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<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>RehabCare</td>
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<tr>
<td>Provider Nominee:</td>
<td>Grainne Fogarty</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Jackie Warren</td>
</tr>
<tr>
<td>Support inspector(s):</td>
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<td>5</td>
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About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: To:
31 May 2017 09:45 31 May 2017 18:30
01 June 2017 09:45 01 June 2017 18:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

Background to the inspection:
This was a monitoring inspection carried out to monitor compliance with the regulations and standards, and to review progress in addressing the issues identified at the last inspection in May 2016. There has been a recent change to the management team for this centre. The new management team have been working to address previously identified non-compliances and have developed an improvement plan to achieve this.

How we gathered our evidence:
As part of the inspection, the inspector observed practices and reviewed documentation such as health and social care files, medication records, and health and safety documentation. The inspector met with all five of the residents using the service at the time, and with four staff members and the person in charge, the provider nominee, and the integrated service manager. None of the residents spoke with the inspector, but all appeared to be relaxed and comfortable in the centre, and in the presence of staff.
Description of the service:
The centre comprised of a house in the outskirts of an urban area, and was within easy reach of shops, restaurants, banks and all other amenities. The centre was intended to provide long term residential accommodation for up to five male and female adults with an intellectual disability.

Overall judgment of findings:
Overall, on this inspection, the inspector found that considerable work has been carried out to address the non-compliances identified at the previous inspection, and that the standard of service has improved. However, further improvement is required and the management team have a plan in place to address all identified non-compliances. Of the ten outcomes inspected on this inspection, one was in compliance with the regulations and two were substantially compliant. Six outcomes were moderately non-compliant and there was one major non-compliance.

Residents received a good level of health and social care. Residents participated in appropriate activities, and were also supported by staff to integrate in the local community. Residents’ healthcare needs were met and there were measures in place to safeguard residents from abuse. The centre was suitably staffed to meet the needs of residents. Staff had attended a range of training, although some had not received up-to-date training in manual handling. The provider had clear governance arrangements for the management of the centre, and auditing was being carried out to review and improve the quality and safety of the service.

Improvement to fire evacuation drills, fire safety and to the risk management policy was required. Improvement was also required to the administration of medication, the medication policy and to the auditing and recording of medication systems. There were some compatibility issues in the centre, which impacted on safeguarding and residents' choices. In addition, service agreements, and some aspects of personal planning required further development.

Minor improvement was required to staff recruitment documentation and to the annual review of the service.

Findings from the inspection and actions required are outlined in the body of the report and the action plan at the end.
Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
This outcome was not examined in full at this inspection; however the inspector did review consultation and residents’ choices around daily living activities. During the last inspection of this centre in May 2016, the inspector found that improvement was required to accessing advocacy services for residents, and in residents’ participation in the organisation, planning and operation of the centre. On this inspection these issues had been addressed, but improvement was required to ensuring residents choices around daily activities.

Monthly residents meetings were taking place in a revised format to suit the needs of residents. These meeting were now carried out on a one-to-one basis with each resident and a staff member, rather than as group meetings. Communication techniques to suit each resident's needs; such as, picture cues, were used to establish residents’ wishes. Records of these meetings were kept, which indicated that food choices, leisure activities and holidays had been considered. An advocacy service was available to support residents.

During this inspection, the inspector found that residents’ choices around participation in some activities of daily living were, at times, limited due the incompatibility of some residents’ living in the centre. For example, as an intervention to manage behaviour that is challenging, all residents did not have unlimited use of the kitchen. This impacted on the opportunity for some residents to become involved in food preparation at times that suited them. The person in charge and provider had identified this deficit and showed the inspector a plan that had been developed to manage it. Part of the plan had been
implemented by the provision of a separate sitting room, part was in progress and another intervention was being planned for the future.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
A written agreement for the provision of services was in use in the centre. However, this had not been agreed on behalf of all residents, and some of the information in the agreement was not sufficiently clear.

