works to the rear of the building were required to ensure that residents in line with their needs and preferences had access to a suitable outdoor recreational area. The provider gave a commitment following the inspection that these works would be complete prior to the relocation of the residents and by the 26th February 2016. The provider confirmed to the Authority that the works were complete on 26th February 2016.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
There were measures in place to ensure in so far as was reasonably practicable the health and safety of residents, staff and others.

The inspector saw both organisational and local health and safety statements that incorporated the procedures for identifying and managing risks and the management of accidents, incidents and adverse events.

The inspector saw a comprehensive range of generic, centre and resident specific risk assessments. The sample reviewed was detailed, identified any required controls, and reflected what staff said and what was written in support plans. There was a dynamic
approach to risk assessment and the process evolved as resident’s needs changed and as matters arose in the centre; risk assessments had been competed to support relocation to the new premises. The risk register also included the risks as specifically required by Regulation 26 (1) (c).

The premises was fitted with an automated fire detection system, emergency lighting, clearly identified fire doors, illuminated escape routes and fire fighting equipment. Certificates were available confirming that fire safety systems had been installed and commissioned to the required standard.

Staff had attended fire safety training in February 2016 but the person in charge said that site specific training would be provided once the service relocated to its new location.

Residents had explicit personal emergency evacuation plans and records indicated that simulated fire drills for staff and residents were convened on a quarterly basis most recently in December 2015. Satisfactory evacuation times had been achieved and staff had identified practical interventions (headphones once the evacuation was in process) to reduce any distress caused to residents from the sound of the fire alarm.

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.

**Judgment:**
Compliant

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

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

**Findings:**
There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, supportive risk assessments and staff training. There was good input into and a presence of other stakeholders in the centre including family, advocates and other health care services.
Staff said that there had been no incident of alleged, suspected or reported abuse. Records seen including communication and behaviour support plans indicated that staff were attuned to resident’s emotions, concerns and worries and any altered patterns of behaviours.

However, training records indicated and the team leader confirmed that one staff member had not attended education and training on adult safeguarding.

Support plans for the supervision and provision of personal and intimate care were in place. However, the inspector based on other records seen was not satisfied that they incorporated specific preferences that had been expressed and articulated to staff. Staff agreed and addressed this in the support plan and included the provider’s commitment in so far as was reasonably practicable to facilitate these preferences.

Overall and on balance there were good strategies in place for preventing and responding to behaviours that had the potential to challenge others. Staff had received the required training up to and including de-escalation and intervention techniques. Staff spoken with communicated an evidence based approach to interpreting and responding to behaviours with due regard for a residents diagnosis and inherent personality.

Explicit behaviour management guidelines were in place; these were informed by relevant personnel including psychiatry, psychology and behavioural therapy. Staff had encountered difficulty in securing timely access to some services but this was being actively managed by staff.

Restrictive practices were in place; the rationale for them was the management of risk and the promotion of resident safety and the safety of others. The inspector was, based on staff spoken with and records seen, satisfied that each practice that was potentially restrictive was clearly identified as such by staff, the required documentation was completed and the ongoing requirement for each restriction was reviewed at prescribed intervals. There was evidence of strategies to reduce the impact of restrictions on residents, such as the allocation to residents of their own kitchen cupboard or the use of a food processor in food preparation. Staff said, and there was no evidence of, negative consequences for residents as a result of manifested behaviours; for example staff said that a planned activity may be delayed to allow a situation to resolve but was never cancelled unless requested by the resident. There was congruence between what staff said, risk assessments, the support plan and the behaviour management guidelines.

However, while there was evidence of good practice as described above improvement was required as;
- there were two sanctioned physical crisis interventions. Staff said that these were not employed but this was not clear from records seen including notifications to the Authority as staff employed a generic description “MAPA” (management of actual or potential aggression) of interventions
- staff completed “body maps” to record any noted resident injuries; these were not however always accurately completed by staff in line with the guidance provided
- staff recorded incidents of manifested behaviours, these were not always completed however in line with the requirements of the behaviour management guidelines, for example in relation to antecedents and duration
• based on records seen the PRN (as required) protocol offered insufficient guidance to staff in relation to the administration of medications prescribed on a PRN (as required) basis particularly where staff identified that medication was required but a regular prescription was also due to be administered and guidance as to how soon after a regular administration a PRN may also be administered
• there was some discrepancy between the behaviour management guidelines prepared by the behaviour therapist and the guidelines in the support plan

**Judgment:**
Substantially Compliant

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**Outcome 09: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe Services

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

**Findings:**
There were policies and procedures and a recently introduced electronic system for recording accidents, incidents and adverse events. Staff were clear on their individual responsibilities including responsibility to submit notifications as required to the Chief Inspector. The inspector was satisfied based on these inspection findings that the person in charge had submitted the required notifications within the mandatory timeframes.

