

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Tralee Residential Services
<b>Centre ID:</b>	OSV-0003426
<b>Centre county:</b>	Kerry
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Kerry Parents and Friends Association
<b>Provider Nominee:</b>	Maura Crowley
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	Conor Dennehy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	12
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
05 April 2017 08:45	05 April 2017 19:00
06 April 2017 08:30	06 April 2017 16:15

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 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 17: Workforce

**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). The last inspection was undertaken in September 2015 and was the first inspection by HIQA of the service. This current inspection was undertaken to follow-up on the actions that had emanated from that inspection and to monitor on-going regulatory compliance so as to inform a registration decision.

The inspection was facilitated by the person in charge and one of the persons participating in the management of the centre (PPIM) who had assumed the day to day management of the centre until very recently while the person in charge was on planned leave. During the course of the inspection inspectors also met with the assistant director of services who was also a PPIM and the frontline staff on duty in

each of the houses; the provider representative attended verbal feedback at the conclusion of the inspection.

How we gathered our evidence:

Prior to the inspection the inspector reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the application for registration of the centre, the previous inspection findings and action plan, all correspondence received in relation to that action plan and notice received of any incidents that had occurred in the centre. In the centre inspectors reviewed records including policies and procedures, fire and health and safety related records, records of complaints received and records pertaining to staff and residents.

Residents and their relatives had also been invited on a voluntary basis to complete HIQA questionnaires so as to elicit their views and experience of the service. The feedback received from both groups was consistently positive in relation to the staff and the quality of the supports that they delivered. Where issues were highlighted they reflect these HIQA inspection findings and the provider's own reviews and records such as the maintenance of the premises and staffing levels.

The inspectors met with all of the residents living in the centre with the exception of one resident who was on leave at home with family. This engagement with residents was guided by each resident and their choices and needs; the majority of the residents conversed freely with inspectors and relaxed with their presence over the course of the two day inspection. Residents invited inspectors to view their rooms, personal items such as family photographs and their personal plans. Inspectors found residents to be engaged, relaxed and in good spirits.

Inspectors noted that residents were comfortable in asserting themselves and communicating in the presence of staff. Residents spoke of their plans for the day, their interests and the importance of family and home, friendships and community links. Residents said that they liked their houses and the staff that supported them.

Description of the service:

The centre was comprised three houses within a short commute from each other and from all of the amenities that the busy local town offered. Residential services were provided to a maximum of 12 residents, many of whom had lived in the centre since it was originally developed.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. While some amendment was required to the document, inspectors found that the service to be provided was as described in that document.

Overall Findings:

There was evidence of good practice.

There was a clear management structure and systems for the review of quality and safety of the care and services provided to residents.

Residents had daily access to a structured programme of activity and engagement and a good balance was struck between what was facilitated on site and accessed in the local community.

Residents had access as required to regular medical review and other required healthcare services; staff maintained a high standard of documentation pertaining to residents needs and the care, supports and services provided.

Residents spoke positively of staff and the inspectors' observations of staff and resident interactions were positive.

There was evidence of fire safety improvement works completed and it was noted that these works had improved the fire safety of the buildings. However, deficits were identified in the provision of suitable fire rated doors so as to contain fire and ensure adequate means of escape.

There was evidence available to inspectors including the report of the provider's own internal review that staffing levels were not at all times adequate to meet the changing needs of residents.

While there was evidence that the provider did act in response to any safeguarding concerns received, an additional risk assessment and safeguarding plan informed by that risk assessment was required. The provider confirmed that one allegation had not been notified to the Chief Inspector.

Of the fifteen Outcomes inspected, the provider was judged to be compliant with eight, in substantial compliance with three and in moderate non-compliance with three. One Outcome Health and Safety and Risk management was judged to be in major non compliance. The findings to support these judgements are discussed in the body of the report.

**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):**

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

**Findings:**

There was evidence to support that residents' rights were respected in the centre and that residents were consulted with in relation to the running of the centre.

A complaints log was maintained in digital format within the designated centre. Inspectors reviewed this log and saw that it included details of complaints made, actions taken by the provider and whether the complainant was satisfied with the outcome. The procedure for complaints was observed to be on display in each unit of the designated centre.