While the written agreement for the support, care and welfare of residents had been agreed with most residents or their representatives, it had not yet been finalised for one resident.

The inspector viewed a sample of these agreements and found that they were informative, and had been prepared in an easy read-format. However, some of the information in the agreement was unclear. While the agreement clearly stated what was included in the service, it did not specify what was not included or what incurred additional costs to residents.

There was a policy to guide the admission process. The inspector viewed a sample of transition plans that had been developed for residents being admitted to the centre. These plans were informative and were completed to a high standard.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

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

**Findings:**
Residents’ social well-being was maintained by a good standard of care and support. During the last inspection of this centre in May 2016, the inspector found that improvement was required to residents’ personal support plans and this had been partially addressed. Furthermore, it was found on this inspection that improvement to the recording of residents’ social care progress was required.

Individualised assessment and personal planning was being carried out for each resident, and residents had opportunities to participate in activities, appropriate to their individual interests and abilities.

The inspector viewed a sample of residents’ support plans. During the last inspection, the inspector found that support plans were not presented in a manner that was accessible to residents and there had been no multidisciplinary involvement in the preparation of the plans. This had been addressed in respect of the accessibility of the plans, but not in respect of multidisciplinary involvement.

There was an annual meeting for each resident, attended by the resident, his or her family and support workers, to discuss and plan around issues relevant to the resident, and to develop personal goals for the coming year. However, while needs assessments had been completed by staff for each resident, these assessments were not detailed, and there was no multidisciplinary team involvement as required by the regulations.

Each resident had a personal plan outlining the things that they liked to do and included information about the resident’s interests. The inspector read a sample of personal plans, and found that residents’ individual needs and life goals were set out. This information was also in a visual, user-friendly, format that included clear text and pictorial images. In the files viewed, residents’ goals for the previous year had been achieved and current goals were being progressed. However, in some instances the plans were not being updated to reflect the progress being made, although the progress was clearly known to staff.

There was a range of activities taking place both in the centre, and in local resource services which residents attended each weekday supported by staff. Residents attended social activities, outings, hobbies of their preference, and some participated in household tasks at a level suited to their abilities.
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):

Findings:
There were arrangements to protect the health and safety of residents, visitors and staff. However, improvements to fire evacuation drills, fire training, moving and handling training, and the risk management policy were required.

During the last inspection of this centre in May 2016, the inspector found that improvement was required to the identification of risk and to fire drills. This had been partially addressed in respect of risk management and had not been suitably addressed in relation to fire evacuation drills.

It was the practice in the organisation to carry out quarterly fire drills, although in the past this target had not been achieved. However, the current person in charge had taken measures to address this. Three fire drills had taken place since late in 2016; which had all been completed during waking hours. Records of fire drills were kept, although these did not indicate which staff had participated in the drills. During one of the fire drills residents had not been evacuated from the centre in a timely manner, although at the time of inspection measures had not been introduced to address this concern.

Some staff had not received up-to-date fire safety training as required by the regulations. Training records indicated that most staff had received up-to-date fire safety training, although some staff had not, and were scheduled to attend it in the near future. All staff who spoke with the inspector confirmed that they had attended fire safety training, and that this training had been informative.

The provider had taken other measures to ensure residents, staff and visitors to the centre were safeguarded in the event of a fire. Service records showed that all fire extinguishers, fire alarms, emergency lighting, and the central heating boiler had been suitably serviced. Fire resistant doors were provided on residents' bedrooms, and these doors closed automatically. At the time of inspection, all exit doors were free from obstruction. Fire evacuation notices were prominently displayed in the centre. Personal emergency evacuation plans had been developed for all residents.

There was a risk management policy and a risk register available to guide staff. The risk management policy identified the procedures for the identification and management of
risk in the centre, although some of the specific risks named in the regulations were not suitably addressed. Suitable control measures had not been identified for the control of self harm, and the controls for absconding focused on the search for a missing person rather than the measures in place to prevent this risk. Personal risk management plans had been developed for each resident to identify risks specific to each person and their control measures.

