<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Listowel Residential Services</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003429</td>
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<td>Centre county:</td>
<td>Kerry</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>Kerry Parents and Friends Association</td>
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<tr>
<td>Provider Nominee:</td>
<td>Maura Crowley</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>9</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: To:
15 August 2017 09:15 15 August 2017 19:30
16 August 2017 09:00 16 August 2017 18:00

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

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Summary of findings from this inspection
Background to the inspection:
This inspection was the second inspection of this centre by the Health Information and Quality Authority (HIQA) and was carried out to inform a decision to register the centre. The centre was inspected previously on the 19 April 2016.

How we gathered our evidence:
Prior to the inspection the inspector reviewed the documents submitted by the provider with the original application for registration of the centre, the previous inspection findings and action plan response and any other correspondence received
in the interim from the provider such as notice of any accident, incident or adverse event.

The inspection was facilitated by the person in charge, the assistant director of services and nursing staff providing support to the centre. The inspector met with the frontline staff on duty over the course of the two day inspection; the provider representative attended the verbal feedback at the conclusion of the inspection.

The inspector observed resident and staff interactions and the delivery of care, supports and services to residents. The inspector reviewed records such as fire and health and safety records, records of accidents and incidents, reports of audits and records as they pertained to residents and staff. The inspector discussed these records and the plans for supporting residents with the staff on duty.

The inspector met with the nine residents in receipt of supports at the time of this inspection; five of these residents receive support on a full-time basis; four residents were availing of respite. The manner in which residents engaged with the inspector was diverse; some residents were relaxed and comfortable with the presence of the inspector in their home and engaged openly and warmly with the inspector; some residents demonstrated their trust and comfort through gesture or facial expression. Two residents while they observed with interest went about their normal routine and choose not to engage with the inspector; this was respected.

Residents invited the inspector to view their personal photographs, spoke of the importance of family and family events and activities that they enjoyed with family and staff. The observed interactions between staff and residents were respectful; residents sought out staff with ease and were noted to be comfortable when receiving supports from staff. Residents responded positively to staff that came on duty and told the inspector that they "loved" the person in charge.

Description of the service:
The designated centre consisted of two houses. One house was located on the outskirts of the busy town and provided full-time residential services to five female residents and respite services to one further resident at any one time. The second house was located in a more rural location in a small housing development at the opposite side of the town. In that house, the provider facilitated respite only to a maximum of three residents at any one time.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The inspector found that the service was provided as described in the statement of purpose. However, in line with guidance issued by HIQA in 2013 and revised in 2015, the inspector was not assured that it was possible for the houses to be combined to form one designated centre with a common statement of purpose given the diverse range of needs of the residents and the supports provided between both houses. The range of needs to be supported in each house was differentiated in the statement of purpose submitted to HIQA.

Overall judgment of our findings:
Overall and on balance the inspection findings were satisfactory in terms of the care, supports and services that residents were provided with. Improvement was noted on the previous HIQA inspection findings.

Resident’s needs were comprehensively assessed; the care and support required to meet these needs so as to promote and maintain resident health and well-being was in place. Three residents living together in one house had known each other since early childhood; their close bond was evident to the inspector. There was an ethos of supporting residents to age in place and the provider had responded to increasing needs to facilitate this for as long as was possible, for example through the provision of nursing input and equipment necessary for the residents comfort. While the premises (one house) presented some limitations in this regard, currently it was suited to the assessed needs of the residents individually and collectively.

Residents needs and supports were viewed holistically and increasing physical needs did not, where reasonably practicable, present as a barrier to ongoing social engagement.

There was a clear management structure and systems for the ongoing review of the safety and quality of the care, supports, and services provided to residents. However, given the diverse and increasing needs of residents the provider had itself identified the limitations in the existing management systems in ensuring effective and consistent, governance and operational management.

While staffing levels were maintained, there was an overreliance on relief staff to maintain these levels in one house.

Individually each house had identified deficits in fire safety measures; one house had significant deficits in that it was not fitted with emergency lighting or fire resistant door-sets and had limited systems for fire detection. The provider had commissioned a fire safety review the report of which issued in June 2016 and specified the works to be completed. With the exception of the installation of emergency lighting in one house the provider confirmed that the works had not been completed; the rationale provided was that the funding required was not available to the provider. In addition while there was evidence of recent review and improvements to be made, further review was required on evacuation procedures given the changing and increasing needs of residents.

Of the full 18 Outcomes inspected the provider was judged to be compliant with 12 Outcomes, in substantial compliance with three and in moderate non-compliance with two Outcomes.

The provider was judged to be in Major non-compliance with one Outcome, Outcome 7: Health and Safety and Risk Management based on the fire safety failings described above.