Resident meetings were facilitated by staff on a weekly basis in each unit of the designated centre. Inspectors reviewed minutes of these meetings and noted the agenda of the meetings varied from week to week. During these meetings issues such as privacy, safeguarding, meals, and finances were discussed on a rolling basis.

Residents were also given the opportunity at these meetings to decide what they wanted to do for the weekend ahead. Activities discussed and undertaken by residents included meals out, going for coffee, going for nature walks and attending mass. If residents choose to not engage in these meetings then this was respected by staff. During the course of inspection staff members were overheard to offer resident choice when it came to their meals and engaging with residents in a respectful manner; residents were seen to approach staff for support with ease.

Residents were supported to manage their finances and records of financial transactions were kept by staff with corresponding receipts. Inspectors reviewed a sample of

residents' financial records and found the balances and transactions recorded corresponded with receipts maintained. Balances and receipts were signed by staff members and subject to oversight and review.

Records of residents' personal property were also kept in the centre in line with the provider's own policies and procedures. Inspectors reviewed a sample of these and in one resident's personal property list it was noted that it included the purchase of two minor items which were related to meeting the resident's medical needs. This did not assure inspectors that there was adequate knowledge and procedures to ensure that residents were charged only for items that they were personally liable to pay for. This was highlighted to representatives of the provider at the feedback meeting for this inspection.

The previous inspection of the centre found that incidents of challenging behaviour in one unit were negatively impacting the quality of life of residents living in that unit. At this inspection the evidence available to inspectors was that this situation had improved; this is discussed again in Outcome 8.

**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:**

Staff reported that all residents could communicate by spoken word though some required more support than others to ensure effective communication.

Staff completed individual communication assessments and from these, plans of support were developed as required. Inspectors saw that these plans were supported as necessary by input from psychology; for example one resident had a recently introduced communication "show me" book where gestures, expressions or behaviours and their meaning were clearly explained.

Communication plans referenced not only expressive ability but also receptive ability and the importance of behaviours as a communication tool. Other supports evidenced by inspectors included the use of pictorial supports; for example the use by catering staff of a pictorial menu to explain and ascertain meal choices.

Inspectors saw that residents had good access to media, a computer and personal and shared I pads.

**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:**

Inspectors saw, from records seen and staff spoken with, that maintaining family and personal relationships was important to residents and staff. Some residents continued to enjoy regular visits home to family and maintained contact by phone and visits from family and friends to the centre; there was a designated room available for visits if required.

Where challenges invariably presented at times inspectors were satisfied and provided with assurance that families had access to the senior management team.

The annual review of the service incorporated consultation with and the feedback received from families during annual reviews, other meetings and general contact; the provider also utilised a formal questionnaire but the response rate to this was low.

Inspectors based on their observations, residents and staff spoken with and records seen, were satisfied that there was a culture of social inclusion and integration in the centre. Residents through their daily routines, social and recreational activities were supported to have meaningful links with the local community.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**



Effective Services

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

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

**Findings:**

The provider had policies and procedures in place to guide the admissions process. In questionnaires reviewed prior to inspection, family members indicated that they were given the opportunity to visit the centre before their relatives began to live in the centre. Since the previous inspection there had been no new admissions to the designated centre.

Inspectors reviewed a sample of contracts which were found to contain the required information such as the services to be provided to each resident. The sample of contracts reviewed were signed by the resident or their representative.

**Judgment:**

Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Based on HIQA inspection findings to date in its designated centres, the provider had recently introduced and piloted in this centre, a comprehensive assessment of the personal, social and healthcare needs of each resident, the findings of which informed the personal support plan.

While this was a comprehensive task to be completed by staff, all staff spoken with spoke positively of this initiative and acknowledged how the tool supported staff to accurately and adequately identify needs and supports.

Inspectors saw that the completed assessments clearly identified any area where

support was required to maintain resident welfare and well-being and that the identified plan of support was in place. The support plans seen were succinct but offered clear and sufficient guidance to staff.

It was evident from inspectors' own observations that residents were familiar with their plan of support; some residents gave their plan to inspectors to review; other residents had signed their participation in the plan. Residents had appointed key-workers who on speaking with inspectors, had sound knowledge of residents and their required supports.