**Judgment:**
Compliant

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**Outcome 10. General Welfare and Development**
Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
Based on staff spoken with, records reviewed and the inspectors own observations, the inspector was satisfied that despite challenges that presented, staff were open to and committed to supporting residents to have opportunities for new experiences and social participation.

All staff spoken with articulated commitment to achieving social inclusion and opportunities for developing relationships with peers for residents. Resident’s goals and objectives in this regard were clearly recorded as were the actions taken by staff to support residents in achieving those goals. Staff used the phrase “not setting the service user up to fail” and this philosophy was evident in the measures taken by staff to ensure participation and success. These measures included risk assessments, planning, researching suitable venues and facilitators, phased introduction and implementation.

With the support of staff residents enjoyed swimming, zumba (a dance fitness programme), computers, trips away from the centre with staff, sporting events, the cinema, access to peer groups, housekeeping and friendship skills workshops, and shopping. Each event had a clear plan with strategies to minimise risks and failure.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Staff said and there was documentary evidence that staff supported residents to maintain and enjoy health and well-being. The support plan assessment encompassed an assessment of residents’ healthcare requirements.

There was documentary evidence that as required staff supported residents to access General Practitioner (GP) review and treatment. Staff had strategies in place to ensure that these visits were successful and not a source of concern or distress for residents. As appropriate to their needs residents were supported to access other healthcare services including dental care, psychiatry, psychology, behavioural therapist; nursing services were accessed through community care. There was evidence of recent blood profiling to ascertain general well-being.
However, notwithstanding each resident’s right to make independent meal choices the inspector did have nutritional concerns in relation to the menu; staff had however identified this. There was evidence that dietetic input had been sought by staff and at the time of this inspection staff were undertaking an information gathering exercise and were maintaining a record of meals requested and consumed by residents at the request of the dietician.

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

**Findings:**
There were policies and procedures in place governing the management of medications. Staff confirmed that education and an assessment of competency was required before staff could engage in medication management; records seen indicated that these had both been completed by staff.

The inspector saw that medications were securely stored and security was further ensured by the maintenance of daily medication counts and signed, verified records of medications both received and returned to the pharmacy.

The medication prescription sheet was signed and dated by the relevant GP; the medication administration record reflected the prescription. The inspector noted no anomalies between the prescription, the medications supplied and their affixed pharmacy labels.
Medications were not required in an altered format (crushed) and no medications requiring stricter controls were in use.

Medication management practice overall was safe, however, based on records seen enhanced guidance, monitoring and review was required in relation to the administration of medications prescribed on a PRN (as required) basis. This is discussed in the context of responding to behaviours that challenged in Outcome 8.

**Judgment:**
Compliant
**Outcome 13: Statement of Purpose**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a statement of purpose that accurately described the services to be provided in the centre and that contained all of the information required by Schedule 1.

**Judgment:**
Compliant

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a clear management structured comprised of the team leader, the person in charge and the regional manager. Each person spoken with was clear on their respective roles, responsibilities and reporting relationships and described positive and supportive working relationships. During the inspection process staff exercised their individual roles and responsibilities in a confident and competent manner. Based on these inspection findings the inspector was satisfied that the management systems were sufficient to ensure that the services and supports provided to residents were effectively monitored to ensure their consistency, quality and safety.

The person in charge worked full-time and this centre was now her only defined area of responsibility. The person in charge had established experience within the organisation and an established working relationship with the regional manager. The person in
The person in charge was suitably qualified for her role and also engaged in all training facilitated by the provider. It was clear from records seen that the person in charge was consistently engaged in the administration and operational management of the service.

On a day-to-day basis the person in charge was supported by the team leader, the PPIM (person participating in the management of the service), who was also employed on a full-time basis. While relatively new to this centre the team leader had established experience in the provision of social care supports and services and had completed education and training in relevant areas. The team leader had a sound understanding of and was willing to undertake the roles and responsibilities of the PPIM.

There was a dedicated shift leader when the team leader and the person in charge were not on duty. There was an on-call out of hour’s rota available to staff and documentary evidence that staff as required sought support and guidance for the on-call manager.

Staff said that they had ready access to their respective managers as required and formal monthly regional meetings were also convened.

Systems of review seen by the inspector included the weekly reviews of systems completed by the team leader, key-worker meetings with residents and formal family meetings. In addition and as required by Regulation 23 the provider had completed an annual review and an unannounced visit to the centre to monitor and establish the quality and safety of the services and supports provided to residents; reports were available for the purpose of inspection.

