Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Killarney Residential Services</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003428</td>
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<td>Centre county:</td>
<td>Kerry</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
<td>Kerry Parents and Friends Association</td>
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<td>Lead inspector:</td>
<td>Mary Moore</td>
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<td>Support inspector(s):</td>
<td>Conor Dennehy</td>
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<tr>
<td>Type of inspection</td>
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<tr>
<td>Number of residents 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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 07 August 2018 08:45  
To: 07 August 2018 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 third inspection of this designated centre by the Health Information and Quality Authority (HIQA); the last inspection was undertaken in November 2017. This current inspection was undertaken to follow-up on the action plan that had emanated from that inspection and to monitor on-going regulatory compliance so as to progress a registration decision.

How we gathered our evidence:
Prior to the inspection inspectors reviewed the information held by HIQA in relation to this centre, this included the previous inspection findings and action plan and all correspondence received from the provider in relation to that action plan. In the centre inspectors reviewed records including fire and health and safety related records, records of complaints received and records pertaining to residents and staff.

The inspection was facilitated by frontline staff and the person in charge. The director of services and the chief executive officer attended verbal feedback at the conclusion of the inspection on behalf of the provider.

Sixteen residents live in the designated centre; residents were on two weeks leave from their day service at the time of this inspection; some residents were on leave
with family or at just returned from leave. Inspectors visited three of the four houses that comprise the designated centre and met with nine residents. This engagement with residents was guided by each resident and their choices and needs and was both verbal and non-verbal. Residents greeted inspectors perhaps with a smile and hand-shake and continued with their routines while observing and listening. Other residents spoke of their plans for the day, recent visits to family or their general health and well-being.

There was a relaxed atmosphere in each house visited; staff spoken with were knowledgeable of each resident and their needs; inspectors’ observations of staff and resident interactions were positive.

Description of the service:
The centre is comprised of four houses located within the general environs of the busy local town and the provider's main day service and administration building. Three houses are in residential areas, the fourth is in a more rural location. Residential services are provided to 16 residents across the four houses and a respite service is provided in one house to one additional resident at any one time; approximately 17 residents avail of this respite service. A team of social care staff led by the person in charge provide support to residents on a 24 hour basis; the night-time arrangement in each house at the time of this inspection was a sleepover staff.

Overall Findings:
Overall inspectors found that the provider sought and aimed to provide residents with care, support and services that were safe and suited to their individual needs. However, failings were identified and the provider reported that it was constrained in its efforts to consistently deliver safe, quality services that were suited to individual resident needs due to inadequate resources. Failings included the failure to complete fire safety works and refurbishment of the premises, governance arrangements and ensuring staffing levels that had the capacity to meet residents' changing and increasing needs. The provider advised inspectors that the provider did not have the resources to address some of these failings as they had not been able to secure funding. Since the last HIQA inspection an integrated fire detection system and emergency lighting for each house had been funded and installed. The outstanding fire works related to fire containment and the continued use of an inner room as a bedroom.

Further to these inspection findings, the provider was formally requested to submit to HIQA the report of a recent fire safety and premises review completed by the HSE (the report was not available to the provider at the time of inspection). The provider was also requested as a matter of urgency to submit a time bound plan to address the identified deficits and, notwithstanding the recent installation of fire detection systems and emergency lighting, provide assurance as to the adequacy of the existing fire safety management systems.

The provider continued to liaise with HIQA, and did respond positively to these requests. The provider took action to mitigate identified risks and also submitted a time-bound plan for addressing the completion of the outstanding fire safety works and refurbishing the premises.
While failings were identified in relation to the adequacy of staffing levels, staff spoken with had good knowledge of residents, their needs and choices and spoke respectfully of residents. Staff had a good understanding of what a safe, quality service was and the factors that constrained the delivery of such a service. Inspectors observed easy interaction between residents and staff.
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:
Inspectors reviewed the actions that issued for the last inspection.

There was one residual shared care arrangement where two residents shared the use of the same bedroom. Inspectors were again advised that neither resident nor their representatives had any concerns about this arrangement and that the arrangement was infrequent (approximately three times to date this year); it was the objective of the provider to phase out the arrangement in a person-centred manner. Inspectors saw that as requested by HIQA a protocol had been implemented and guided practice that promoted and protected resident choice, privacy, personal space and belongings and infection prevention and control. The plan submitted subsequent to the inspection indicated that the practice was to cease by the 30 September 2018.