The personal plan incorporated the process for identifying, agreeing and progressing residents' personal goals and priorities. Staff spoken with said that this was an area that presented challenges at times dependent on each resident's desire to participate and engage. However, the records seen by inspectors indicated that this process was multidisciplinary in nature, residents and their families where possible attended review meetings, agreed goals were recorded as were responsible persons and achievement timeframes; there was evidence of goals achieved and actions taken in relation to goals in progression.

**Judgment:**  
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:**

Since the previous inspection works to improve the premises had been carried out and there was evidence of ongoing maintenance despite challenges such as layout and age of construction. Generally, across the three houses that comprised this designated centre, communal, dining and bedroom areas were well presented and improvements had been completed to some sanitary facilities. However, there were still some parts of the centre which required some painting and decorating. Where design and layout posed challenges this is addressed in Outcome 7.

The designated since was comprised three separate units located in relatively close proximity to each other in a large busy town. The first unit was an older two story building with one section of the building providing a day service while the other section

constituted the designated centre and was home to five residents. This unit had five resident bedrooms, a staff bedroom;office, a visitors room, sitting room, dining room, laundry facilities, a toilet and shower area and a separate toilet. A kitchen was shared between the day and residential services.

Since the previous inspection, this building had undergone improvement works. These included painting and works to improve the condition of an external fire escape. However, it was noted that in the hall on the first floor of this unit, that there was a section of the ceiling surface that was peeling off. In addition, the separate toilet did not have a hand basin which posed a challenge to maintaining good infection prevention and control. This will be actioned under Outcome 7.

The second unit was a single story bungalow located on the outskirts of a housing estate and was home to four residents. The unit had five bedrooms, one of which was used for sleepover staff, a sitting room, lounge area, kitchen and dining area, utility room, a toilet and shower area and another toilet.

The third unit was a two story house where three residents lived. Each resident had their own bedroom, two of which were ensuite. There was also a staff bedroom;office, kitchen and dining area, sitting room and two more bathrooms. It was noted that there was rust evident on a handrail in one bathroom and on the pipes of radiators. As discussed under Outcome 7, the layout and location of one of the bathroom areas in this house presented challenges in relation to infection prevention and control practice.

In each of the three units inspectors viewed some residents' bedrooms; some residents requested inspectors to view their bedrooms and were evidently proud of their presentation and eager to share this with inspectors. Bedrooms were seen to be pleasantly decorated and personalised with photographs, ornaments and other items that reflected resident's personal interests. Adequate space was provided for residents to store their personal belongings.

All three units had space for parking to the front of the units and access to garden areas at the rear.

The centre was presented in a clean and welcoming manner during the course of inspection.

**Judgment:**

Substantially Compliant

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

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

Since the previous inspection upgrading works had been completed on the fire safety management systems in place in the designated centre. However, inspectors observations led to further review post inspection by the estates and fire safety inspector and collectively inspectors were not satisfied that there was sufficient fire containment provisions in place, notwithstanding the works that had been completed. In addition, improvement was required in relation to the review of risks and personal evacuation plans while the layout of some toilet facilities in the centre required review in line with infection prevention and control guidance.

An immediate action plan was issued at the time of the last HIQA inspection in relation to the fire safety systems that were in place at that time; subsequently, the provider had carried out fire safety improvement works. These works included the installation of improved fire alarm system, emergency lighting and some fire doors. It was noted that the completed works had improved the fire safety of the buildings.

However, in one unit, works carried out to improve fire containment included the installation of fire strips into existing internal doors. Inspectors were not satisfied that the work carried out resulted in these doors being fire rated doors and as such they would not provide the level of protection that would be required to contain a fire or ensure that an adequate means of escape was provided. It was not clearly evidenced which existing doors across all of the three units, were, fire rated doors. As such the evidence was that where escape stairs and corridors formed part of the means of escape, particularly from areas with a sleeping risk, the door openings along the escape routes were not fitted with fire rated door-sets and as such adequate fire containment measures were not in place.

