| **Centre name:** | The Glen |
| **Centre ID:** | OSV-0002648 |
| **Centre county:** | Limerick |
| **Type of centre:** | Health Act 2004 Section 39 Assistance |
| **Registered provider:** | RehabCare |
| **Provider Nominee:** | Grainne Fogarty |
| **Lead inspector:** | Mary Moore |
| **Support inspector(s):** | Kieran Murphy |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 4 |
| **Number of vacancies on the date of inspection:** | 0 |
About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: To:
25 September 2017 10:15 25 September 2017 19:00
26 September 2017 09:30 26 September 2017 15:30

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

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Summary of findings from this inspection
This inspection was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA); the last inspection was undertaken on 20 May 2017. Further to those inspection findings a meeting was convened with the provider on 13 July 2017. On 25 August 2017 the provider was issued with notice of the Chief Inspectors decision to propose to cancel and refuse the registration of this designated centre. In accordance with Section 54 of the Health Act 2007 the provider submitted written representation to the notice of proposal to cancel registration.

The representation outlined the actions that the provider had taken and intended to take to address the failings identified. These actions included the ceasing of the operation of the centre as it was currently configured by 31 July 2018. The provider articulated to the office of the Chief Inspector its commitment to ensuring that the designated centre would be operated in accordance with the requirements of the Act, the Regulations and Standards until that configuration was complete.

How we gathered our evidence:
The inspection was facilitated by the person in charge and the team leaders. The regional manager who was the provider’s representative, and the integrated services manager also met with inspectors during the inspection and attended verbal
feedback at the conclusion of the inspection.

Prior to the inspection, inspectors reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider such as the representation referenced above, the previous inspection findings and action plans, and any notice received of any incidents that had occurred in the centre.

In the centre inspectors reviewed records including fire and health and safety related records, accident and incident records, records of complaints received, records pertaining to residents, their assessed needs and required supports and records pertaining to staff such as records of staff training.

Inspector’s met with all of the residents living in the centre; this engagement with residents was guided by each resident and their choices and needs. For example residents communicated verbally with inspectors or expressed their general demeanour and desire for engagement through facial expression or gesture.

Inspectors observed the delivery of supports and services to residents, discussed these with the staff on duty and observed staff and resident interactions. These discussions and observed interactions were positive and resident-focussed.

Description of the service:
The centre comprised a domestic style two-storey building located on a spacious site in a rural location; transport was available.

Residential services were provided to a maximum of 4 residents who required a high level of staff support to meet their assessed needs.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided.

Overall Findings:
Overall inspectors found that the provider had and was implementing the actions committed to in the representation submitted to HIQA.

The provider had taken action to put management systems in place in the designated centre to ensure the appropriateness, quality and safety of the supports and services provided to residents. However, these inspection findings indicated that further improvement was required to ensure and provide assurance of effective oversight.

The provider had largely addressed staffing inconsistencies and the use of agency staff but there was still regular reliance on relief staff. Mandatory training and training identified by the provider as required by staff was either completed or planned.

Generally improvement was noted in the follow-up and implementation of interventions recommended in response to residents needs such as communication, nutrition and sensory needs. However, in the ongoing absence of a comprehensive
assessment tool it was not demonstrated how the assessment process was holistic and comprehensive as it did not fully capture and reflect all needs.

With the support of speech and language intervention, staff were clearly demonstrating how they consulted with residents, gave residents choice and ascertained residents’ preferences.

It has been clearly established that the premises and model of shared living does not meet the individual and collective needs of the residents. Given the complex and diverse needs of the residents, the environment presented challenges to residents and staff and posed risks on a daily basis to resident welfare and safety. The provider has a funded, time-bound plan to address this. However, until this plan is realised, risk, behaviours, behaviour related incidents and their management, and the use of restrictive practice required robust, timely and consistent review and monitoring.

Inspectors reviewed eight regulatory Outcomes five of which were found to be in major non-compliance with regulatory requirements at the time of the last inspection. The provider was now judged to be compliant with one Outcome, in substantial compliance with a further Outcome and in moderate non-compliance with the remaining six.