Moving and handling assessments had been carried out for all residents.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe Services

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

**Findings:**
There were measures in place to protect residents from being harmed or abused. However, improvement to the compatibility of residents in the centre was required. During the last inspection, improvement was required to safeguarding training for staff and this had been addressed.

The inspector found that improvement was required to the compatibility of residents in the centre to ensure that residents were protected from the risk of peer to peer abuse. It was evident from discussion with staff, and from review of incident records, that some residents were not residing compatibly together. Incidents of peer to peer abuse at the centre were investigated and some safeguards had been put in place, while other safeguarding measures were in progress. There were behaviour management plans for the support of these residents. However, behavioural issues continued to be evident, and to impact consistently on the quality of life of residents. While it was evident that the organisation was taking this issue seriously, actions had not been completed to resolve the safeguarding issues arising from residents co-habitation.

There was a policy for responding to allegations of abuse, and all staff had received safeguarding training. Staff who spoke with the inspector understood the types of abuse and what to do in the event of an allegation or suspicion of abuse. The person in
charge, and the provider nominee, were also clear on how an allegation or suspicion of abuse would be investigated and managed.

There was a number of designated persons within the organisation, with the centre being assigned their own designated person who had responsibility for responding to allegations of abuse.

The inspector observed staff interacting with residents in a respectful and friendly manner. Intimate care plans had been developed for each resident to guide staff in the safe and appropriate delivery of intimate care.

There was a policy for the provision of behavioural support. All staff had received training in managing actual and potential aggression. There was a behaviour therapist employed in the organisation who worked with residents and staff, and who was involved in developing plans of care and strategies for behaviour management. The inspector viewed a sample of behaviour support plans which had been developed for residents and discussed these plans with staff. These plans included proactive and reactive measures to be used for each resident, and were reviewed and updated as required. Staff were very clear about residents’ support needs and explained measures that would be used if required.

Judgment:
Non Compliant - Moderate

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<th>Outcome 11. Healthcare Needs</th>
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<tr>
<td>Residents are supported on an individual basis to achieve and enjoy the best possible health.</td>
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| Theme: |
| Health and Development |

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

| Findings: |
| Residents’ healthcare needs were well met and residents had access to appropriate medical and healthcare services. |

Residents were supported to visit their general practitioner (GP) as required and records of GP visits were recorded. Referrals were also made for residents to be assessed by other healthcare professionals and consultants as required. For example, there were records of visits to a neurologist, a psychologist, epilepsy clinics and dentists.

All residents had personal plans which outlined the services and supports to be provided to achieve and maintain good health. The care and support plans viewed by the inspector contained information around residents’ healthcare needs, assessments,
medical histories and support required from staff. For example, care plans for epilepsy management had been developed as required.

The inspector found that residents’ nutritional needs were well met. Staff prepared healthy meals for residents, and offered choice at mealtimes by using pictorial cues. The inspector saw residents eating healthy, home cooked meals which they appeared to enjoy. At the time of inspection there were no residents who required modified diets. Some residents required special diets, such as gluten free diets, and these were supplied.

There were no residents in the centre with wounds or pressure ulcers, with diabetes, or assessed as being at risk of malnutrition.

**Judgment:**
Compliant

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector found that improvement to medication management practice was required.

During the last inspection of this centre in May 2016, the inspector found that residents’ capacity to manage their own medications had not been assessed. Improvement was also required to medication storage and administration. On this inspection, these had been addressed. However, improvement was required to prescribing and administration practices.

The inspector viewed a sample of medication prescribing and administration records and found that on some administration records viewed, staff had not signed to confirm that prescribed medication had been administered. Furthermore, there were no comments recorded to indicate if the medication had been withheld for any reason. In addition, the administration times in some administration records were not consistent with the times prescribed by the GP. Inspectors also found that the maximum dosage for some p.r.n. (as required) medication was not stated to guide staff.