The fire evacuation procedure was on display in all units of the centre while maintenance checks on the fire alarm, emergency lighting and fire extinguishers had been carried out by external contractors. In addition, internal staff checks were also being carried out on a daily and weekly basis as required. Fire exits were observed to be unobstructed on the day of inspection. However, while visiting one resident's bedroom it was observed that there was a sliding lock on the inside of the bedroom door which, if used, could prevent someone gaining access to the bedroom in the event of fire. This was highlighted to the person in charge who informed inspectors that the sliding lock was to be removed following this inspection.

Fire drills were being carried out in each unit of the centre at regular intervals. Since the start of 2017 a new record sheet for such drills have been introduced which allowed for more key information relating the drills to be recorded. All residents had personal evacuation plans in place which had been updated within the previous twelve months. However, while reviewing drills records it was noted that some issues had arisen on drills such as residents refusing to evacuate or panicking; residents' personal evacuation plans had not been reviewed to reflect these possible challenges to safe evacuation.

Since the previous inspection controls to restrict access to the kitchen area which was shared between residential and day care service users had been put in place; the service was monitored by the local environmental health officer (EHO )and the most recent inspection report was available.

As mentioned under Outcome 6, one toilet did not have a wash-hand basin within the room which posed a challenge to maintaining good infection prevention and control practice. In addition, in the week before this inspection an infection prevention and control review by a competent person had been carried out of the sanitary facilities in another of the three units at the request of the provider due to specific challenges posed by the needs of one resident. The review found that the layout of the environment, location of one toilet and location and type of washing machine used presented difficulties in maintaining infection prevention and control in the unit.

An electronic risk register was maintained in the centre. This system was also used to record accidents, incidents and near misses. This electronic system was reviewed by inspectors and it was noted that in general risk assessments were in date. However, it was noted that the risk rating applied to certain risks required review to ensure that they accurately reflected the level of risk posed. For example, risks were assigned an initial risk rating which could be lowered based on the resulting control measures introduced but were not. This was also identified by the provider's most recent unannounced visit report.

**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 harm and abuse; these included organisational policy referenced to national policy and procedure, a designated person, risk assessments, plans of support (safeguarding support) and staff training. Further measures described by the person in charge included the newly implemented electronic reporting system that provided for an immediate alert to the designated person once a

safeguarding incident was logged by staff. Safeguarding was seen to be discussed at resident's house meetings and at staff meetings.

All staff spoken with confirmed that they had attended safeguarding training and articulated an understanding of what may constitute abuse including more subtle indicators; staff spoken with identified no barriers to the reporting of any alleged or suspected abuse.

There was evidence that the provider responded and took action including the invoking of protective measures in response to any alleged, suspected or reported safeguarding matter.

However, having spoken with staff over the course of this inspection and having reviewed relevant records (risk assessments and plans of support) deficits were identified in safeguarding measures. One alleged safeguarding incident in 2015 as brought to the attention of inspectors had not been notified to the Chief Inspector. The providers representative assured inspectors that though admittedly not notified to HIQA, the matter had been appropriately responded to.

While there were general risk assessments completed for assessing the risk to staff of physical or psychological harm, there was no risk assessment and safeguarding plan completed, that identified the controls in place or any additional controls that may have been required to prevent/manage a specific concern as raised by staff spoken with; staff gave clear examples of how their concerns impacted on the delivery of supports. The details of these concerns and this safeguarding issue were discussed with the person in charge and the provider nominee at verbal feedback.

Residents did at times present with behaviours of concern or risk to themselves, staff or others. All staff spoken with reported improvement in the management of such behaviours since the findings of the last HIQA inspection. Staff attributed this improvement to clear behaviour management guidelines that were informed and supported by the psychologist and their consistent implementation by staff, a solid programme of activity and engagement for residents and a structured daily routine. Staff had received training in responding to and managing behaviours of concern both through formal training in MAPA (Management of Actual and Potential Aggression) and support from the psychologist in multi-element behaviour support planning.

Residents had as required access to and support from psychiatry and psychology. However, while staff said that a review had taken place it was not clear from the records seen that both the resident and the behaviour support plan had been reviewed in line with recent significant changes.

There were procedures in place for the identification and review of any restrictive practices. Medicines prescribed as an adjunct to the behaviours of concern were, based on the records seen, infrequently prescribed and administered.

