Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Thurles Residential Service
Centre ID:	OSV-0002657
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	2
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

From:	To:
06 December 2016 13:30	06 December 2016 19:30
07 December 2016 09:30	07 December 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 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

Background to the inspection:
This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA) and was undertaken to inform a registration decision. The last inspection was the first inspection of the centre and was undertaken on 4 March 2016.

How we gathered our evidence:
The inspector prior to the inspection reviewed the information held by HIQA including the application for registration, the inspection findings from March 2016

and any other information including notifications submitted by the provider in line with its regulatory obligations.

The inspector was in the centre for two days and in that time reviewed and discussed with staff records including fire safety and health and safety records, staff related records, records of complaints received and records pertaining to supports delivered to the residents living in the house.

The inspector met with the frontline staff on duty, with the person in charge and with both team leaders. A regional manager attended on behalf of the provider to receive verbal feedback on core inspection findings.

Services are provided to two residents and their responsible family members came to meet with the inspector and to give their account of the centre and the support and services provided. The feedback received from families was consistently positive. Staff were described as facilitative and supportive. Families said that they were happy with the care and supports provided, would complain if there was a need to and were confident that their family member was safe in the centre. Families were aware that there were issues in relation to the suitability of the premises.

The inspector was in the centre when both residents returned in the evening from their respective day services and before they left the house in the morning. Given the nature of their disability residents could not provide feedback on the supports and services that they received. The inspector observed the delivery of supports to residents and staff/resident interactions.

Description of the service:
The inspector reviewed the document titled the statement of purpose and saw that it had been reviewed and updated as required however, it was not an accurate reflection of the support and services provided.

Residential services to one resident and shared services (shared with home) to the other resident were provided to two adult residents with high support needs in a domestic type two-storey premises conveniently located in the busy town.

Overall Findings:
There was evidence of improvement for example in relation to assessment, record keeping, monitoring of well-being and the review of restrictive practice.

However, the design and layout of the premises did not meet the individual and collective needs of the residents. This had been identified at the time of the last inspection but had been compounded by the admission of a resident to full-time residential services in August 2016. This resident had been assessed and accepted for full-time support but the premises and the facilities that it provided were not appropriate to their needs and would also impact negatively on the other resident.

Prior to August 2016 the residents had shared and only used the downstairs facilities as they were present in the centre on alternative weeks. One resident was now required to access the first floor and this arrangement was not suited to the

resident’s physical and sensory disabilities.

The unsuitability of the premises meant that restrictive practices and risk control measures were used to manage risks; these interventions did not maximise resident independence, quality of life and did not facilitate the achievement of potential with respect to independence in personal care.

Of the full 18 Outcomes inspected the provider was judged to be compliant with nine and in substantial compliance with two; in moderate non-compliance with three and in major non-compliance with the four; admissions, the premises, health and safety and the statement of purpose.

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

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

Theme:
Individualised Supports and Care

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

Findings:
As discussed below in Outcome 2 residents were non-verbal but staff sought to demonstrate how they consulted with residents and supported their participation in the supports and services provided to them. For example in each personal plan staff had documented how they had established resident preferences, for example meals and activities, by trial and error, that is, what was enjoyed and what had not gone so well. Staff also recorded how and what they discussed with each resident at service user meetings; the records seen reflected the individuality of each resident and their support plan. The process would have benefited however, from documentation of what was agreed and if it was achieved.

Staff had established each resident's religious/spiritual preferences and sought to facilitate these in line with the resident's expressed ongoing wishes.

It was clear from speaking with families and from records seen such as case conferences and reviews of personal plans that families advocated for and on behalf of the service user. The person in charge said that she planned to invite the advocate to come, meet with a group of parents and explain the availability and role of advocacy.

There were policies and procedures for making and managing any complaints received. There was documentary evidence that the complaints procedure had been made available to families. Families spoken with said that they would raise their concerns if and when necessary but were satisfied and happy with the centre and the services provided. Staff did maintain a log of any complaints received; the action taken to resolve the matter was also recorded but not if these actions were sufficient to address the

matter and satisfy the complainant.