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

Theme:
Individualised Supports and Care

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

Findings:
Improvement was evidenced in how staff sought and ascertained residents’ choices, preferences and decisions and in how this was demonstrated by them. This improvement was informed by recent speech and language therapy assessments and recommendations.

Inspectors saw and staff explained the use of visual supports and individualised choice-books where visual cues were used to give choice to residents and ascertain residents’ preferences. This system was used daily between staff and residents in relation to choices such as meals and activities or to explain and agree the planned routine.

Previously inspectors had been advised that residents did not engage with collective forums of consultation. However, weekly resident meetings had been reintroduced and it was clear from the minutes seen that residents did individually and collectively engage and participate in these meetings. While the interest shown by each resident may have fluctuated, it was clear from the minutes seen that the engagement was sufficient to be meaningful.

Staff in the manner in which they completed the minutes successfully captured how they communicated with each resident, for example by using the tools referenced above, the choices made by each resident and each resident’s level of engagement and participation.

At these meetings staff also included a more substantive topic for discussion such as “keeping safe”, personal space and privacy. Again staff used supportive tools such as
social-stories and visuals to communicate with residents; staff recorded residents’ responses to the topic discussed.

Inspectors reviewed the record of complaints received since the last inspection; three complaints were recorded, one of which was known at the time of the last inspection. There was evidence of the actions taken to resolve the complaint and actions necessary to prevent reoccurrence. One matter complained of twice reflected the incompatibility of residents’ needs and the impact of this. While the matter was resolved each time by staff it will potentially reoccur until the centre is reconfigured; the provider has a plan for this.

The person in charge told inspectors that she had, since her appointment in late July 2017, met with the families of all residents living in the centre.

All staff spoken with spoke respectfully of residents and the observed interactions and engagement with residents was positive and as outlined in the support plan.

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

Findings:
Three files were maintained for each resident; the main file that included records such as records of referrals and reviews, the person centred plan and a daily working folder. Inspectors were advised that each personal plan had been reviewed in full since the last inspection. However, inspectors found collectively, records were not maintained in a manner to facilitate the easy retrieval of accurate information. While staff said that they were in place, inspectors did not see plans for progressing residents’ individual goals and priorities. A tool for comprehensively assessing each resident’s holistic needs was still required.
Each personal plan was seen to commence with a detailed synopsis of each resident, their needs and required supports. These were current and incorporated the recommendations made by members of the multidisciplinary team. There were action plans for monitoring the implementation of these recommendations. Deficits in supports in communication, sensory needs and nutrition identified at the time of the last inspection had been addressed both in the personal plan and in practice. The person in charge clarified the pathway for psychology referral.

However, in the absence of a comprehensive assessment tool it was again not evidenced that the assessment process was holistic and comprehensive, captured all needs and informed inputs, as it did not fully reflect residents' needs, for example, in relation to neurology review as discussed Outcome 11.

Inspectors saw that notwithstanding the complexity of residents’ needs, residents were supported to attend an external day service or were provided with an individualised day service in the centre to suit their needs. Where an individualised service was provided, residents were supported to be active, to pursue interests that they enjoyed and to choose between different options. This was also facilitated in the evening for residents who attended day service. For example, inspectors saw that residents engaged in tabletop activities or activity outside of the centre with staff. However, inspectors did not see a personal plan where each resident’s personal goals and priorities were identified, agreed and progressed.

The person in charge said that a review of each resident, their needs and required supports had taken place in the week prior to this inspection. The person in charge confirmed that the resident, their family, representatives of the funding body and the multidisciplinary team were all invited to attend. The minutes of these reviews were not yet available for review.

**Judgment:**
Non Compliant - Moderate

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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

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

**Findings:**
In the representation submitted following the issuing of the notices of proposal to refuse and cancel the registration of the centre, the provider had provided specific assurances in relation to risk management, infection control and fire safety. On this inspection there
were good infection control procedures in place. However improvement was still required in relation to the management and ongoing review of risk and in relation to evacuation plans for residents in an emergency.

There was a risk management policy and separate risk assessments to control hazards including safeguarding, unexplained absence of a resident, injury, aggression and self harm. Each resident had a suite of records identifying specific hazards relating to their lives that were called individual risk assessments. For example, risk assessments relating to swimming, travelling in vehicles and behaviours of concern.