**Judgment:**

Non Compliant - Moderate

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<b>Outcome 09: Notification of Incidents</b> <i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i>
<b>Theme:</b> Safe Services
<b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.
<b>Findings:</b> While reviewing the complaints log inspectors saw that reference was made in one complaint to a prior allegation of abuse. This was raised with representatives of the provider who confirmed after the inspection that this allegation had not been submitted to HIQA as required.
<b>Judgment:</b> Non Compliant - Moderate

<b>Outcome 11. Healthcare Needs</b> <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i>
<b>Theme:</b> Health and Development
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> Based on their observations, staff spoken with and records seen, inspectors were satisfied that the provider had arrangements in place to support and maintain resident health and well-being.  Staff said and records seen indicated that staff monitored resident well-being and sought medical advice and review from the general practitioner (GP) when necessary. Staff on behalf of residents liaised with four different GP practices.  Measures implemented by staff to assess general well-being included regular monitoring of body weight and vital signs (pulse and blood pressure), the use of recognised assessment tools, for example to assess the risk of falls, and annual seasonal influenza vaccination. There was daily access to nursing advice in the annexed day service and support was also provided by the community nursing service. The team leader was also

a registered nurse in intellectual disability nursing.

As appropriate to their needs, inspectors saw that residents had access to other health care services such as speech and language therapy (SLT), neurology, psychiatry, physiotherapy, dental care, optical care and chiropody. There was evidence that where concern was noted an effective plan of support and care was implemented; for example review and input from the dietitian in response to weight loss and the satisfactory monitoring and resolution of the issue by staff.

Residents and staff had ready support from the psychologist who was employed by the provider; staff said that at times residents had weekly access. However, this support and the ready availability of the psychologist were not reflected in the records seen, (for example the "trans-disciplinary record" of reviews). This was highlighted to the provider at verbal feedback.

Catering staff were employed and meals were prepared freshly on site. Staff spoken with confirmed that they had daily access to fresh produce, a menu operated on a monthly cycle and residents had a choice of two main meals each day; the menu was informed by feedback received from residents; residents had direct access to the chef. In addition, staff had good knowledge of healthy and safe practice, such as portion size and the provision of modified diets in line with the SLT recommendations.

**Judgment:**

Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

There were policies and procedures in place to guide the management of medicines.

The person in charge told the inspector that staff only administered medicines to residents after the successful completion of training; the training included the administration of medicines prescribed to be used in emergency situations. Training records seen indicated that staff employed had attended training and all staff spoken with confirmed this.

Medicines were supplied to residents by a community pharmacy in a medicines compliance aid or in the original packaging; on delivery, medicines were checked by a



member of the nursing staff and checked again at the point of administration. The pharmacy supplied information to staff on the medicines in use in the centre.

Facilities were in place for the secure storage of medicines; these facilities included a refrigerator specifically for medicines; its temperature was monitored.

Overall, the sample of prescription records seen by the inspector were current and legible, the maximum daily dosage of medicines prescribed on a p.r.n basis (as required) was stated; discontinued medicines were signed and dated as such. One anomaly in this standard was highlighted at verbal feedback.

Residents also had medicines administration protocols for the administration of medicines required in emergency situations. Staff maintained a record of medicines administered; records seen reflected the instructions of the prescription.

The person in charge and staff spoken with confirmed that strict systems and protocols were in place for medicines related incidents; remedial actions included staff re-training and supervision. Records seen of such events did not demonstrate any particular or concerning patterns.

The pharmacist had undertaken on behalf of the provider an audit of medicines management in each of the three houses that comprised the designated centre. The overall finding of that audit was a high standard of medicines management and practice that maintained this high standard.

**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):**

No actions were required from the previous inspection.

**Findings:**

While the statement of purpose contained much of the required information, it required review and some minor amendment to ensure that it contained all of the required information.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Overall, inspectors were satisfied that there were structures and systems in place to ensure the effective operational management of the centre and for reviewing on an ongoing basis, the quality and safety of the care, supports and services provided to residents.

There was a clear management structure comprising the social care leader, the person in charge, the assistant director of services and the director of services who was the person representing the provider. All staff spoken with were clear on their roles, responsibilities and their reporting relationship.