The evidence to support these judgements is found in the body of the report in each respective Outcome; the regulations breached and the action required of the provider are detailed in the action plan at the end 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:**

Both houses presented quite differently in so far as that one house offered residents an unhurried and relaxed pace of life that suited their needs while the other was noted to be busy and active, again in line with the needs of the residents that accessed that service. However, in both houses the inspector noted that residents were relaxed in the company of the staff on duty and welcomed staff warmly when they came on duty. The interactions observed and heard by the inspector were timely and respectful.

Staff were seen to deliver supports in a manner that was person centred and promoted the privacy and dignity of the resident, for example while providing assistance at mealtimes or for personal hygiene.

Staff were seen to engage with residents throughout the day but they were also consulted with formally through house meetings; these were convened weekly in the respite house and fortnightly in the residential house; the person in charge had a schedule of dates for these meetings and monitored adherence to it. Items discussed included options for outings, trips away and menu choices. The house meetings also provided an opportunity for staff to engage with residents in relation to safeguarding or making a complaint. Overall the inspector found that staff captured how they offered and ascertained resident choice and preference particularly where verbal communication was limited.

There was evidence that staff educated residents as to their civil rights and political
There was a complaints policy which was displayed prominently throughout the centre and was also available in an accessible format. House meeting minutes indicated that the topics of making a complaint and complaints management were discussed regularly with residents.

The inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints and whether the complainant was satisfied; there was only one complaint logged since June 2016; the person in charge said that this was correct. Families surveyed and spoken with said that had never had a reason to complain but would have no hesitation in doing so if the need arose. The records indicated that the investigation undertaken in response to the complaint was comprehensive and timely. In practice there was evidence of the implementation of actions to prevent a reoccurrence of the matter complained of.

The provider engaged the services of an independent advocate; families and residents were advised of the availability of this service.

The importance of religious observance to residents was acknowledged in their personal plans. The person in charge said that attendance at religious services was in line with resident choice and was supported as requested. A group of residents and staff had recently made a trip to a religious shrine as part of the personal goals process.

The inspector discussed the management of resident finances and reviewed a sample of the financial records maintained by staff. The inspector saw that a financial ledger was maintained for each resident; the ledger listed all financial transactions and the reason for the transactions; supporting receipts were in place. Periodic oversight was maintained by the person in charge and designated financial personnel. However, the person in charge did not always record her oversight and it was recommended that she do so.

The majority of the residents attended structured day service Monday to Friday; for some residents attendance was phased in line with their changing needs and their requirement for a more relaxed pace of life. For some residents, an activation programme was delivered in the house itself. Improvement was noted in this latter programme since the last inspection. Staff had undertaken education in and facilitated for residents a certified therapeutic programme; the inspector met with an external music therapist who also attended the house weekly; staff were currently exploring the facilitation of pet-therapy. There was extensive photographic evidence of social activities and events undertaken in the community.

However, what was not always evident from the records seen was how goals, priorities and activities were identified and agreed and how the residents participated in these decisions so as to clearly demonstrate that the chosen activity was in line with the resident’s ability, choices, and preferences.

**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:**
There was evidence of good practice in supporting effective communication with and for residents.

The inspector saw that each resident’s expressive and receptive ability was assessed and a plan of support was devised as appropriate, based on the assessment findings. Again as appropriate to each resident’s assessed needs, the plan and practice was comprehensively supported by input from the psychologist.

The inspector saw supportive interventions such as a visual staff rota, pictorial menus and communication passports and dictionaries.

Staff spoken with were very attuned to non-verbal means of communication such as gestures and facial expressions and these were also well referenced in the support plans seen, for example how a resident may communicate pain and discomfort or their displeasure with a particular requested activity.

Again as appropriate to their needs the inspector saw that residents had access to assistive technology and specific communication applications, used at times in combination with other skills such as manual signing.

Some residents enjoyed printed media and were seen to be supported by staff to access and choose these from the local shop.

**Judgment:**
Compliant

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**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:
The inspector met with one family member during this inspection and three completed HIQA questionnaires were returned by families.

The inspector saw and family feedback confirmed that families were invited to attend the annual review of the personal plan and in the intervening period were kept informed and updated of any changes in their family members needs. Records seen indicated that at times both family and staff attended scheduled reviews and appointments. Notwithstanding increasing needs, staff supported residents and families to enjoy visits home.

There were no unreasonable restrictions on visits; family spoken with confirmed that they called to the centre generally unannounced as the visits may be co-incidental rather than planned. It was possible to secure a private space for visiting in both houses if required.