There was an incident management system in place and inspectors reviewed the records of incidents reports from June 2017 to September 2017. Inspectors saw records for 54 reported incidents the majority of which related to behaviours of concern and risk. In relation to learning from these incidents inspectors were not assured that this was adequately demonstrated. For example, inspectors reviewed the record of an incident that had the potential to escalate; it was noted in the incident report forms that a second similar incident had occurred soon afterwards and that could have been prevented if an appropriately timely review had taken place. Subsequently support had been provided by the service behaviour therapist in relation to making recommendations. The adequacy of review is discussed again in Outcome 8 in relation to chemical and physical interventions to manage risk of harm and injury.

There were records to show that incidents were discussed at staff team meetings. However, there had not been a review of incidents at a service level by the health and safety management team on a six monthly basis, with the most recent review cancelled due to a scheduling conflict. Given the needs of residents, the frequency and intensity of incidents, this was not adequate to provide assurance on the effectiveness of risk management processes. Inspectors were advised that a clinical risk specialist from the provider’s resources had visited the centre in August 2017. However, there was no report or recommendations in place following this visit.

The centre had a separate risk register in place which was designed to log all the hazards that the centre was actively managing. In practice the risk register identified health and safety issues and did not identify centre specific issues; for example, the unsuitability of the living arrangements for all residents and the risks that this created. In addition, it was also unclear if, or how, hazards on the risk register were being escalated to the provider's senior management team.

There was a separate safety statement that identified hazards to staff health safety and welfare. There was an additional document called the service business continuity plan which was a plan to prepare the centre to cope with the effects of an emergency. Issues covered in this plan included utility failures and the weather preventing staff getting to work.

During this inspection the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site. It was noted that new emergency evacuation signage was available throughout the centre and further works were being completed during the inspection.
There were records to show that there had been fire evacuation drills in August and September 2017. Each resident had a personal emergency evacuation plan which outlined what assistance, if any, the resident required in the event of an evacuation. It was noted that residents' personal emergency evacuation plans were easily accessible to staff in the event of an emergency. However, not each evacuation plan seen by inspectors had been reviewed to reflect each resident’s changing needs.

Procedures were in place for the prevention and control of healthcare associated infections. A new infection prevention and control policy had been drafted with specific, clear instructions for staff to follow in the event of an infection control incident. There had been specific training provided to staff from a community infection control nurse. Staff spoken with demonstrated a knowledge and understanding of how to prevent and control the spread of any healthcare associated infection.

**Judgment:**
Non Compliant - Moderate

### Outcome 08: Safeguarding and Safety

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

**Theme:**
Safe Services

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

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

**Findings:**
Residents in this designated centre did present with behaviours of concern and of risk to themselves and others. It has been clearly established and agreed that the premises and model of shared living does not meet the individual and collective needs of the residents. Given the complex and diverse needs of the residents, the environment presented challenges to residents and staff and posed risks on a daily basis to resident welfare and safety. The provider has submitted a plan to cease the operation of the centre as it is currently configured so as to provide each resident with the environment and supports they require in response to their individual needs. In the interim, the provider had systems in place for the prevention and management of behaviours; however, improvement was required in these systems.

The systems in place included regular input from the behaviour therapist for example in
relation to the review of behaviour management guidelines and the provision of workshops to staff. This support included a relatively recent full-day of shadowing by the behaviour therapist in response to an increase in behaviours of concern. The report indicated positive engagement and responses from the staff team. Staff who spoke with inspectors had good knowledge of behaviours, associated risks and behaviour management guidelines.

However, given the incidence, intensity, unpredictability and level of risk associated with some exhibited behaviours, records seen by inspectors lacked the consistency and robustness required to support effective monitoring of behavioural incidents. This robust monitoring was required to ensure adherence to behaviour management guidelines and PRN (medicines administered as required) protocols.

It was recorded on the incident report forms seen by inspectors that PRN medicines had been administered on 13 occasions in response to incidents (approximately 33% of the recorded behaviour related incidents). It was also noted that physical restraint holds had been recorded on two occasions in response to incidents including one where as required medicines had also been administered.