The provider had reviewed its complaint management policy to ensure that there was a person identified whose responsibility it was to ensure that all complaints were responded to appropriately and that a record of all complaints was maintained.

Records seen by inspectors over the course of the inspection indicated that staff continued to consult with residents through the format of the residents meetings. The records of these meetings and of complaints received indicated that no significant issues or concerns had been raised with the provider since the last HIQA inspection. Residents were facilitated to exercise their rights including their right to vote, to exercise their spiritual and religious beliefs, to maintain personal and family relationships, their right to privacy and to remain as independent as possible despite increasing needs and declining health.
Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors reviewed a sample of assessments of residents' needs and the plans to support these needs including the plan for progressing resident's personal goals and objectives. Inspectors found that improvement was required to ensure that the assessment process consistently captured changes in needs and that the plan of support was updated accordingly to ensure that the arrangements in the designated centre were appropriate to each resident's needs and promoted their general well-being and welfare.

Since the last inspection the provider had created a pre-retirement group for five residents operated from one of the houses that comprised this designated centre. Staff reported that the programme was well organised and benefited four of the five residents that attended. However, staff also reported that the programme was not suited to the needs of one resident; staff reported negative impacts including reduced opportunity for community access, reduced social engagement, and a further deterioration in an already compromised dietary pattern. These reported impacts were reflected in records seen including the records maintained by the programme co-ordinator, (there was a consistent pattern of non-engagement with the activities offered), the minutes of staff meetings and clinical records. The finding was also reflected in the providers own review of the service which identified that the possible cause was incompatibility of resident needs and the anxiety that this created for one resident. However, despite the concerns raised and the finding of the provider review from April-May 2018, the matter had not been reviewed as requested by the provider review. The assessment of the resident’s needs and the ensuing plan of support did not reflect these significant changes of circumstances, the impact of them, or how the provider planned to address them to ensure that the operation of the designated centre was suited to appropriately meeting each residents needs and improving their quality of life.
Improvement was required in relation to ensuring that the process of identifying, agreeing and progressing residents personal goals and objectives was meaningful, continuous and supported general welfare and development. For example some goals seen were last updated in November 2017, where challenges had arisen to pursuing other goals the goals were not reviewed. The person in charge confirmed that 4 annual reviews were overdue and that some reviews while completed were not yet integrated into the personal plan. The providers internal review had also found that while goals were meaningful the process laced continuity.

However, the daily narrative notes seen by inspectors did indicate that residents attended the day service, accessed community services, enjoyed shopping and dining out locally, had contact with friends and family including visits facilitated by staff to more dependent relatives.

**Judgment:**
Non Compliant - Moderate

### Outcome 06: Safe and suitable premises

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

**Theme:**
Effective Services

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

**Findings:**
While presenting as clean and reflective of resident’s individual choices (for example the personal presentation of their bedrooms); elements of the design and layout of the designated centre were not suited to all residents needs and some areas were in a poor state of repair and decoration. This finding is pertinent in particular to two of the four houses. There was evidence of some work completed since the last inspection but equally there was evidence of deterioration.

Two houses were in a good state of repair and overall staff reported that these houses met the needs of the residents who lived in them. Two ramps had been provided to the front and rear of one house since the last inspection to improve accessibility; direct access to the outdoors from a bedroom had been provided in another house to meet specific resident requirements. An occupational therapy assessment of the bathroom was pending in this house but staff advised that in the interim the available facilities met residents’ needs.
The other two houses were of earlier construction and both were showing evident signs of age and a requirement for maintenance and upgrade. There were evident areas of damp, defective paintwork, cracks, poor or damaged plasterwork and joinery, and broken floor tiles in one house. There was evident deterioration following a roof leak. Correspondence received from the provider prior to the inspection based on a recent review of the properties stated that while some work was required in each house, interior remodelling and reconfiguration requiring significant financial resources was required in these two houses.

One resident's bedroom was accessed directly through the kitchen and utility room; this bedroom is referenced again in Outcome 7 in the context of fire safety. Another bedroom in this house (there was a short corridor leading off it and there was an external door from the en-suite), was also routinely accessed through the kitchen and the utility room. At the time of the last inspection staff had formally raised their concerns with the provider as to the unsuitability of this particular bedroom to the resident’s needs. Staff had raised concerns in relation to the location of the bedroom, and the unsuitability of the available space and the en-suite sanitary facilities to the residents needs. There was no alteration to these findings.