### 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 on admission, transfer and discharge to and from the designated centre; the policy included as required by Regulation 24 (1) (b), the requirement for admission procedures to protect residents from abuse by their peers. However, inconsistencies were noted in residents' contracts of care.

There was documentary evidence that the provider kept each resident, their needs and required supports under review to ensure that these needs could be adequately and appropriately met in the designated centre.

Residents had an explicit contract for the provision of support and services. However,
based on the sample of records seen by the inspector the contracts required review as inconsistencies were noted. Some contracts did satisfy regulatory requirements; the fee to be charged for care and accommodation, the general terms of what residents were personally liable for, for example personal items, non-essential therapies and social events, and the fees for such services where these were known were all detailed; other contracts however did not contain this information or contained the incorrect information.

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

Findings:
While minor improvements were recommended, overall based on the representative sample of records reviewed, the inspector saw that there was a recent comprehensive assessment of resident’s needs and plans of support were in place based on the findings of the assessment.

The support plans seen were detailed and offered good guidance to staff; staff spoken with were familiar with the plan and the observed supports were as detailed in the plan, for example, the provision of modified diet and fluids, plans to protect skin integrity and to promote and maintain independence.

The plans of support were seen to be kept under review in line with changing needs and to reflect any recommendations made by the multidisciplinary (MDT) team.

A nurse registered in both general and intellectual disability nursing supported staff in both the completion of assessments and plans of support and care; all staff spoken with acknowledged both the requirement and benefit of this support given the increasing needs of residents, particularly in one house.

Currently given the standard of assessment and support evidenced, the inspector was
satisfied that the designated centre was suited to meeting the assessed needs of the residents and that the provider had the required arrangements in place such as the provision of additional equipment.

The accessibility of the plan was enhanced through the use of pictorial and photographic supports; the language used was person centred and respectful.

Records seen demonstrated that in addition to the ongoing review referenced above the personal plan was the subject of an annual review to which both family and members of the MDT were invited.

The support plan incorporated the process for identifying and progressing resident’s personal goals and priorities. Timeframes and responsible persons were identified; the actions taken to progress and achieve each goal were recorded.

Based on the inspector’s review of the plans, the improvements recommended at verbal feedback to strengthen the existing plans included; the review of a skin integrity assessment tool, the inclusion of the baseline vital sign so that staff would know when advice was required and the inclusion of infection prevention and control precautions.

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):
No actions were required from the previous inspection.

Findings:
The designated centre consisted of two domestic type properties; both houses presented well, were well-maintained and visibly clean. However, the design and layout of one house posed some challenges in light of the increasing needs and dependency of residents.

One house, in which respite supports were provided, was of more recent construction and was located on a spacious site in a small housing development; all facilities were at ground floor level.

In this house each resident was provided with their own bedroom, bedrooms offered
sufficient space including personal storage space. There was one spacious bathroom (a maximum of three residents were accommodated) with bath, shower, toilet and wash-hand basin. Residents had a choice of two communal and or recreational areas and this was seen to support resident’s individual needs. The kitchen was appropriately equipped and incorporated the dining area which offered sufficient space for the number of residents accommodated. There was a separate utility area with laundering facilities.

The other house was located in a residential area on the outskirts of the busy town and was a dormer type domestic premises; both floors were utilised with residents bedrooms located on both the ground and first floors. The house accommodated a maximum of six residents (the provider had itself reduced the occupancy from seven so as to best meet the needs of residents) and was relatively spacious having originally functioned as a bed and breakfast facility.

Four residents were accommodated on the ground floor including one bedroom utilised for the provision of respite supports. Three of these bedrooms had full en-suite facilities but as they were domestic in design they were limited in their use in light of residents' needs; this was reflected also in the findings of a recent occupational therapy review. However, there was a further ground floor universally accessible bathroom with shower, toilet and wash-hand basin.

Also accommodated on the ground floor were two rooms for communal and or recreational purposes and the combined kitchen and dining area.

Upstairs there were a further two bedrooms for residents, the staff office; sleepover room and a vacated bedroom that was to be used shortly as an office by the nurse. There was a further bathroom at this level with toilet, wash-hand basin and floor level bath; residents were seen to access and use this facility but staff reported that residents did not choose to use the bath.

As stated in the summary of this report the provider aimed to support residents to remain in this house, their home, with their peers for as long as was possible; the design and layout posed some challenges to this.

However, the inspector saw that the bedroom offered sufficient space to allow staff to access the bed from both sides and to safely use a floor based hoist for patient handling. The en-suite did not offer sufficient space but there was a universally accessible bathroom in close proximity to the bedroom. Door saddles had been removed to facilitate safe movement of the hoist and wheelchair. A recent occupational therapy review had recommended works to the en-suite that would improve the space available but fundamentally not the accessibility of the services, for example it was recommended that the shower be removed.