However, some records seen did not provide assurance of adherence to the PRN protocol, for example the administration of a PRN when the behaviour had actually occurred or the administration of the PRN outside of the timeframes outlined in the protocols. Given the unpredictability, intensity and associated risk there was some fluidity to the protocol and scope for staff discretion. However, more robust recordkeeping and timely review was required to clarify why the behaviour was responded to, as it was if the response was outside of the definitive aspects of the protocol.

One behaviour management guideline referenced the use of PRN medicine as a reactive strategy but the chemical intervention had been discontinued in April 2017. One PRN protocol seen by inspectors did not evidence if there had been multidisciplinary input into the development of this protocol either from a behaviour therapist or other appropriate healthcare professional.

In response to some incidents staff completed an incident record, the medicines administration record and the restrictive practices log. A sample of restrictive practices logs seen for chemical intervention did not correspond to the medicines administration record. The log was not an accurate record and therefore not conducive to the accurate monitoring of chemical intervention in response to behaviours of concern and risk.

In addition to the PRN medicines referred to above there were other identified restrictive practices including approved physical interventions and environmental restrictions. There was a procedure for the sanctioning of both approved and any unapproved interventions. However, one record of an unplanned physical intervention in March 2017 simply referenced the use of physical restraint but included no further details as to what was implemented.

While intrinsic clinical needs would always impact on the level and type of behaviours exhibited it was again clear that the incompatibility of residents’ needs and the
unsuitability of the environment to these needs increased the likelihood of behaviours and the requirement for restrictive practices. Residents required different supportive interventions in terms of shared living, noise management and environmental modifications. Some assessed needs required a specifically modified low-stimulating environment while others required a stimulating environment. For example, two residents were recorded as enjoying the sensory stimulation of meal preparation and household chores, however, for the safety of another resident, access to the kitchen and utility area was regularly restricted. Records seen indicted that access had been restricted on 19 occasions between the 17 June 2017 and the 5 September 2017 at times for up to two hours. However, a further record seen referenced two further episodes of restricted access for this timeframe each of two hours duration.

Since the previous inspection one safeguarding issue had been submitted to HIQA. Inspectors were informed that no further similar incident had taken place following that reported incident. However, on review of the incident records there had been a similar incident. At verbal feedback inspectors were advised that it had been concluded that the interaction was not abusive. However, it was not evidenced how and why this had been concluded.

In summary given the incompatibility of residents needs, the unpredictability of behaviours and the level of risk posed at times to the resident from these behaviours, given the timeframe required for the completion of the provider's reconfiguration plan, clear consistent recordkeeping and regular and robust timely monitoring and review of behaviours, their management and restrictive practices was required.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Improvement was noted in the follow-up, implementation and monitoring of recommendations specific to the healthcare requirements of residents. However, in the ongoing absence of a comprehensive assessment by an appropriate healthcare professional, a gap was identified in the holistic monitoring of needs and the identification of the possible requirement for further action such as referral and review of seizure activity.
Since the last inspection inspectors saw from the records and the practice observed that staff had followed up on reviews and recommendations made by members of the multidisciplinary team. There were action plans for the monitoring of the implementation of the recommendations. The positive outcome of this for residents was evident in practice.

For example, as discussed in Outcome 1 there was evidence of the implementation of communication- specific speech and language (SALT) recommendations. In addition staff had followed through on and clarified with SALT a risk for choking seen at the time of inspection but that was not clearly evidence- based at the time. In addition records seen indicated that staff had scheduled an ophthalmic review for a resident last seen in 2014.

The person in charge confirmed that the pathway for access to psychological review was through the behaviour therapist and that currently the requirement for psychology support had not been identified for any of the four residents.

There was a requirement for healthy eating and weight management programmes for residents’ overall health and wellbeing, for example their mobility and effective metabolism of medicines. Inspectors were satisfied that there was a clear plan of support and that the plan included monitoring of the effectiveness of the plan by the dietitian. Staff had sound knowledge of these plans and were seen to freshly prepare nutritious meals and snacks for residents that reflected residents’ choices but also the dietetic recommendations. However, the records maintained by staff in relation to these plans such as daily food intake charts and records of body weight were inconsistently maintained. It was from the dietetic reviews and not from the centre based records that inspectors were satisfied that the plans were implemented with positive effect.