The inspector reviewed a sample of records pertaining to the management of resident's personal finances. The records reviewed indicated that monies were managed in line with the provider's policy and procedures. Each resident had a financial transaction sheet, each financial transaction was recorded, supporting receipts were in place, staff countersigned each transaction; oversight was provided and documented by the person in charge.

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:
Residents did not communicate verbally; staff spoke with had a good understanding of how residents could and did communicate by non-verbal means and their comprehension of the spoken word.

Staff described gestures, facial expressions, different vocalisations and their interpretation and the significance of behaviours. Staff confirmed that no resident had ever utilised a specific form of communication such as manual signing. Staff described how they had introduced and were using "object cues" to communicate routines and activities; that is developing an association between a particular object with a particular event or activity. There was further evidence of communication supports in use such as pictorial cues and an alert clock to communicate to the resident planned routines and timeframes.

All of the strategies described by staff were outlined in detailed communication support plans and communication diaries/dictionaries.

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:
Family members spoken with confirmed that the planning and provision of supports and services were completed in consultation with them and that staff were flexible in relation to changing needs.

Staff maintained a family communication agreement that set out the frequency and preferred method of communication; staff maintained a record of communication and records seen by the inspector confirmed a regular process of communication between staff and families.

The inspector saw that staff were familiar to families. Staff said that there were no restrictions on visits; the communication log indicated that family did call at times unannounced to the centre. Other records seen such as minutes of personal plan reviews and case conferences indicated that family were invited and did attend these important reviews of needs and supports.

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):
No actions were required from the previous inspection.

Findings:
There were policies and procedures for admission to the centre and these involved the input of the statutory body and assessment by the provider to ensure that the supports available met assessed needs.

However, based on these and previous inspection findings there was clear evidence that this was not a robust or safe process. Residents had been assessed and accepted for

admission when it was clear that the premises and the facilities that it provided were not appropriate to their needs.

The assessment and admission process was not in line with the statement of purpose and had not considered the needs and safety of all residents.

Residents did have a contract for the provision of supports and services signed by their representative and a representative of the provider. One contract reflected the supports and services provided and the fee to be charged; one did not as it had not been reissued and agreed further to admission to full-time rather than shared services in August 2016.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Each resident was seen to have a detailed personal plan of support. The plan was seen to be informed by an assessment of needs completed in 2016.

The inspector was satisfied that the plans of support were an accurate reflection of residents assessed needs and were the subject of review and update as necessary in line with changing needs and circumstances.

Staff said and there was documentary evidence that the plan and its review were multidisciplinary. Minutes of reviews were in place and demonstrated that relevant stakeholders including parents, the statutory body and day services attended. Staff had established good systems of communication with other providers of supports and services to ensure that all relevant information and updates were available to the centre.

There was a process for agreeing resident’s personal goals and objectives; again this

was a joint process between day and residential services. Timeframes and responsible persons were identified and there was evidence of the follow-up on the achievement or not of previous agreed goals. There was a social and developmental dimension to agreed goals. However, for one resident a clear link was not demonstrated between what was agreed at the review meeting and the goals that were currently in progress.

The personal plan was available in a format that was accessible and meaningful to the resident but it needed to be demonstrated how it was made available.

Arrangements were not in place in the designated centre to meet the assessed needs of residents and achieve all of their goals. The inspection findings did not support that this was an assessment failing as residents needs were clearly assessed and known but rather the decision to admit the residents in the knowledge that the centre was unsuited to their needs. This is therefore addressed in the Outcomes of admissions, premises, governance and the statement of purpose.

Judgment:
Substantially Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The design and layout of the premises was not suited to the individual and collective needs of the residents; this failing had been compounded by the admission of one resident to full-time support in August 2016. This decision meant that the other resident now had to access a bedroom on the first floor when availing of shared services (approximately 154 nights per annum).

The premises was a domestic style, three bedroom, two storey premises located in a residential development in close proximity to the town.

There was one ground floor bedroom which prior to August 2016 residents had shared as they were in the centre on alternate weeks. However, one resident now occupied this room on a full-time basis which meant that the other resident had to access a first floor bedroom. There was no issue with bedroom sizes but it was clear that both residents in

line with their assessed needs required ground floor accommodation; this was clearly stated in assessments of needs and risk assessments. For example staff said and risk assessments stated that one resident had attempted to climb over the first floor banister and could not safely descend the stairs; this resident was accommodated on the ground floor.