The inspector found instances of staff administering crushed medication to some
residents where this had not been prescribed to be administered crushed. Staff had also discontinued the administration of some prescribed medication without this action being suitably verified by a GP.

Some safe medication management practices were identified. There were colour photographs of each resident available to verify identity if required. Personal administration plans had been developed for each resident. The inspector found that medication was suitably stored and there was a secure practice for the return of unused and out-of-date medication to the pharmacist.

There was a medication policy to guide staff and all staff had received training in safe administration of medication.

Self administration assessments had been undertaken for all residents, although it was found that self administration was not suitable for current residents.

At the time of inspection, none of the residents required medication requiring strict controls.

**Judgment:**
Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The provider had established a clear management structure, suitable supports were available to staff and there were systems to review and improve the quality of service. However, some improvement was required to the annual report, and to medication auditing.

Since the last inspection there had been considerable change to the management team for this centre. The provider nominee, integrated service manager, person in charge, and team leader had changed and the new management team were working together to
improve the level of compliance in the centre. This management team had devised an improvement plan which was being implemented and an improvement in the level of compliance in the centre was found on this inspection. The inspector viewed this plan and found that required actions were clearly stated, the responsible person was identified, and timeframes for completion were set.

The person in charge had responsibility for the overall management of the service. He worked closely with a team leader who was based in the centre and had responsibility for the day-to-day running of the service, for overseeing the quality of care delivered to residents, and for supervision of the staff team. The person in charge was not based in the centre, but called there frequently and clearly knew the residents and their care needs. There were arrangements to cover the absence of the person in charge and there were on call out of hours arrangements in place to support staff.

There were procedures in place for monitoring the quality and safety of care. All accidents and incidents were recorded and kept under review for the purpose of identifying trends. Other audits carried out by staff included, audits of medication, and residents’ finances. However, the monitoring of medication management was not effective, as the audit failed to identify several issues identified during the inspection.

Unannounced six monthly visits to the service had been carried out on behalf of the provider. Copies of the reports, which included an action plan of required improvements, had been supplied to the person in charge for attention. Most of the actions identified in the report had been addressed, while others were in progress.

An annual report on the quality and safety of care in the designated centre had been prepared. The inspector viewed the annual report and found that consultation with residents and their relatives, and their level of satisfaction with the service had not been incorporated into the report. In addition, the report did not present any overview of how the quality of service had improved, or otherwise, since the previous year.

**Judgment:**
Substantially 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):**
Some action(s) required from the previous inspection were not satisfactorily
implemented.

**Findings:**
There were appropriate staff numbers and skill mix to meet the assessed needs of residents at the time of inspection. Staff had received a range of training appropriate to their roles.

There was a planned roster prepared and this was being updated as required to reflect the actual roster. The roster accurately reflected staff on duty at the time of inspection. There were staff based in the centre at all times when residents were there, including at night. Staffing levels were allocated based on residents needs, and there were sufficient staff rostered to ensure that each resident could have individualised care.

Staff accompanied residents when they wanted to do things in the local community such as going shopping, for leisure outings or for exercise. Separate staff supported residents while attending the day service. The inspector observed staff interacting with residents in a respectful and friendly manner. The inspector observed that residents were clearly comfortable in the company of staff and staff knew the residents' needs well.

Training records indicated that all staff had received training in safeguarding, safe medication administration, and management of actual and potential aggression in line with the organisation’s practice. While the majority of staff had attended all mandatory training, some staff had not attended up-to-date training in fire safety and manual handling. This had been identified by the person in charge, and this training was scheduled to take place in the near future. In addition, staff had attended other training relevant to their roles, such as training in epilepsy care, report writing, food safety, and nutrition.