The general design, layout and presentation of this section of the house is poor and not adequately suited to residents needs though staff sought to make the bedroom as comfortable and as suited to the resident's needs as possible. Staff again confirmed that the resident choose to spend a considerable amount of time in their bedroom; space was limited, the only source of natural light was a ceiling based skylight. Personal storage was provided but there was no space available for a wardrobe. There was no natural ventilation unless the main door or the door to the en-suite (which had a window) was left open.

**Judgment:**
Non Compliant - Major

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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:**
While some works had been completed since the last inspection there were ongoing deficits in the provision of fire safety systems across the designated centre.

The provider had in April 2016 carried out a fire safety review for all four houses.
Various recommendations were made including the upgrading of the fire alarm system, improvements in fire containment and the need for alternations in two houses to address concerns with the use of inner rooms as bedrooms. Inspectors were informed that a further more recent fire safety review had been completed by the HSE and that based on the findings of this review each house had been fitted as a matter of priority with an integrated fire detection system and emergency lighting. The provider advised that it was not in a position to provide HIQA with the report of this most recent fire safety review as it was not made available to them; the report was formally requested by HIQA.

Works not completed were infrastructural works to contain fire, to protect escape routes and works to ensure that inner rooms were not used as bedrooms. The provider advised inspectors that it did not have the financial resources required to complete these works and with the exception of the fire detection systems and emergency lighting, has not been able to secure funding from the funding body despite having made repeat efforts to secure funding.

Based on the inspection findings the provider was requested as a matter of urgency to submit to HIQA its plan to address these failings. The provider responded positively and took action to reduce risk and promote resident safety; these actions included the provision of an additional waking staff in two houses and a commitment to cease the use of the inner bedroom by the 30 September 2018. The provider submitted a longer-term time-bound plan for the completion of the outstanding works.

Inspectors found that regular fire drills were taking place in each house and adequate evacuation times were recorded; the evacuation procedures for each resident were detailed in their PEEP (Personal Emergency Evacuation Plan). However, while the majority of staff had completed training and staff members spoken with demonstrated a good knowledge of what to do in the event of a fire and of the contents of residents’ PEEP, not all staff had completed fire safety training.

A risk register was maintained in an electronic format. This system was also used to record accidents, incidents and near misses. This system was reviewed by inspectors and it was noted that overall risk assessments were in date and had been updated for example in response to changing resident needs. There was evidence of control measures in response to identified risks, for example alarms to alert staff. However, some additional control measures were resource dependent and linked to the outstanding fire safety works or staffing resources.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe Services

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

**Findings:**
The provider had safeguarding measures to protect residents from harm and abuse. While residents enjoyed routines and environments that were minimally restrictive there were matters outstanding since the last HIQA inspection.

Safeguarding practice was informed by organisational and national safeguarding policies and procedures. There was a designated safeguarding person known to residents and who was in regular contact with them; staff had completed safeguarding training. Staff and residents discussed keeping safe at residents meetings.

The person in charge told inspectors that she had no concerns and was assured as to the safety of the care and supports that residents received; she worked frontline duty at regular intervals and completed formal staff supervisions. There were residents in each house that had to capacity to raise concerns with her, staff or the designated officer who had almost daily contact with residents in the day service.

Residents did at times present with behaviours of concern and risk to themselves and others. Staff spoken with said that behaviour management interventions were effective in relation to preventing negative peer to peer interactions (this would concur with notifications submitted to HIQA) and that the consistency of staffing required by residents was generally provided for. Residents and staff were supported by regular and consistent input from the psychologist. Environmental modifications planned at the time of the last inspection had been completed by the provider.

Overall there was a good understanding in relation to the use of restrictive practice. Staff described how they discussed and agreed restrictive practices with residents. Inspectors followed up on one particular environmental restrictive practice, restricted access to the main kitchen of one house: the kitchen was accessible to residents only when staff were present. There was a rationale provided for this practice and staff described how they managed the practice so that it did not impact negatively on residents. Staff did maintain a record of the frequency and the duration of the restricted access.

However, while inspectors were advised that behaviour management guidelines were in progress they were still not in place. In the absence of a specific behaviour management plan for the behaviours of concern, it was not demonstrated that restricted access and the duration of the restricted access was the least restrictive procedure that could be applied to ensure resident safety and well-being.
Judgment:
Substantially 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 provider had arrangements that ensured residents enjoyed and maintained good health and wellbeing.