However, this necessitated the accommodation of the other resident on the first floor; this resident was fully visually impaired and also had impaired mobility. The inspector saw that while the resident applied determination to the task of climbing the stairs and was accompanied by staff in line with the risk assessment, this was a physically challenging task for the resident. Once upstairs a stair-gate was secured and staff said that the resident would call or bang when they required assistance. However, other staff said that the resident was demonstrating increased confidence and was increasing the space he explored before calling for staff, that is, from bedside to bedroom door. A personal plan review for this resident dated October 2016 stated that the resident "was not to use the stairs anywhere".

The available sanitary facilities were of a domestic type and were unsuited to residents needs due to inadequate space and the type of fittings provided. Staff said and a recent occupational therapy assessment agreed, that the available space was too compact to accommodate the resident and the two staff that were required to attend to personal care needs.

Incident records indicated that fittings were regularly dismantled or broken by a resident; the inspector saw that fittings were then restricted by staff and were effectively not in use. It was clearly stated that rehabilitative and developmental goals for residents in relation to their personal and intimate care were "currently on hold" due to the inadequacy of the current facilities to meet their needs. At the time of this inspection there was no accessible/functioning sanitary facility on the ground floor.

The inspector saw that while the one available communal space was in of itself spacious this space was needed for and used predominantly for one resident and did not safely accommodate both resident's due to their divergent needs.

The kitchen was adequately equipped and incorporated the dining area. The available dining space was limited and was limited further by the furniture in place; staff said that this robust furniture was required to mitigate behaviours of concern and risk.

The utility area contained the equipment required for the completion of personal laundry.

Judgment:
Non Compliant - Major

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

Findings:
While improvement was noted in the systems in place for identifying, assessing and reviewing risk, it was of concern to the inspector that risk assessments and control measures were required due to the unsuitability of the premises and these measures impacted negatively on resident's freedom of movement and quality of life.

The inspector saw a local and national health and safety statement both of which were signed as read and understood by staff in 2016. The safety statement incorporated the procedures for the identification of hazards and the assessment of risk and the reporting and investigation of any adverse events, incidents and accidents.

The register of risks had been reviewed since the last inspection; the content was centre specific and covered a broad range of work related hazards; the control measures identified were provider and centre specific. The risks as specifically required by Regulation 26 (1) (d) were also included in the register. Risk assessments specific to each resident were contained in their personal plan.

The inspector saw that the hazards identified and the assessment of risk did reflect residents assessed needs. However, the design and layout of the premises and the hazards it posed to residents because of their needs increased the need for risk assessment and controls that did not enhance resident autonomy and independence and did not maximise their quality of life. All hazards had not been identified; there was a risk assessment for accessing and descending the stairs but none for maintaining the resident's safety when on the first floor. A record seen dated September 2016 stated that the resident may attempt to access the stairs unaided.

There were clear policies and procedures for the identification, recording and investigation of incidents and accidents. Records seen dated October 2016 indicated that there had been repeated incidents of a resident removing his seat-belt and getting out of his seat while the transport vehicle was in motion; however, the last formal incident report of such an event was dated December 2015. It was of concern to the inspector that minutes of a staff team meeting held in May 2016 stated that staff were to "stop recording" these incidents. There was no clear rationale or explanation for this instruction. The person in charge was requested to address this apparent breach of the provider's policy on the management of safety incidents with immediate effect. The inspector was furnished with a copy of a memo to this effect issued to all staff.

On visual inspection the premises was fitted with a fire detection system and emergency lighting; manual call points and fire fighting equipment were prominently located. Final exits were indicated and unobstructed. The fire register was well maintained and certificates were in place confirming that fire safety equipment was inspected and tested

at the prescribed frequency in 2016. Staff completed daily, weekly and monthly internal inspections; no gaps were noted in these records which were overseen and signed off by the person in charge. Each resident had a Personal Emergency Evacuation Plan (PEEP) that outlined any difficulty that could be encountered should an evacuation be required and the props/cues to be used by staff to support effective evacuation. The inspector saw that these props were available as outlined in the PEEP. Staff did undertake simulated evacuation drills with residents; the inspector saw that staff did implement the recommended props but all of the recorded evacuation times were somewhat outside of that which is recommended. Also, it was not always recorded where residents were evacuated from, that is, the ground floor or the first floor.