Circulation areas and doorways were not designed to accommodate universal access; staff confirmed that they could safely manoeuvre the hoist and the wheelchair but not seating used by the resident. This is discussed further in Outcome 7.

In summary, while there were limitations to the design and layout of the premises in meeting the changing and increasing needs of the residents, the provider and staff were
aware of this, were making modifications required and residents needs were currently being met adequately and safely.

**Judgment:**
Compliant

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

**Theme:**
Effective Services

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

**Findings:**
There were deficiencies in the fire safety systems in both houses but particularly so in one house; this was confirmed in a report from a review completed by an external person as commissioned by the provider following the last HIQA inspection.

The house that predominately provided residential services was seen to be serviced by an automated fire detection system, fire fighting equipment was provided and emergency lighting had been installed since the last inspection. On visual inspection there appeared to be some provision of fire resistant doors and self-closing devices.

The second house had no emergency lighting, no fire resistant doors and minimal provision for smoke and or fire detection; two detectors were noted by the inspector. The utility room that accommodated electrical appliances and the heating boiler had no detector. The report referenced above in paragraph one detailed the works that were required in both houses. The provider representative confirmed that with the exception of the installation of the emergency lighting in one house, the recommended works had not been completed as the required financial resources were not available to the provider. There was evidence that the provider continued to liaise with the statutory body in an attempt to secure funding to complete the required works.

Records seen indicated that staff had attended fire safety training; staff spoken with confirmed their attendance; staff undertook regular in-house inspections of the existing fire safety measures. Certificates were in place attesting to the inspection and testing of the fire fighting equipment in November 2016; the fire detection system in June 2017 and the emergency lighting in August 2017.

Each resident had a personal emergency evacuation plan (PEEP) and staff undertook simulated evacuation drills with residents. However, reports seen of these drills and staff spoken with confirmed that an adequate evacuation time was not always achieved in one house. It was also noted the that up to a period just prior to this inspection there...
was evidence of an significantly inadequate PEEP for one resident in the event of the resident not vacating their first floor bedroom in the event of fire; this matter was in the process of being addressed; the inspector requested and the provider provided confirmation to the inspector that the recommended evacuation device had been ordered. A further PEEP for a dependent resident referenced the requirement for a further assistive evacuation device. Notwithstanding the actions that were being taken at the time of this inspection a full review with support from a suitably qualified person was required of evacuation procedures to ensure that staff could evacuate residents safely and in a timely manner.

Final fastenings were all manual key locks; some key boxes were in place; however, these had coded access and would not be accessible to all persons in the event of an emergency; proprietary key-boxes that allowed the keys to be readily accessible in the event of an emergency were required.

The laundry facilities in one house were external to the house in the adjoined garage. There was no evident smoke and or fire detection in the garage that housed both electrical and gas appliances and also served as a general storage area. From a fire and infection prevention and control perspective this area required attention and organisation.

Residents did have patient handling requirements and a patient handling assessment had been completed; however the resident's needs had since increased. Having spoken with staff, reviewed the equipment available and the limitations posed by the environment there was duplication of manual handling tasks, for example in relation to chair transfers and attending to showering. A further manual handing assessment of the resident, their needs, the environment and the equipment currently available to staff was required so as to minimise where possible repeat manual handling tasks thereby promoting the safety and comfort of both resident and staff.

The person in charge maintained the risk register; the inspector saw that a good range of centre-specific risks, risks as they pertained to individual residents and the risks as required by Regulation 26, for example a resident unexpectedly missing from the centre, had been identified and assessed; the controls had reduced the level of identified risk to low and medium for the majority of identified risk, with the exception of fire given the above deficiencies.

**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 and national policies and procedures, a designated person, risk assessments and safeguarding plans, and staff training.

There was evidence that staff sought to support residents to develop skills in self-protection; the safeguarding and complaints policy were available in an easy-read format and both topics were discussed regularly with residents at the residents meetings.

The inspector saw in both houses that residents presented as comfortable with all of the staff on duty, approached and engaged freely with staff or demonstrated their comfort by gesture and facial expression.

Staff spoken with confirmed their attendance at safeguarding training and articulated a good understanding of practice and actions that might constitute abuse. There were no identified barriers to staff raising concerns or reporting any alleged or suspected abuse. The inspector was advised that there were no safeguarding concerns; families surveyed and spoken with raised no concerns; the person in charge said that she had confidence in the staff team both in the quality of the supports that they delivered and in their reporting responsibilities.