Staff recruitment files were maintained to a good standard. The inspector viewed a sample of staff recruitment files and found that the majority of the required information, such as Garda vetting and photographic identification was present. However, in one file, there was an unexplained gap in employment history.

During the last inspection of this centre, the inspector found that improvement was required to medication administration training and some aspects of staff recruitment, and these had been addressed.

**Judgment:**
Non Compliant - Moderate

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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:
This outcome was not reviewed in full at this inspection. Samples of documents were reviewed during the inspection, which, overall, were found to be satisfactory. Some improvement; however, was required to the medication policy.

During the course of the inspection, a sample of documents such as staff recruitment files, health and safety records, and healthcare documentation were viewed and were generally found to be satisfactory. All records requested during the inspection were promptly made available to the inspector. Records were orderly and suitably filed. Some records, such as staff training records, were not retained and managed in the centre. However, this information was made available to the inspector for review.

The inspector viewed the medication policy, and found that some aspects of the policy did not provide sufficient information to guide staff when transcribing medication from prescriptions onto prescription sheets. The person in charge told the inspector that a new medication policy was at an advanced stage of development and would include guidance on transcribing.

During the last inspection of this centre in May 2016, the directory of residents required improvement and this had been addressed. The inspector viewed the directory of residents and found that it contained all the information required by the regulations.

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:
Provider’s response to inspection report

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002652</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>31 May 2017 and 01 June 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26 July 2017</td>
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Requirements

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

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

Outcome 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:

Residents’ choices around participation in all activities of daily living were at times being limited due the incompatibility of some residents’ living in the centre. Some residents did not have unlimited use of the kitchen for food preparation at times of their choice.

1. **Action Required:**

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
• A review is taking place regarding the resident mix within the house. It is planned that one resident will move out to a more appropriate setting by 31st October 2017. All restrictive practices will be reviewed at this time.

• A Restricted practice protocol is in place outlining that the Kitchen door is only to be locked during food preparation and when individual service users are eating their meals at specific mealtimes. This is to afford individuals a pleasant environment in which to prepare and eat their food without interference to their food from other residents in the house.

• It is clearly stated in the restrictive practice protocol that access is not restricted at any other time for any of the service users.

• Plans are being developed to install a second smaller kitchen area where residents can prepare and eat meals without depriving others access to the main kitchen and its amenities. The lock will then be removed from the main kitchen door. It is proposed that this work will be completed by 31 October 2017.

Proposed Timescale: 31/10/2017

Outcome 04: Admissions and Contract for the Provision of Services
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the information in the service agreement was unclear. While the agreement clearly stated what was included in the service, it did not specify what was not included or what incurred additional costs to residents.

2. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
• New service agreements are being drawn up which will include areas/activities that RehabCare will be financially responsible for and those that the resident will be expected to self-fund.

• This will be completed and discussed with the residents and/or their representatives. They will be requested to sign off to indicate that they are happy with the conditions in the agreement.
Proposed Timescale: 31/08/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A written agreement for the provision of service had not been finalised on behalf of all residents.

3. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Outstanding agreement has been signed off and this has now been addressed for any new admissions.

Proposed Timescale: 05/06/2017

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:
Some instances the plans were not being updated to reflect the progress being made.

4. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
• All resident’s plans have now been reviewed in line with this action. A document is in place to record reviews of personal plans.

Proposed Timescale: 14/07/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no multidisciplinary team involvement in the assessment of residents' needs and in the development of their personal plans.
5. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
- Ongoing input from MDT will continue to be recorded in the service and used to inform updates of resident’s plans and staff practice on a day to day basis.
- All members of the Multi-disciplinary team will be invited to all review meetings held on a minimum annual basis. A record will be held of the attendance/non-attendance of any members of the team invited.