Staff confirmed that they had access to personal protective equipment including gloves and aprons and water-dissolvable bags for the management of linen; staff described their correct use. Staff had completed education on infection prevention and control since the last inspection; a wash-hand basin had been reinstalled in the ground floor bathroom. There was documentary evidence that staff sought clinical clarification and updates where there was a known infection-prevention and control matter.

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

Findings:
There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons and staff training. Staff said that there had been no incident of alleged, suspected or reported abuse or any concern for any resident’s safety.

Staff training records indicated that staff had attended training on safeguarding vulnerable adults and responding to behaviours that had the potential to challenge or harm. Staff spoken with had a clear understanding of their responsibility to safeguard residents from harm and abuse and of the reporting procedures.

Family members spoken with said that they knew that their family member was happy in the centre and that they would raise concerns immediately if they had any.

Residents did present with behaviours of concern or that had the potential to harm themselves or others. Residents did have explicit plans for supporting them in the management of their behaviours. However, only one of these plans had received input from the behaviour therapist in March 2016, the other had not. The behaviour management plan was undated and signed off by the team leaders. The plan did have a therapeutic focus and did describe the exhibited behaviours, what they meant and staff responses. However, one intervention observed by the inspector was reactive and was not outlined in the behaviour management plan.

It was evident from records seen that since the last inspection there had been a review of restrictive practices and enhanced supporting documentation was in place that was in line with the providers policy and procedures on restrictive practices. It was clear that in line with the resident's disability and for their safety some restrictive interventions were necessary, for example for their safety while travelling, or the restriction of window openings. There was a "fade-out" plan for restricted access to the main kitchen.

However, it was clear that the unsuitability of the premises dictated the requirement for some restrictive practices that would not be necessary in premises that was suited to residents needs. This included restricted access to ground floor sanitary facilities due to locked doors and sealed toilets; restricted access to personal space, communal space and kitchen facilities due to the requirement to ascend and descend a stairs. While some mitigating controls were seen to be put in place such as a armchair in the bedroom and a press for snacks and refreshments, these simply attempted to reduce the impact rather that addressing the substantive matter of the unsuitably of the premises to residents needs.

Judgment:
Non Compliant - Moderate

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

Findings:
Notifications, predominantly those of a quarterly nature had been submitted to the Chief Inspector. These addressed the use of restrictive practices and reflected what was seen

on inspection.

There have been no notifications of events that required notification within three working days, for example, any alleged abuse or an injury that required medical or hospital treatment. There was no evidence that this was not correct, however, a concerning deficit was identified in the recording of incidents in the centre; this has been addressed in Outcome 7.

Judgment:
Compliant

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:
Staff spoken with clearly understood and believed in each resident's capacity for enjoying new experiences and ongoing learning and development.

Each resident had access to structured day services Monday to Friday some of which were provided by other stakeholders. Records seen indicated that residents were supported to access a broad range of activities including swimming, day trips, shopping, concerts, walks in the local community and local amenity areas, social-skills and life skills.

Staff said and records seen supported staff that sought to facilitate development and improved outcomes for residents for example in relation to mobility, medication compliance and social skills. However, it was also clearly recorded that due to the unsuitability of the premises some goals were "on hold" and that the environment was unsuitable and did not facilitate the achievement of potential with respect to independence in personal care and toileting.

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

Findings:
Improvement was noted in the systems and records in place in relation to supporting each resident to maintain their health and general well-being. Records seen indicated that staff did monitor residents for any sign of ill-health and facilitated medical review by their General Practitioner (GP) as required. Records seen also confirmed that as appropriate to their needs residents had access to other healthcare services including psychiatry, neurology, optical review, occupational therapy, speech and language therapy and dental care; physiotherapy assessments were awaited at the time of inspection. There was documentary evidence of annual influenza vaccination and regular blood-profiling. Staff had implemented systems for monitoring resident's body weights at a minimum quarterly.