In one house residents did present at times with behaviours of concern or risk to themselves and others. Residents had access to the supports that they required to assist them in the management of these behaviours, for example psychiatry and psychology. The inspector reviewed a sample of behaviour management guidelines; there was a strong emphasis on the reasons for the behaviour, the purpose of the behaviour, triggers and the importance of communication in both avoiding and managing exhibited behaviour. Staff completed tools such as Antecedent Behaviour Consequence (ABC) records so as to monitor the effectiveness of the strategies outlined.

Staff spoken with articulated a good understanding of what might constitute a restrictive practice. There was a policy on the use of restrictive practice; there was a formal process for the identification, sanction and review of restrictive practices. Records seen detailed the rationale for practice, alternatives that had been considered, justification for the use of particular interventions, consultation with the resident and a strict protocol for their use. There was evidence of alternatives and reduced restrictions; for example the introduction of falls prevention strategies, following specialist review, such as movement alarms and impact reducing floor mats. Waking night staff completed monitoring checks where it was deemed necessary for a resident’s safety to erect bedrails to prevent a fall from bed.
However, it was of some concern to the inspector that staff had used bedrails as a falls prevention strategy even though staff had acknowledged that the resident had the ability to climb over the bedrail. This practice had now ceased but would however indicate that staff would benefit and be empowered in practice by education in the use of restrictive devices; this is addressed in Outcome 17.

**Judgment:**
Compliant

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**Outcome 09: Notification of Incidents**

_A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector._

**Theme:**
Safe Services

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

**Findings:**
The risk management policy informed the identification of hazards, the assessment and management of risk and the management of any accidents, incidents and adverse events. The person in charge maintained an electronic record of accidents, incidents and adverse events that occurred in either house; there was evidence of review and actions taken to prevent reoccurrence such as the review of the existing relevant risk assessment.

The person in charge had sound knowledge of her responsibility to submit notifications to the Chief Inspector, what these notifications were and the timeframe within which they had to be submitted as prescribed by Regulation 31

**Judgment:**
Compliant

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**Outcome 10. General Welfare and Development**

_Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition._

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

Findings:
Between the two houses residents presented with a broad range of needs and abilities; this was reflected in the opportunities facilitated for occupation and recreation; however, increasing age and dependency were not viewed as a barrier to ongoing activity and social engagement.

The majority of residents attended the day service on a full-time basis; some residents attended less than full-time as was appropriate to their needs; in addition staff in one house facilitated a programme of activation in the house itself. Given the increasing needs of the residents, the inspector was satisfied that a reasonable balance was struck between activation in the house and community engagement; planned activities included trips to the beach and other areas of interest including an upcoming local festival. There was good photographic evidence of excursions that were enjoyed including residents meeting favoured musicians and television celebrities.

Equally where a planned activity had not been successful, this was acknowledged so as to avoid a future occurrence. Staff explained the strategies that they employed to ensure that residents were not excluded on social events, for example, the provision of modified diets and fluids when out in the community.

During the course of the inspection the inspector saw that staff escorted residents on short excursions in the community for a walk or to go to the local shop. Transport was available in both houses and staff confirmed that while the available transport was not wheelchair accessible, suitable transport was secured as needed for dependent residents; the provider absorbed the cost of this.

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:
The inspector was satisfied that residents’ healthcare needs were met through timely access to health care services. A registered nurse supported social care workers in meeting residents' healthcare needs (this is discussed again in staffing).
Residents' healthcare needs were appropriately and comprehensively assessed and met by the care and support provided in the centre. The assessments informed the development of individual healthcare plans for each resident. Healthcare plans were comprehensive and contained adequate information to guide staff in supporting residents. The plans reviewed were current and reflected the residents' current status. Staff were familiar with the content of plans and their implementation.

There was evidence of regular monitoring and assessment of health and wellbeing. Residents' body weight was measured regularly to identify any loss or gain that may require intervention. Regular monitoring of blood pressure and pulse where appropriate, was undertaken in line with each resident's assessed needs and healthcare plan.

Residents attended their choice of general practitioner (GP) as required. The GP service facilitated was flexible, timely and pro-active. An "out of hours" service was available if required.

Where a resident was anxious or declined a treatment there was a plan to support successful intervention but ultimately the resident's choice was to be respected.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had access to healthcare professionals including psychiatry, neurology, chiropody, optical, speech and language, occupational therapy and dental care; psychology review and support was available as required from within the organisation.

Over the course of the inspection meals were prepared by staff in the centre and residents were seen to be offered regular snacks and refreshments. The menu plan reviewed was varied. The advice of the dietitian was incorporated into the resident's healthcare plan; speech and language recommendations were seen to be adhered to by staff.