A record seen of a neurological review dated January 2016 recorded a change in treatment with the objective of achieving better seizure control. However, other records indicated that to date five seizures had occurred in 2017; a prescribed emergency medicine had been required on four of these five occasions and review in the emergency department had been required on one occasion. The summary of the residents' support needs said that the frequency of seizures was three to four annually. Neurological review further to these events and in the context of the objective of the 2016 review was not evidenced. This was not indicative of the effective monitoring and review of residents’ healthcare needs and requirements to ensure that the treatment in place was appropriate and adequate to meet those needs.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.
Theme: Health and Development

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

Findings:
Improvement was noted, however there was still evidence to support that further action was required to ensure the robustness of the oversight of medicines management practice.

Inspectors saw that medicines were supplied to residents by a community based pharmacy either in a compliance aid or in the original container. Medicines were seen to be supplied on an individual resident basis and securely stored.

Staff maintained records of all medicines supplied and any medicines returned to the pharmacy; these records were verified and signed by the pharmacist. Staff maintained records of any movement of medicines, for example for home leave. Stock balance reconciliations were completed twice daily; a random check completed by the inspector corresponded to that completed by staff.

Staff training records indicated that staff had completed medicines management training including the administration of prescribed emergency medicines.

Staff had recorded the date of opening of medicines requiring use within a specified timeframe.

Prescriptions were current and legible; the sample of medicines administration records reviewed by inspectors reflected the instructions of the prescription. The labels affixed by the pharmacy reflected the instructions of the prescription. Where there was a designated code identifying the reason why a medicine was not administered it was used by staff, for example during home leave.

However, deficits noted on this inspection included a medicines supply error that was identified and addressed by staff but was not recorded as an error.

A recording error where staff had recorded two administration times for the same medicine.

Incident records reviewed indicated that notwithstanding the controls that had been put in place there were still six staff related medicines management errors since the last inspection.

Two residents had plans for the management of seizure activity and the administration of their emergency medicine. The plans contained guidance to staff on the administration of emergency medicine, recovery times, repeat administration and when and why the assistance of emergency services was required. Both plans were signed as reviewed in March 2017 and read as identical. However, the inspector noted that only
one of these plans reflected the instructions of the prescriber, the other did not. It was of concern that this had not been noted on review and that the review had not included the reconciliation of the plan to the prescriber's instructions.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The provider had implemented the actions identified by it to strengthen the governance arrangements of the designated centre. There was evidence of improvement; however, there was also evidence of further improvement required to ensure that the management systems provided assurance of the effective oversight of the appropriateness, quality and safety of the supports and services provided to residents.

The provider had (as committed to in the plans submitted to HIQA) on the 24 July 2017 appointed a suitably qualified and experienced person in charge. The person in charge had qualifications in social care studies and frontline management and had acquired management experience within the organisation since 2008 in the role of team leader and person in charge since November 2016.

To support the person in charge the provider now had in place three team leaders who were deemed to be persons participating in the management of the centre (PPIM). The team leaders confirmed to inspectors that they worked so as to ensure that there was a management presence in the centre every day including weekends. As the house was generally unoccupied by day, a team leader was on duty up to 21:00hrs Monday to Friday and 20:00hrs at weekends when both staff and residents were in the house. The team leaders said that this arrangement facilitated supervision and communication.

The person in charge had responsibility for two designated centres and told inspectors that her routine was to spend Tuesday, Wednesday and Thursday in this centre. The team leaders confirmed that they met with the person in charge each Tuesday.
The person in charge was aware of the challenges in the centre and any residual barriers to change; the person in charge was confident that these were identified and addressed through supervision.

The person in charge was required to submit weekly monitoring progress reports to the provider’s representative; these reports were available to inspectors. These reports provided feedback on events such as incidents, medicines management issues and staff related issues and the actions taken by the person in charge in response to them.