Where responsibility for healthcare provision was shared with other stakeholders there was documentary evidence that staff had negotiated and agreed systems such as regular meetings between both staff teams for the sharing of information.

Detailed healthcare support plans were in place.

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:
Staff said that each resident was facilitated to retain the service of their preferred pharmacist and staff liaised with two pharmacies.
The inspector saw that medications were supplied directly to the centre in a compliance aid or in their original containers.

Medicines were seen to be securely stored and staff implemented systems to enhance to safety and security of medicines such as signed verified records of all medicines received and twice daily stock balance checks.

Residents did not input into the management of their own medicines; there was a formal assessment of capacity to support this dated November 2016.

Medicines prescription records were current and legible; the maximum daily dose of medicines required on a p.r.n basis (a medicines administered only as required) was clearly stated. Medicines supplied were seen to be congruent with the prescription. There were explicit protocols for the administration of p.r.n medicines and rescue medicines.

There were no reported medicines errors; this was also reflected in the providers own internal reviews of the centre.

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

Findings:
There was a written statement of purpose dated September 2016.

However, the statement of purpose was not an accurate reflection of the services and supports that were provided in the centre. The statement of purpose stated that residents would be provided with a safe environment; that residential services were provided on a shared care basis and that admission to the centre was dependent on assessment and the suitability of needs to the centre.

Based on these and the previous inspection findings this information was inaccurate; admission procedures did not accurately match residents and their needs with the facilities available in the centre; the safety of the premises given its unsuitability was then dependent on risk control measures and restrictive practices.

Judgment:
Non Compliant - Major

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:
There was a clear management structure consisting of two team leaders, the person in charge and the regional manager. Staff were clear on their respective roles, responsibilities and reporting relationships.

The person in charge while recently appointed to this centre had established management experience with the provider, in the supervision of staff and in the provision and monitoring of supports provided to residents. The person in charge held relevant qualifications including supervisory management and worked full-time. The person in charge was responsible for two designated centres and was confident that she had the capacity and the supports to effectively manage both of the services within her remit. On a day to day basis the person in charge was practically supported by the team leaders. The person in charge said that she based herself in either house depending on need and priority.

The team leaders worked with each other so as to ensure continuity of information but also worked opposite each other so as to provide supervision and monitoring of the service, for example in the evening when residents and staff were present in the house and at weekends.

Both team leaders were suitably qualified and clear on their role and duties, readily answered queries and retrieved any requested information.

There was a structured process of staff supervision. Records seen indicated that this was a meaningful process and that staff were supervised relative to their roles and responsibilities.

The person in charge told the inspector that she had ready access to the regional manager, (her line manager) as required and they also met formally once a month.

There was an agreed out-of-hours manager on call rota that was available to all staff.

The provider had arrangements for the annual review and the unannounced visits to the centre as required by Regulation 23 (1) (d) and (2). The inspector reviewed the reports from the two most recent visits, April and July 2016. These reports indicated that compliance was evidenced but that deficits were also identified and action was required. The person in charge said that the unsuitability of the premises limited the progress to completion of all required actions. Improvement was noted however for example in the area of healthcare related and restrictive practices records.

There were formal systems for consulting with and eliciting feedback from residents and their families; the feedback was positive.

However, from the perspective of governance it was of concern to the inspector that residents had been admitted to the centre when it was clear that the premises was not suited to meeting their needs. In that context it could not be concluded that management systems ensured that the service provided to all residents was appropriate to their needs, safe, and effectively and consistently monitored.

Evidence of planning compliance for the premises had not been submitted with the application for registration.

Judgment:
Non Compliant - Moderate

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:
Arrangements were in place for the management of the centre in the absence of the person in charge. The two team leaders confirmed that as necessary they assumed responsibility for the management of the centre; support was available if necessary from the regional manager. The provider was aware of its responsibility to inform the Chief Inspector of any expected or unexpected absence of the person in charge and of the arrangements in place for the management of the centre.