**Judgment:**
Compliant

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**Outcome 15: Absence of the person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

There were arrangements in place for the management of the centre in the absence of the person in charge; the PPIM confirmed that she would undertake this role supported by the regional manager. There had been no absence of the person in charge of a duration that required notification to the Chief Inspector.
### 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):**  
No actions were required from the previous inspection.

**Findings:**  
Based on these inspection findings and as confirmed by staff spoken with, the provider ensured that sufficient resources were in place for the effective delivery of supports and services to residents.

**Judgment:**  
Compliant

### Outcome 17: Workforce
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**  
Responsive Workforce

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

**Findings:**  
Staff said that there had been some challenges to both recruiting and retaining staff primarily due to the geographical location of the centre. The person in charge however was now responsible only for this centre and no other designated centre and the team leader had been recruited in November 2015.

There was a requirement for agency staff to maintain staffing numbers. Staff said that this was managed to ensure continuity for residents; that is, the same small number of agency staff worked the required shifts; this was reflected in the staff rota seen by the inspector. Service level agreements setting out the responsibilities of the provider and
the agency were also seen.

A planned and actual staff rota was maintained and it reflected the agreed staff to resident ratio as described by staff and as seen by the inspector. There was one waking staff and one sleepover staff each night and no evidence that this arrangement was not sufficient. The shifts worked by staff had also been revised to reduce the number of handovers in the day and enhance consistency for residents.

Staff files were available for the purposes of inspection. The sample reviewed by the inspector was well presented and contained all of the information required by Schedule 2.

Staff records indicated that staff had core qualifications suited to their role and records were maintained of training completed post employment. Again these records were clearly presented and indicated that staff attended mandatory training in fire safety, responding to behaviours that challenged, manual handling and safeguarding. There was one confirmed gap in staff attendance at safeguarding training and this is addressed in Outcome 8. Further training completed by staff included medication administration, report writing, first aid, and providing personal care.

Policies, procedures, risk assessments, support plans and behaviour management plans were all signed as read and understood by staff. What staff relayed to the inspector over the course of this inspection reflected the content of these records.

Staff confirmed structured supernumerary induction for all new staff including agency staff. There was evidence that staff were supervised and assessed while on probation and on an ongoing basis through the formalised supervision process.

**Judgment:**
Compliant

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### Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
**Findings:**
The inspector was satisfied that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were in place and were readily retrieved as requested by the inspector.

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

There were policies that satisfied regulatory requirements and reflected the centre's practice; those seen by the inspector had been reviewed and updated by the provider.

The residents guide satisfied regulatory requirements and was available in a format that enhanced its accessibility and usefulness to residents.

A directory of residents was maintained and available. However, it did not include all of the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Judgment:**
Substantially Compliant

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**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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005375</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>10 February 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 February 2016</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The issue of voting had not been discussed or explored with residents so as to ascertain their understanding or interest in exercising their vote.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
Voting will be discussed with resident prior to the upcoming election

Proposed Timescale: 26/02/2016
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Meetings with residents to agree the weekly planner were held each Monday morning, staff did not however maintain records of these meetings.

2. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
Weekly meetings with residents will be recorded

Proposed Timescale: 22/02/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
•there were two sanctioned physical crisis interventions. Staff said that these were not employed but this was not clear from records seen including notifications to the Authority as staff employed a generic description “ MAPA” (management of actual or potential aggression) of interventions
•staff completed “body maps” to record any noted resident injuries; these were not however always accurately completed by staff in line with the guidance provided
•staff recorded incidents of manifested behaviours, these were not always completed however in line with the requirements of the behaviour management guidelines, for example in relation to antecedents and duration
•based on records seen enhanced guidance, monitoring and review was required in relation to the administration of medications prescribed on a PRN (as required) basis. The inspector saw that at times staff administered the PRN medication when it may have been more appropriate to administer the regular dose and wait for its therapeutic effect but staff proceeded to administer both the PRN and the regular medications within a very short timeframe of each other
•there was some discrepancy between the behaviour management guidelines prepared
by the behaviour therapist and the guidelines in the support plan

3. **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:**
Notifications to the Authority will describe any physical interventions employed.
Staff will complete Body Maps accurately.
PRN protocol to be reviewed by Psychiatrist
Behaviour management guidelines and support plan to be reviewed to ensure consistency of guidelines

**Proposed Timescale:** 29/02/2016

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One staff member had not attended training on adult safeguarding.

4. **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:**
The training department have confirmed that they will provide a hard copy of the safeguarding course material as well as the videos used in the training for the staff member prior to his training in April. This will be facilitated in the service early next week the week commencing the 7th March. Formal training will then be provided centrally on the 12th April 2016.

**Proposed Timescale:** 11/03/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not include all of the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
<table>
<thead>
<tr>
<th>5. <strong>Action Required:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
Directory of Residents updated to include marital status and gender

**Proposed Timescale:** 19/02/2016