The person in charge worked full-time and had an office in one of the three houses that comprised the centre (in the annexed day service). The person in charge was suitably qualified to advanced practitioner level in social care; the person in charge was suitably experienced having worked for the provider since 2007 and in the post of person in charge since February 2016. The person in charge said that she called to each house at least once a week but had daily access to the majority of the residents in the day service.

Formal monthly management team meetings were held; the senior management team also met monthly and at these meetings issues from the management meetings were brought to the attention of senior management.

The person in charge convened staff meetings in each house and there was a formal system of staff supervision for all grades of staff.

There was a management on-call system for weekends that staff were familiar with; the person in charge was available if necessary to staff during the week and the team leader worked alternative weekends.

Staff said that members of the management team, for example the director of services,

called to the houses both announced and unannounced. Inspectors saw that residents were familiar with the management team.

There was a quality and standards committee that also met on a monthly basis; the person in charge attended these meetings and described them as informative and a good source of learning and improvement; this was reflected in the minutes seen by inspectors.

Unannounced visits and the annual review of the quality and safety of the care and services provided to residents as required by Regulation 23 had been completed and the reports were available for inspection. There was evidence of learning from previous HIQA inspections as to the completion of these reviews; comprehensive lines of inquiry were applied, action plans, timeframes and responsible persons were identified. The annual review sought and incorporated feedback from residents and families. While records indicated some repeat failings over the course of provider reviews, these HIQA inspection findings found that these matters were generally satisfactorily resolved at the time of this inspection, for example in relation to staff supervisions, training deficits, healthcare support plans and residents' personal goals.

**Judgment:**

Compliant

**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:**

The provider was clear on its requirement to notify and had submitted such notification to the Chief Inspector of any expected or unexpected absence of the person in charge. The provider had also as required put suitable arrangements in place for the management of the centre in the absence of the person in charge.

**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:**

Based on these inspection findings, a review of staffing was required to ensure that the centre was adequately staffed to meet the changing needs of residents on an ongoing basis.

Throughout the inspection the staff members present were observed interacting with residents in a caring and positive manner. It was clear that there was a close bond between residents and staff. For example, one resident had bought a card to give a member of staff who was departing the centre on the day of inspection. Staff members were also seen to provide residents with discreet assistance where required.

From speaking to staff members, observing practice and reviewing documents there was sufficient evidence to show that a review of current staffing arrangements within the designated centre was required to ensure that the needs of residents were met on an ongoing basis. For example, in one unit of the centre, where four residents lived, the specific needs of one resident required close monitoring as a risk control measure from the single staff member working in the house. This placed a particular burden on that staff member during peak times if other residents required assistance. A further concern articulated by staff was in relation to safeguarding; as discussed in Outcome 8; there was no risk assessment completed of the safety and adequacy of existing staffing supports.

Staff also said that it was a challenge at times to schedule appointments and facilitate differing social activities for residents and that this was dependent on the availability of a second staff or the co-operation evidenced between staff. Staff confirmed however that no scheduled appointments had been missed. Inspectors were also informed that only certain members of staff could drive the buses assigned to the centre and that it was a challenge to ensure that staff with the required skill were on always on duty. The changing and increasing needs of residents and the challenge this placed on staff due to staffing levels had also been identified and clearly articulated by the provider in the most recent report of an unannounced visit carried out in October 2016.

Since the previous inspection a system of staff supervision had been introduced in the designated centre. As part of this, meetings were held every six months between individual staff members and the person in charge. Inspectors saw records of the first cycle of these meetings which took place in October and November 2016 were staff were given the opportunity to discuss issues including matters relating to the daily

operation of the centre and training. The next cycle of supervision meetings for staff was scheduled to begin the day following this inspection.

The unannounced provider's visit from October 2016 had also highlighted the infrequent pattern of staff meetings. This HIQA inspection evidenced minutes of staff team meetings from 2017 which were happening on a monthly basis individually in the three units of the designated centre; each meeting was attended by the person in charge. During these meetings issues such as safeguarding, health and safety and residents were discussed.

Training records for staff were reviewed and it was noted that all staff had undergone training in areas such as the management of behaviours including de-escalation, safeguarding, manual handling, fire safety and first aid. It was noted that two staff members had not received fire safety training in the previous 12 months but inspectors were informed that fire safety training was scheduled to be provided in the weeks following inspection.