Judgment:
Compliant

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:
The person in charge confirmed that the centre was adequately resourced to ensure the delivery of supports to residents in line with their individual support plans, for example transport was provided and agreed staffing levels were maintained.

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

Findings:
Staff described the agreed staffing levels. Night-time staffing levels consisted of one sleepover staff and one waking night staff. When both residents were present in the house there was three staff on duty from approximately 15:30hrs to 22:00hrs. The staffing levels observed were as described; all staff spoken with said that the staffing numbers were sufficient to meet resident's needs both internal and external to the centre, that is, where a two to one ratio was required in the community.

There was some reliance on relief and agency staff to maintain staffing levels. The team leaders (who prepared the rota) said that a small core group of relief and agency staff

were used to ensure continuity for residents. This core group was reflected in the sample of staff rotas reviewed by the inspector.

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

Records were maintained of completed staff training. These records demonstrated that attendance at training was monitored and initial and refresher training was scheduled and completed as required. Training completed in 2016 included safeguarding, fire safety, responding to behaviours that challenge, people handling, medication management, first aid and infection prevention and control. Staff spoken with confirmed their attendance at training.

Records maintained in relation to staff employed via a staffing agency indicated that these staff had also completed the required mandatory training. However, the person in charge confirmed that agency staff were not permitted to administer medicines and this meant that staffing arrangements did not at all times ensure that residents would receive continuity of care. Staff spoken with confirmed that on one recent occasion staff were required to come from another centre to administer medicines. However, one resident had a prescription for a rescue medicine that would not/could not have been administered if required as prescribed; "stat"; meaning instantly, immediately, without delay. Based on the specifics of the rescue medicine plan staff had risk assessed this occurrence as a moderate "yellow" risk. The person in charge said that staffing would be managed to ensure that this would not reoccur.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Overall 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 available for inspection. Records were retrieved by staff as requested by the inspector and were generally seen to be well maintained and in a manner that ensured completeness and accuracy.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002657
Date of Inspection:	06 and 07 December 2016
Date of response:	13 February 2017

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 effectiveness of action taken and complainant satisfaction or not was not recorded.

1. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a

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

complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaint has been recorded on the organisations complaints management system in line with organisational policy. The system facilitates the process to be followed, including recording details of the complaint, actions taken and satisfaction of complainant with the outcome. This process will be followed for all complaints going forward. Complaints are monitored by the Organisation's Complaint's Officer to provide oversight of process and compliance with policy.

Proposed Timescale: 13/01/2017

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:
Residents had been assessed and accepted for admission when it was clear that the premises and the facilities that it provided were not appropriate to their needs.

The assessment and admission process was not in line with the statement of purpose and had not considered the needs and safety of all residents.

2. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
• HSE were advised by the service provider of the need for one of the service users to be discharged from OSV – 0002657 by 31/05/17. HSE have advised the service provider that they may have suitable alternative accommodation. Conference call with the HSE scheduled for the 14/2/17.

• Two premises are currently being evaluated by the service providers property department re suitability for the provision of service for the service user who is to be discharged from OSV – 0002657 by the 31/05/17.

• One service user to remain in OSV – 0002657 and to be given access to the ground floor accommodation by the 31/05/17.

Proposed Timescale: 31/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract had not been reissued and agreed further to admission to full-time rather than shared services in August 2016.

3. 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:
Contract of Care has been updated to outline services provided on a full time basis rather than a shared care basis. This was discussed with and signed by the service user's family.

Proposed Timescale: 31/01/2017

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:
A clear link was not demonstrated between what was agreed at the review meeting and the goals that were currently in progress.

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

Please state the actions you have taken or are planning to take:
Review Meeting notes and support plans to be reviewed to identify all current goals.

Action Plans have been developed for all current goals, this includes rationale for same, names of those responsible and timeframes. Keyworkers are responsible for overseeing progress of the goals and updates will be recorded on action plans on an ongoing basis.

Proposed Timescale: 14/02/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The design and layout of the premises was not suited to the individual and collective needs of the residents.