Residents and their representatives were consulted about and involved in the meeting of health and medical needs.

Where appropriate, staff described and records seen indicated the commencement of discussion and planning for end-of-life needs and care; the initiated and planned discussions incorporated the residents known wishes, family and the MDT.

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

Findings:
Overall there was good practice evidenced in the management of medicines; however, improvements were required in the protocols for the administration of a rescue emergency medicine in response to seizure activity.

Medicines for residents were supplied by a local community pharmacy. The inspector noted that the pharmacist was facilitated to meet their obligations to residents in accordance with relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Staff reported that the pharmacist had a longstanding relationship with the centre and was very familiar with the residents. Many medicines were supplied in compliance aids and resources were supplied and available to staff to confirm the medicines in the compliance aid; medicines supplied were checked on delivery by nursing staff.

Residents availing of respite supports were required to supply their medicines in the original container, as supplied by their pharmacist with the appropriate label affixed by the pharmacy. Medicines in stock were seen by the inspector to adhere to this requirement.

A medicines management policy was in place which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. The inspector spoke with nursing and care staff who demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements.

The inspector noted that medicines were stored securely. Medicines requiring refrigeration were stored appropriately and the temperature was monitored daily. Medicines requiring additional controls were not in use in the centre at the time of the inspection.

Medical authorisation was in place for medicines required to be administered in an altered format; that is, crushed, as required due to impaired swallow.

Staff maintained a record of each medicine administered including medicines prescribed on a PRN basis, (medicines taken as required); this record included the reason for their administration and their effectiveness.

The pharmacist undertook an audit of medicines management practices in the centre; the audit template reflected regulatory requirements and included the management of any unused medicines or medicines no longer required; a high level of compliance was evidenced in this audit report.

The inspector saw that medication related incidents were identified, reported on an incident form and there were arrangements in place for investigating incidents. The
person in charge reported a low incidence of such events and this would concur with the records seen by the inspector for the 12 month period prior to this inspection.

A sample of medication prescription and administration records was reviewed. Medication prescription records were current and contained the information required by legislation. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications.

Overall there was good practice in the management of epilepsy. Residents had ready access and were supported to attend regular appointments with a consultant neurologist. The service offered support and advice to staff as required the details of which were seen in residents’ individual plans. Staff had completed training in the administration of the emergency medicine. However, while individual plans were developed in relation to the administration of emergency medicine in the event of seizure activity, the standard of the plans seen was inconsistent. The plans seen did not always outline clear guidance to staff on the administration of emergency medicine, recovery times, repeat administration, when and why the assistance of emergency services may be required. One such plan that was of concern to the inspector was reviewed by staff in consultation with the GP and the neurologist prior to the conclusion of the inspection; the revised plan was comprehensive and outlined clear guidance for staff. However, in view of the inconsistency noted, a full review of all such plans was required in line with each individual resident’s requirements, current prescription and provider protocols.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
A revised statement of purpose was submitted to HIQA prior to this inspection. The statement of purpose contained all of information prescribed by Regulation 3 and Schedule 1; the statement accurately described the centre and the supports and services to be provided. However, the inspector was not assured that the two houses that comprised this designated centre shared a common statement of purpose given the diverse range of needs of the residents between both houses. The range of needs to be
supported and the service to be provided in each house was differentiated in the statement of purpose submitted. This is discussed again below in Outcome 14 in the context of governance.

**Judgment:**
Compliant

**Outcome 14: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Management systems were in place to ensure that the centre was effectively governed and the service provided was safe, appropriate to residents’ needs, consistent and effectively monitored. However, the provider confirmed that it had itself identified, discussed and agreed that the working arrangements of the person in charge were not sustainable; the inspector would concur with this conclusion.

There was a clear management structure. Frontline staff reported to the person in charge who in turn reported to the assistant director of services who was also one of the nominated persons participating in the management of the centre (PPIM); the PPIM reported to the director of services who was the provider nominee. The inspector noted that residents were very familiar with both the director of services and the assistant director of services.

There was an out-of-hours on call support system for staff operated by the senior managers.

Monthly management team meetings were held, the chief executive officer chaired these meetings, the persons in charge attended and the minutes were disseminated to all staff. In addition monthly quality and standards meetings were held where issues, including medicines management, incident reporting and audits across services were discussed and shared for the purposes of learning.

The person in charge convened staff meetings in each house; the minutes seen of these
meetings were detailed. The provider had implemented a formal system of staff supervision.

The person in charge confirmed that she had support and access as required to the assistant director of services and or the director of services.