A sample of staff files were reviewed by inspectors. While the files reviewed contained most of the information required such as Garda vetting and employment histories, it was noted that some files did not have evidence of staff members' identity that included a recent or clear photograph.

Files, which included garda vetting, were also maintained in relation to volunteers involved with the centre and adequate provision was made for the supervision of volunteers.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

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



## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Kerry Parents and Friends Association
<b>Centre ID:</b>	OSV-0003426
<b>Date of Inspection:</b>	05 and 06 April 2017
<b>Date of response:</b>	08 May 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

In one resident's personal property list it was noted that it included the purchase of two items which were related to meeting the resident's medical needs. This did not assure inspectors that there was adequate knowledge and procedures that ensured that residents were charged only for items that they were personally liable for.

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

**1. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

A Document on Personal Monies and Property Guidelines is currently being drafted and will be circulated to all staff to ensure that everyone is aware of what personal items residents can be liable to pay for.

The purchase cost of the two items identified will be refunded by the Association to the Residents.

**Proposed Timescale:** 31/05/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

A section of the ceiling in the upstairs hall of one unit was peeling off. In another unit there was rust evident on a handrail in one bathroom and on the pipes of radiators

**2. Action Required:**

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

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

The upstairs ceiling will be repaired and the handrail will be replaced and pipes in the bathroom will be treated and painted.

**Proposed Timescale:** 30/06/2017

**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:**

The risk register requires review to ensure that the assigned risk rating accurately reflected the level of risk posed following the application of control measures.

**3. Action Required:**

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



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

The risk register will be reviewed in line with the Risk Assessment Management Policy which includes emergency responses and the recording on the Xyea system. Staff have received training in completing risk assessments and the Person In Charge will monitor the risk ratings following the application of controls. Also risks are reviewed regularly as per the risk matrix by the PIC. Risk Management is discussed at Team Meetings and at Quality and Standard's meetings.

**Proposed Timescale:** 26/05/2017

**Theme:** Effective Services

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

The layout of the environment, location of one toilet and location and type of washing machine used presented difficulties in maintaining infection prevention and control in one of unit of the centre. In another unit one toilet did not have a hand basin.

**4. Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

The washing machine will be relocated to an outside shed. The carpet in the downstairs hallway will be replaced with linoleum. The bathroom which does not have a sink will be closed up and no longer in use.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

Personal evacuation plans had not been reviewed following issues that arose during fire drills.

**5. Action Required:**

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

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

Personal Emergency Evacuation Plan's have been reviewed and updated. These will be reviewed after each fire evacuation and updated to reflect this in the Monitor and Review section of the form.

**Proposed Timescale:** 11/05/2017

**Theme:** Effective Services

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

It was not clearly evidenced which existing doors across all of the three units, were, fire rated doors. As such the evidence was that where escape stairs and corridors formed part of the means of escape, particularly from areas with a sleeping risk, the door openings along the escape routes were not fitted with fire rated door-sets and as such did not provide for adequately protected means of escape.

**6. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

An urgent application for funding for fire doors has been submitted to the HSE.

Remaining fire doors will be installed on receipt of funding.

A meeting is scheduled to take place between our engineer, CEO and the Kerry County Council Fire Officer week ending 26th May, to agree immediate, medium and long term plans for fire safety in the designated centre.

Fire Strips are fitted to all the upstairs doors.

All safety precautions are being taken which include:

An L2 fire alarm system is currently in place in the properties for escape with three external doors on the ground floor and one safety stairs on the first floor.

Emergency lighting is fitted in all houses.

Fire extinguishers in place in first floor landing, downstairs lobby and hallway.

An emergency plan is in existence in the houses, with escape routes marked.

Each resident has a personal Fire Safety Plan with specific instructions for evacuation, taking into account their particular needs.

Staff in the designated centre have completed Fire Warden Training.

All staff carry out two fire drills each per year and relief staff who move from house to house carry out fire drills in every house within the designated Centre.