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

Please state the actions you have taken or are planning to take:
• HSE were advised by the service provider of the need for one of the service users to be discharged from OSV – 0002657 by 31/05/17. HSE have advised the service provider that they may have suitable alternative accommodation. Conference call with the HSE scheduled for the 14/2/17.

• Two premises are currently being evaluated by the service provider's property department re suitability for the provision of service for the service user who is to be discharged from OSV – 0002657 by the 31/05/17.

• One service user to remain in OSV – 0002657 and to be given access to the ground floor accommodation by the 31/05/17.

Proposed Timescale: 31/05/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All hazards had not been risk assessed.

6. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
• A risk assessment with appropriate control measures has been put in place to ensure service user safety when accessing first floor of the premises.

• On a monthly basis a safety review is carried out in the service, this will support then identification of hazards.

• Support from the organisation's Chief Risk Officer and Health & Safety Manager will be provided to support this process on an ongoing basis.

Proposed Timescale: 08/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safety incidents had not been recorded in line with the providers policies and protocols.

7. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
• Memo sent to all staff to remind them of policy and procedure for reporting incidents on 7/12/16

• Health & Safety policy and procedure was discussed at next team meeting 27/1/17

Proposed Timescale: 27/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the premises and the hazards it posed to residents because of their needs increased the need for risk assessment and controls that did not enhance resident autonomy and independence and did not maximise their quality of life.

8. Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
Control measures currently in place have been considered and are deemed proportionate to the risk. Risk assessments will be continue to be reviewed with a view to ensuring the control measures in place have as little impact on the quality of life of the service users as possible.

On acquiring more suitable premises risk control measurements currently in place will not be required.

Proposed Timescale: 31/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Simulated evacuation drills were outside of the time recommended. Staff did not always record the location in the centre of residents at the time of the drill.

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:
Regular fire drills will continue with a view to improving evacuation time.

All future fire evacuations records will include where in the building that the residents were evacuated from.

Proposed Timescale: 31/01/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One behaviour support plan had not been reviewed by the behaviour therapist. The behaviour management plan was undated and signed off by the team leaders

10. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
Behaviour Support Plan to be reviewed by Behaviour Therapist.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One intervention observed by the inspector was reactive and was not outlined in the behaviour management plan

11. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her

representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
• Interventions with service users to be discussed individually with all staff at supervisions by 28/2/17.
• Interventions with service users was discussed with all staff collectively at next team meeting 27/1/17.
• Appropriate intervention workshop was conducted with all staff by Behaviour Therapist on 24/1/17.
• Behaviour management plan will be updated by the Behaviour Therapist by 28/02/2017.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The unsuitability of the premises dictated the requirement for some restrictive practices that would not be necessary in premises that were suited to residents needs.

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

Please state the actions you have taken or are planning to take:
Restrictive practices currently in place have been deemed to be the least restrictive options available within the premises. Each of the existing Restrictive Practices will be reviewed within required dates in line with organisational policy.

On acquiring a more suitable premises all restrictive practices will be reviewed.

Proposed Timescale: 31/05/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose was not an accurate reflection of the services and supports that were provided in the centre.

13. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and

Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose and Function has been updated to include both full time placement and shared care.

Proposed Timescale: 31/01/2017

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:
Evidence of planning compliance for the premises had not been submitted with the application for registration.

14. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Remedial work is required in order to secure planning compliance.

The service provider's property department has approved works to be scheduled. On completion the service provider will engage the services of a suitably qualified person to sign off on the planning compliance declaration.

Proposed Timescale: 30/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From the perspective of governance it was of concern to the inspector that residents had been admitted to the centre when it was clear that the premises was not suited to meeting their needs. In that context it could not be concluded that management systems ensured that the service provided to all residents was appropriate to their needs, safe, and effectively and consistently monitored.

15. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by

the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
• Unannounced visits to the service will continue to be carried out twice yearly.

• Written reports will be prepared and actions will be put in place to address any issues identified.

Proposed Timescale: 31/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Agency staff were not permitted to administer medicines and this meant that staffing arrangements did not at all times ensure that residents would receive continuity of care.

16. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
The PIC will ensure that there is always a member of staff trained in the administration of medication on each shift in the service.

Proposed Timescale: 09/12/2016