However, while acknowledging that the person in charge was in post only since 24 July 2017, in the context of the management resources that the provider has allocated to the centre, there was still, based on these inspection findings, improvement required in oversight including clinical oversight. The evidence to support this conclusion is discussed throughout the body of this report and includes the appropriate maintenance of records to support effective monitoring and the retrieval of accurate information, adequate oversight of medicines management practice and residents’ healthcare requirements and robust timely review of incidents and their management.

**Judgment:**
Non Compliant - Moderate

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<th>Outcome 17: Workforce</th>
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<td><strong>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.</strong></td>
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<td>Responsive Workforce</td>
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<th>Outstanding requirement(s) from previous inspection(s):</th>
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<td>Since the last inspection the provider had put a comprehensive programme of staff training in place. In its representation following the issuing of the notices of proposal to refuse and cancel the registration of the centre, the provider had outlined that the service no longer had a requirement for agency staff and only regular relief staff from the provider's own resources were used in an emergency to cover unscheduled absences. However, from a review of the staff rota for an 11 week period it was noted by inspectors that there was an average of seven relief staff on duty each week.</td>
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| Staff spoken with were knowledgeable about residents' needs, likes and dislikes and |
residents’ supports. During the course of the inspection staff were observed to be respectful of residents at all times and ensured that residents’ personal choice was respected.

Inspectors were told that since the last inspection two permanent staff had left the centre. Both staff had been replaced, with the second new staff on induction on the week of this inspection. Inspectors reviewed the planned and actual staff rota for the previous 11 weeks from 10 July 2017 to 18 September 2017. It was noted that in planning the rota there had been consideration given to the specific needs of residents to ensure consistency in approach by the staff team. However, for each of the 11 weeks of the rota there was an average of seven relief staff on duty each week; and on one week, from 21 August 2017, there had been 13 relief staff on duty. Inspectors were told that all the relief staff were familiar with the residents and worked in other parts of the provider’s services. The staff rota showed that on three separate occasions, staff from a healthcare recruitment agency had been used to provide support at night. The provider’s representative confirmed that this had organisational sanction to facilitate staff training. It was noted that an agency staff had also supported one resident to enjoy a recent holiday.

Since the previous inspection the provider had committed to a programme of staff training to ensure the quality and safety of the supports and services provided to residents. A comprehensive programme of training had been introduced including, autism support, disability awareness, professional boundaries training and “positive dignity” training. It was noted that some mandatory training was scheduled for the coming weeks including food preparation and behaviour support training.

There was a system of formal supported supervision for staff. Issues covered in supervision meetings included financial budgeting, wellbeing, staff issues, quality compliance, personal development and quality practice.

Inspectors reviewed a sample of staff files and noted that all of the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities were available.

**Judgment:**
Substantially Compliant

**Closing the Visit**

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

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

*Report Compiled by:*

Mary Moore  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002648</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>25 &amp; 26 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>01 November 2017</td>
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Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors did not see a personal plan where each resident’s personal goals and priorities were identified, agreed and progressed.

1. Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident’s wishes, age and the nature of his or her disability.

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

- The personal plans for the residents (PCP Plan) with goals identified were not available on the day of inspection. The plans have now been updated, printed and stored into the PCP folders.

**Proposed Timescale:** 20/10/2017

**Theme:** Effective Services

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

In the absence of a comprehensive assessment tool it was again not evidenced that the assessment process was holistic and comprehensive, captured all needs and informed inputs, as it did not fully reflect residents' needs.

**2. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

- A healthcare needs assessment (Annual Needs Screening) has commenced for all service users as a component part of an overall comprehensive assessment of need. Advice has been sought from medical practitioners and appointments scheduled. This will be reviewed at a minimum annually going forward.

- Multi-Disciplinary meetings took place on 19th September 2017 for all residents, these will be held at a minimum of annually.

**Proposed Timescale:** 25/10/2017

**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 required review. Timely review of incidents, any learning required, escalation of risks as appropriate, and the recommendations to prevent reoccurrence were not adequately demonstrated.