The person in charge worked full-time and was responsible for two designated centres which comprised, in total, three different houses; the person in charge was based in this designated centre. The person in charge held suitable qualifications in social care and healthcare studies and was currently undertaking a management qualification; the person in charge had been appointed to her role in April 2016 and had relevant supervisory experience as a team leader and social care leader.
The person in charge facilitated the inspection with ease, was visible and accessible to residents and staff and had sound knowledge of regulatory requirements.

The person in charge facilitated the inspection with ease, was visible and accessible to residents and staff and had sound knowledge of regulatory requirements.

The person in charge had exercised her personal and professionally responsibility to raise any concerns she had in relation to her capacity to ensure the effective governance, operational management and administration of both designated centres; the provider supported the person in charge and concurred with these concerns. The inspector would concur with this as the inspector was not assured as to the configuration of this designated centre. Each house had a different purpose and the range of residents needs differed between each house in type and complexity; each house in its own right was busy; while a maximum of nine residents were accommodated at any one time, a total of 20 resident’s accessed regular respite in the centre.

In addition while the person in charge worked fulltime and had allocated shifts for the purpose of administration the person in charge was also required to work 10 to 15 hours per week as a frontline staff. In addition to this requirement, the staff rota demonstrated that given the reliance on relief staff, the person in charge was required to work further frontline shifts if relief staff were not available. On the week of the 22 July 2017 this had occurred on three occasions, two of which were designated administration days for the person in charge. This was not sustainable and not conducive to management systems that were effective in ensuring the governance, operational management and the quality and safety of supports and services on a consistent basis in all of the designated centres concerned.

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. The annual review sought and incorporated feedback from residents and families. The unannounced visits utilised comprehensive lines of inquiry, action plans, timeframes and responsible persons were identified; the person in charge recorded the actions taken in response to the action plan. A significant action plan issued form the February 2017 review; there were 22 individual actions. However, the most recent unannounced review was undertaken just prior to this inspection; the number of actions issued had reduced to seven.

Judgment:
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 responsibilities. The provider had notified the Chief Inspector as required of any absence of the person in charge, the arrangements in place for the management of the centre in the absence of the person in charge, and the return of the person in charge

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 provider’s representative told the inspector that the provider did not have available to it, the financial resources required to complete the recommended fire safety works. This is actioned under Outcome 7; Health and Safety and Risk Management.

Documentation has previously been provided to HIQA confirming that the provider was in ongoing discussions with the statutory body in relation to general funding and financial challenges. There was a commitment to address issues as they arose to ensure the maintenance of services. However, the inspector was satisfied that on a day-to-day basis sufficient resources were provided to the centre to support residents’ changing needs and their support plans so as to maintain their health and well-being.
### 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

### Findings:
Based on the inspector’s observations, the review of resident assessments and support plans and staff spoken with, the inspector was satisfied that staffing numbers and arrangements were currently adequate to meet the assessed needs of the residents; however, there was consistent over-reliance on relief staff to maintain the staffing levels in one house.

The night time staffing arrangement in each house was one waking staff and one sleepover staff; based on records seen this arrangement was clearly required to meet residents needs and ensure their safety as these needs included disturbed sleep patterns and nocturnal seizure activity.

By day there was a minimum of two staff on duty in each house (the respite house was ordinarily closed during the day as residents attended day service; the other house was always occupied with a minimum of three residents present each day); the inspector saw that additional staff supports were in place where there were specific one-to-one requirements. The inspector saw that staff were busy but responded to residents' needs in a timely manner and in line with the prescribed support plan, for example rest periods and personal hygiene programmes.

The person in charge confirmed that the staff team in the respite house was established and consistent. However, in the other house the staff rota demonstrated and the person in charge confirmed that insufficient regular staff were employed and on average 11 relief staff were required each week to work an average of 20 vacant shifts by day and by night. In addition the rota also demonstrated that the person in charge had to cover some shifts if relief staff were not available; this impacted further on her ability to ensure the effective operational management and administration of all of her designated centres. The nurse affiliated to the centre but not a member of the staff team was also seen to work shifts as required.
At the time of the last HIQA inspection the provider had identified the requirement for additional nursing support for this centre due to increasing assessed healthcare needs of a resident. The provider had and was, providing nursing input and support on a daily basis from within its own nursing resources.

Records were maintained of training completed by staff. These records indicated that all staff had received mandatory baseline training but there were gaps in refresher training in safeguarding, safe administration of medicines management, manual handling and the management of behaviours of concern and risk. While the numbers of non-attendance were low, some of the gaps were persistent and had not been addressed though the required training was facilitated by the provider on a rolling basis.