**Proposed Timescale:** 19/07/2017

<table>
<thead>
<tr>
<th><strong>Outcome 07: Health and Safety and Risk Management</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The specific risks named in the regulations were not suitably addressed. Suitable control measures had not been identified for the control of self harm.</td>
</tr>
</tbody>
</table>

6. **Action Required:**
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**
- All risk assessments regarding self-injurious behaviour are being reviewed. In addition risk assessments regarding self-harm will be developed at the same time. All risk assessments will be completed by 31st July 2017
- Local identification and management of self-harm procedure will also be reviewed.
- An individual risk assessment will be completed for each resident including control measures to prevent the incidents of resident engaging in Self Harm in accordance with the organisation’s Self harm procedure and draft Self Harm Policy which will be endorsed by the Senior Leaders Team before the end of 31st December 2017.

**Proposed Timescale:** 31/12/2017

<table>
<thead>
<tr>
<th><strong>Theme:</strong> Effective Services</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The specific risks named in the regulations were not suitably addressed. Suitable control measures had not been identified to control the unexplained absence of a</td>
</tr>
</tbody>
</table>
7. **Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
All risk assessments are being reviewed to include measures to minimise the potential of unexplained absence of a residents.
- An individual risk assessment will be completed for each resident including control measures to prevent the unexpected absence of any resident in accordance with the organisation’s Missing Service User Policy. The risk assessment will outline steps to ensure staff are aware of the whereabouts of service users at all times. All risk assessments will be completed by 31st July 2017.

**Proposed Timescale:** 31/07/2017
**Theme:** Effective Services

8. **Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
- All future documentation will reflect which staff attended. The drills will also be conducted at different times each quarter to reflect different times of the day/night and will ensure that all staff experience a drill at least once a year.
- A night time simulation was conducted on 7th June and Personal Emergency Evacuation Plans reviewed.

**Proposed Timescale:** 07/06/2017
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
During a fire drill residents had not been evacuated from the centre in a timely manner,
and immediate measures had not been introduced to address this concern.

Records did not demonstrate whether or not staff could effectively and safely evacuate residents consistently and in a timely manner.

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

Please state the actions you have taken or are planning to take:
- All staff have completed fire evacuation training and are aware of what action is to be taken in the event of a resident who declines to leave the building during an evacuation.
- Individual Personal Emergency Evacuation Plans will contain information regarding individuals known cooperation during emergency evacuations and methods which may be used to encourage the person to leave.
- There will be a review of local fire evacuation procedures and PEEPs will be updated as required and following every fire drill or requirement to leave the building in case of emergency (activation of alarm system not related to a drill) this will assess the effectiveness of plans.
- Additional measures or changes to existing measures will be identified as required to ensure residents can evacuate in a timely manner.
- Fire evacuation will be an agenda item at team meetings.

**Proposed Timescale:** 31/07/2017

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not received up-to-date fire safety training

10. **Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
- All staff working within the service now have up to Fire safety training.
- All staff receive information regarding emergency procedures building layout and escape routes, location of fire alarm call points and first aid firefighting equipment, fire control techniques and arrangements for the evacuation of residents as part of their
Proposed Timescale: 05/07/2017

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Sufficient measures had not been implemented to ensure that residents were protected from the risk of peer to peer abuse.

### 11. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
- A review of all residents needs is currently being conducted. It is anticipated as a result of this review it will be proposed that some residents move to more suitable alternative accommodation.
- A structured transition plan will be developed as required.
- Staff will ensure that daily activities are planned to ensure a safe environment for all participating and cognisance given to individuals need for a personal safe space/environment.
- A second lounge is available for residents to afford them greater personal space.
- The behaviour therapist is continuing to work with the staff team in reviewing existing and developing new strategies to address issues relating to peer-to-peer abuse.
- A plan to relocate one resident to a service more appropriate for the individual's needs is in process with the anticipated move to take place in a respectful manner by the end of October 2017 which will provide a less crowded living space within the house. This in turn should have a direct effect in reducing incidents of peer to peer abuse.