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

**Please state the actions you have taken or are planning to take:**
- The risk register has been reviewed, additional risks have been identified and added to the risk register.
- Following the inspection a review of incidents was conducted by the PIC, ISM and the Health and Safety Department, these are now scheduled to occur quarterly.
- Any risks rated over 12 will be escalated to senior management within 24 hours.
- Incident review will continue to be a standard item on all Team Meetings to ensure learning and minimise the risk of reoccurrence.

**Proposed Timescale:** 02/10/2017

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not each evacuation plan seen by inspectors had been reviewed to reflect each resident’s changing needs.

4. **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:**
- One evacuation plan was in the process being updated at the time of inspection to reflect a change in evacuation methods. This has now been completed, all plans are up to date and reflective of residents changing needs.

**Proposed Timescale:** 26/09/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As outlined in detail in Outcome 8, given the incompatibility of residents needs, the unpredictability of behaviours, the level of risk posed at times to the resident from these behaviours and the timeframe required for the completion of the provider’s reconfiguration plan, clear consistent recordkeeping and regular and robust monitoring and review of behaviours, their management and restrictive practices was required.

5. **Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and
alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
- A risk assessment has been developed with control measures identified and implemented in the service to minimise the risk of residents being impacted by behaviours that challenge.
- All incidents of behaviour will be recorded and reviewed by the PIC, PPIM's and the Behaviour Specialist on a weekly basis with a view to informing practice in order to ensure the impact of behaviours is minimised in the service.
- All alternate measures will be explored before the use of any restrictive practice, all restrictive practices will be reviewed by the PIC, ISM and Behaviour Specialist on November 13th and as required thereafter.

**Proposed Timescale:** 13/11/2017

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors were advised that it had been concluded that a peer to peer interaction was not abusive. However, it was not evidenced how and why this had been concluded.

**6. Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
- The incident had been reviewed by the PIC and the ISM, the outcome of this review was not documented in the service users file and attached to the incident.
- All incidents of alleged/suspected abuse with undergo an appropriate investigation and documentation of same.

**Proposed Timescale:** 26/09/2017

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A gap was identified in the monitoring and review of residents’ healthcare needs and requirements to ensure that the treatment in place was appropriate and adequate to meet those needs.
7. **Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

**Please state the actions you have taken or are planning to take:**
- The service has introduced a healthcare needs assessment process for all service users as a component part of an overall comprehensive assessment of need (Annual Needs Screening). This document will assist the review and monitoring of residents healthcare needs.
- Treatment required as a result of the assessment will be organised in a timely manner.
- This document will be fully in operation in the service by the below date and will become an integral part of the support plan for the residents.

**Proposed Timescale:** 31/10/2017

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<table>
<thead>
<tr>
<th>Outcome 12. Medication Management</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Deficits identified on inspection indicated that further action was required to ensure the robustness of the oversight of medicines management practice.

8. **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:**
- All practices relating to medication management are in the process of being reviewed in line with new organisational policy, it envisaged that the new policy will be fully implemented by December 1st.
- All administration of medication will be overseen by an identified member of management.
- All errors including near misses will continue to be recorded on the incident reporting system.

**Proposed Timescale:** 01/12/2017

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<table>
<thead>
<tr>
<th>Outcome 14: Governance and Management</th>
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<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further improvement was required to ensure that the management systems provided assurance of the effective oversight of the appropriateness, quality and safety of the supports and services provided to residents.

9. 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:
• There is a clear management structure in the service. There is a PIC in the service who is supported by three PPIM’s. One of the management team is present in the service across a 7 day period, this will continue until the re-structuring plan is complete in July 2018.
• All paperwork has been updated to reflect the new structure in place since 24th July 2017.

Proposed Timescale: 31/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of 11 weeks of staff rotas between 10 July 2017 and 18 September 2017 demonstrated that on a weekly basis an average of seven relief staff were still required to maintain the staffing supports required by residents.

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

Please state the actions you have taken or are planning to take:
• As a result of the control measures identified in the risk assessment for the minimising of the impact of challenging behaviour additional staff are required in the service.
• Every effort is made to ensure the relief staff are regular in order to minimise to ensure they are known residents.
• This situation is being reviewed and managed on an ongoing basis.

Proposed Timescale: 31/10/2017