Staff carry out a number of health and safety checks as follows:

- Emergency routes and exits and traffic routes and doors giving access to the emergency routes, are free from obstruction.
- Weekly check of smoke detectors and carbon monoxide detectors.
- A fire Attendance sheet is completed each evening, detailing who is in the building.
- Extinguishers are checked monthly by staff (clip & gauge) and six monthly by Apex Fire.
- The fire box contains torch, whistle, lamp, fluorescent jacket, each residents fire evacuation plan, fire notice and attendance sheet.
- The Fire Safety Register is updated regularly, recording fire drills and evacuation, inventory of fire projection equipment, detailing inspections, tests and certification and any servicing carried out.

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

**Theme:** Effective Services

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

Some internal doors were not fire rated doors. Inspectors not assured that these doors would provide the adequate level of protection that would be required to contain a fire.

**7. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

An urgent application for funding for fire doors has been submitted to the HSE.

Remaining fire doors will be installed on receipt of funding.

All safety precautions are being taken which include:

An L2 fire alarm system is currently in place in the properties.

For escape with external doors on the ground floor and one safety stairs on the first floor.

Emergency lighting is fitted in all houses.

Fire extinguishers in place in first floor landing, downstairs lobby and hallway.

An emergency plan is in existence in the houses, with escape route marked.

Each resident has a personal Fire Safety Plan with specific instructions for evacuation, taking into account their particular needs.

Staff in the designated centre have completed Fire Warden Training.

All staff carry out two fire drills each per year and relief staff who move from house to house carry out fire drills in every house within the designated Centre.

Staff carry out a number of health and safety checks as follows:

- Emergency routes and exits and traffic routes and doors giving access to the emergency routes, are free from obstruction.
- Weekly check of smoke detectors and carbon monoxide detectors.
- A fire Attendance sheet is completed each evening, detailing who is in the building.
- Extinguishers are checked monthly by staff (clip & gauge) and six monthly by external person.
- The fire box contains torch, whistle, lamp, fluorescent jacket, each residents fire evacuation plan, fire notice and attendance sheet.
- The Fire Safety Register is updated regularly, recording fire drills and evacuation, inventory of fire projection equipment, detailing inspections, tests and certification and any servicing carried out.

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

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

**the following respect:**

It was not clear from the records seen that the behaviour support plan had been reviewed in line with recent significant changes.

**8. 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:**

The behaviour support plan identified in the report has been reviewed and updated. Following any incident/change in behaviour, therapeutic interventions will be reviewed and updated. These interventions will also be reviewed annually with the person we support and their representative.

**Proposed Timescale:** 04/05/2017

**Theme:** Safe Services

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

There was no risk assessment completed, that identified the controls in place or any additional controls that may have been required to prevent/manage a specific concern as raised by staff spoken with and thereby supporting both staff and residents; staff gave clear examples of how their concerns impacted on the delivery of supports.

**9. Action Required:**

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

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

A risk assessment has been developed addressing the safeguarding of staff. Controls and additional controls will be identified to support the risk assessment. A draft Policy on allegations has been developed to safeguard staff. All staff will receive appropriate training in relation to safeguarding residents.

**Proposed Timescale:** 31/05/2017

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

An allegation of abuse had not been notified to HIQA as required.

**10. Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The retrospective NF06 notification and follow up report was forwarded on 21/04/2017. The PIC will ensure that all allegation of abuse are reported through the Association's Incident Report Xyea and that HIQA will be notified within 3 working days through the online portal.

**Proposed Timescale:** 21/04/2017

**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 required review and some minor amendment to ensure that it contained all of the required information.

**11. 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:**

The minor amendment has been made to the Statement of Purpose and submitted.

**Proposed Timescale:** 28/04/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Some files did not have evidence of staff members' identity that included a recent or clear photograph

**12. 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:**

Clear up to date photos of all staff will be placed on their files.

**Proposed Timescale:** 31/05/2017

**Theme:** Responsive Workforce

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

A review of staffing was required as there was evidence that indicated that the designated centre was not sufficiently staffed to meet the needs of residents on an ongoing basis.

**13. Action Required:**

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

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

A submission to the HSE for additional funding was made for staffing on 04/10/2016 for changing need in the residential houses. Contact was made with the HSE to follow up on this application on 05/05/2017. As a result a review of the staffing in the designated centre will be undertaken by the Disability Manager HSE Kerry using an assessment tool to determine the staffing level need in the services and to make an urgent business case for the additional funding.

**Proposed Timescale:** 02/06/2017