Staff had completed training that reflected the assessed needs of residents; this training included communication, epilepsy awareness, first-aid, disability and health-skills studies, autism, falls prevention and the provision of modified diets. However, as discussed in Outcome 8 these inspection findings would indicate that staff and their practice would be supported by education on restraint to ensure that practice was at all times evidence based. Also given the needs of residents there was low recorded completion of infection prevention and control training.

Staff files were made available for the purpose of inspection; the random sample of files reviewed was well presented and contained all of the records required by Schedule 2.

**Judgment:**
Non Compliant - Moderate

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**Outcome 18: Records and documentation**

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

**Theme:**
Use of Information

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

**Findings:**
The inspector was satisfied that the records listed in part 6 of the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 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.
Disabilities Regulations 2013 were in place. The required records were retrieved for the inspector with ease; the records were well maintained. Core records such as safeguarding and complaints procedures were available to residents in an easy-read format.

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
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by Kerry Parents and Friends Association
Centre ID: OSV-0003429
Date of Inspection: 15 and 16 August 2017
Date of response: 11 September 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:
What was not always evident from the records seen was how goals, priorities and activities were identified and agreed and how the residents participated in these decisions so as to clearly demonstrate that the chosen activity was in line with the resident’s ability, choices, and preferences.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

**Please state the actions you have taken or are planning to take:**
A review of personal plan guidelines and the function and role of the key worker monthly meetings with the resident will be on the agenda for team meetings to ensure that residents are getting opportunities to participate in activities they are interested in. Liaise with day service manager to ensure that training needs are identified for all people attending the day service.

**Proposed Timescale:** 16/10/2017

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**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:
Inconsistencies were noted in the sample of contracts seen.

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

**Please state the actions you have taken or are planning to take:**
Review all contracts of support to ensure all are up to date and reflect the services being offered.
Any contract reviewed on the day that had inconsistencies have been rectified.

**Proposed Timescale:** 29/09/2017

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**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:
A further manual handing assessment of the resident, their needs, the environment and the equipment currently available to staff was required so as to minimise where possible repeat manual handling tasks thereby promoting the safety and comfort of both resident and staff.

3. **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:**
Manual handling review carried out on 21/09/2017 report received re same.

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**Proposed Timescale:** 21/09/2017

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were deficiencies in the fire safety systems in both houses but particularly so in one; with the exception of the installation of the emergency lighting in one house, the recommended works had not been completed.

**4. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
Association is negotiating with the HSE to fund the installation of fire safety measures for compliance. The Senior Management team have also applied for funding from other bodies to complete this work as matter of urgency.

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**Proposed Timescale:** 31/01/2018

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Final fastenings were all manual key locks; some key boxes were in place; however, these were coded access and would not be accessible to all persons in the event of an emergency.

A full review with support from a suitably qualified person was required of evacuation procedures to ensure that staff could evacuate residents safely and in a timely manner.

**5. 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:**
Key holder units to be installed at final exits to ensure ready access out in case of an emergency.
Evacuation review and evacuation training held on 11/09/2017.
Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In view of the inconsistency noted a full review of emergency rescue medicine plans was required in line with each individual resident’s requirements, current prescription and provider protocols.

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

Please state the actions you have taken or are planning to take:
On agenda for review at policy level at Safe Administration of Medication committee meeting in September.

Proposed Timescale: 29/09/2017

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:
The provider confirmed that it had itself identified, discussed and agreed that the working arrangements of the person in charge were not sustainable.

The inspector was not assured that the two houses that constituted this designated centre shared a common purpose and function.

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

Please state the actions you have taken or are planning to take:
The two houses in the current designated centre will be separated to two separate designated centres. The recruitment of a Person in charge is being processed at present for a new respite centre and this new PIC will also have responsibility for our current respite house.
### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Insufficient regular staff were employed in one house and on average 11 relief staff were required each week to work an average of 20 vacant shifts by day and by night.

8. **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:**
Full review of the roster is being carried out. One staff is due back to a 39 hour post in November following a career break, where possible identified posts will be filled.

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### Proposed Timescale: 27/10/2017

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had received mandatory baseline training but there were gaps in refresher training in safeguarding, safe administration of medicines management, manual handling and the management of behaviours of concern and risk; some of the gaps were persistent.

These inspection findings would indicate that staff and their practice would be enhanced by education on restraint to ensure that practice was at all times evidence based; also given the needs of residents there was low recorded completion of infection prevention and control training.

9. **Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
Informal counselling will take place with any staff who has consistently not been attending mandatory training.
Education on restraint will be sourced and delivered.
Action plans from training audit will be closely monitored.
**Proposed Timescale:** 15/10/2017