Proposed Timescale: 31/10/2017

## 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:
On some administration records viewed, staff had not signed to confirm that medication had been administered as prescribed. Administration times in some administration
records were not consistent with the times prescribed by the GP. The maximum dosage for some p.r.n. (as required) medication was not stated to guide staff.
Staff administered and discontinued some medication to residents which had not been suitably prescribed by a GP.
Staff administered crushed medication to some residents and this had not been prescribed to be administered crushed.
Staff discontinued the administration of some prescribed medication without this action being suitably verified by a GP.

12. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
• The organisations revised medication policy is now in the process of being rolled out in the service. The policy includes updated procedures and new documentation for use with administration of medication which address issues highlighted above. This will standard agenda item on team meeting going forward.

• On review of previous records, the GP’s instruction of crushing or opening medication capsules was present; however this had been omitted on the present forms. This has now been updated by the GP.

• A review of all incidents recorded on the internal Health and Safety Management system Rivo relating to medication will be conducted by the service manager and Team Leader on a weekly basis. The RIVO report will be updated by the service manager to reflect on the outcome of the review and any additional controls that may need to be implemented.

• Practices of team members involved in administering medication will be monitored on an ongoing basis by the Team Leader who is also a Medication Assessor.

• Safe administration of medication practice in line with organisational policy will be an agenda item on every team meeting and individual supervision session.

• Support will be given to all staff as required and staff will be given the opportunity to attend refresher courses earlier than prescribed if it is identified as beneficial.

Proposed Timescale: 31/08/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Monitoring of medication management was not effective, as audits failed to identify several issues identified during the inspection.

13. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
- The organisation is currently rolling out a new medication policy, under this policy there is a requirement for local medication audits to be completed and a template in line with the new policy has been provided.
- It is the responsibility of the PIC to ensure these audits are implemented at regular intervals going forward. The first audit will take place before 31/08/2017.
- Monthly reviews of medication records will be conducted by the Team Leader.
- Adherence to the Medication Policy will be reviewed during the formal 6 monthly internal inspection and recommendations acted upon with immediate effect.

**Proposed Timescale:** 31/08/2017

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Record of consultation with residents and their relatives, and their level of satisfaction with the service had not been incorporated into the provider’s annual report.

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

**Please state the actions you have taken or are planning to take:**
- The 2017 annual review will be updated to include record of consultation with residents and their relatives, and their levels of satisfaction with the service.
- This information will be drawn from satisfactions surveys and from consultations with families and residents completed through the six monthly unannounced visits.

**Proposed Timescale:** 15/08/2017

**Theme:** Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual report did not present any overview of how the quality of service had improved, or otherwise, since the previous year.

15. **Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
The 2017 annual review will be updated to present an overview of how the quality of the service has improved, or otherwise, since previous years review.

**Proposed Timescale:** 15/08/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In one staff recruitment file viewed, there was an unexplained gap in employment history.

16. **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:**
- The employment details of the individual highlighted during the recent inspection were rectified following the second day of inspection.
- All current records are complete and correct including those of agency staff.
- Record of employment will be checked by the Team Leader and verified by the service manager for every new employee or agency staff used, prior to them working in the service going forward.

**Proposed Timescale:** 01/06/2017

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received up-to-date moving and handling training.
17. **Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
- A number of staff have completed manual handling training, all remaining staff requiring this training will have completed it by 31/08/2017.
- An ongoing schedule is being formalised with dates to year end to cover all necessary training requirements.
- A training calendar will be planned in December to secure dates for all mandatory and statutory training and refresher courses for 2018.

**Proposed Timescale:** 31/08/2017

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some aspects of the medication policy did not provide sufficient information to staff.

18. **Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
- The organisation's revised medication policy is now in the process of being rolled out in the service. The policy includes updated procedures and new documentation for use with administration of medication.
- This policy will be reviewed at minimum every three years or more frequently if required in line with organisational policy.

**Proposed Timescale:** 31/08/2017