While there was some general inconsistency noted in assessments and support plans, staff spoken with had good knowledge of residents current needs and the support they required to keep well. There were healthcare support plans (care plans) and where there were specific changing and increasing needs these plans were current. Narrative notes indicated that staff monitored resident well-being and in addition to the annual review of healthcare needs sought medical review with the GP (General Practitioner) as required.

The provider review of April/May 2018 found that residents had the access that they required to allied health professionals. Records seen by inspectors confirmed that residents were supported to access other healthcare services such as specialist consultant review, speech and language therapy, optician, dentist, chiropody and psychiatry; residents had ready access to the psychologist.

Residents were seen to be provided with an appetising and nutritious main meal that they enjoyed prepared by staff; where there was a specific dietary requirement (modified diet) this was provided, again in an appetising and pleasing manner.

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:
Overall inspectors were satisfied that the provider did aim to provide residents with safe, quality services and largely achieved this in terms of day to day routines, access to day services, community access and integration and maintaining relationships that were important to residents. However, identified failings such as the unsuitability of parts of the premises, staffing limitations, the failure to complete fire safety works and failure to review arrangements that were not suited to all residents needs impacted negatively on the quality and the safety of the service provided to residents. Inspectors were also concerned as to the capacity and sustainability of the working arrangements of the person in charge.

The management structure was clear and consisted of the person in charge, the assistant directors of services and the director of services; there was clarity on roles, responsibilities and reporting relationships and ready access to line managers.

The person in charge was employed fulltime and was suitably qualified and experienced. The person in charge continued to work alternate weekends as a frontline member of staff. While this supported ready access to both residents and staff this was a busy centre, comprising four separate houses that could accommodate a maximum of 17 residents, respite services were provided to an additional 17 residents. Residents presented with a diverse range of needs and these needs were increasing. Consequently the operational management and administration of the centre was described as challenging given the working arrangements of the person in charge. The provider confirmed that they hoped to address this in 2018.

Regular staff meetings were convened in each house and there was a formal system of staff supervision. Inspectors were assured based on records seen that staff did exercise their responsibility to raise any concerns they had about the quality and safety of the service provided to residents, for example the compatibility of resident needs and the suitability of staffing arrangements.

The provider was complying with the requirement of the regulations to conduct an annual review of the quality and safety of the service and to undertake a six monthly unannounced visit to the centre. The report of the unannounced review completed in April/May 2018 was reviewed by inspectors. The review was centre specific in that it did focus on the particular challenges within the service and identified actions to promote further improvement. Twenty-two individual actions issued with approximately half of these addressed at the time of this HIQA inspection. Consequently inspectors concluded
that the reviews identified and at times reiterated known deficits such as the unsuitability of parts of the premises and inadequate staffing resources but did not result in a robust plan to address the issues raised both infrastructural and operational. The review did not demonstrate that all actions were appropriately allocated for completion. The person in charge was deemed the person responsible for overseeing twenty of the 21 actions with only one action (the review of outstanding policies) allocated to the senior management team.

**Judgment:**
Non Compliant - Moderate

### 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:**
Inspectors were advised that adequate staffing levels were not available within the provider's allocated resources to meet the changing needs of all residents. Inspectors found that this failing had become more pronounced since the last inspection due to residents changing and increasing needs.

At the time of the last inspection inspectors found the provider had failed to provide for sufficient staffing arrangements for one resident at all times of the week in response to their changing needs. Concerns were raised as to the appropriateness of the arrangement that was in place at that time to meet the resident's staffing needs. Inspectors were advised that this arrangement was no longer in place as the provider had created the pre-retirement group referred to in Outcome 5. However, as discussed in Outcome 5 this arrangement required review due to the reported negative impact on another resident’s needs.

In addition the night-time staffing arrangement in all houses was a sleepover staff. Staff reported and inspectors saw from records that due to deteriorating health and increasing needs this arrangement was no longer suitable and required review. The resident had developed needs and an associated pattern of regular night waking that required supervision and assistance from sleepover staff, at times up to three occasions nightly. In response to the urgent action plan the provider confirmed that an additional
waking staff was introduced in two houses; this action addressed this particular aspect of the staffing arrangements.

Inspectors reviewed a random sample of staff files and found them to be well presented. The files contained all of the required records, for example previous employment references, proof of identity and evidence of Garda vetting.

Inspectors reviewed staff training records and found that overall the majority of staff had attended recent/current training in de-escalation, safeguarding, manual handling, fire safety and medicines management. It was noted however that some staff members were overdue refresher training in some of these areas.

Staff spoken with had good knowledge of residents, their needs and choices and spoke respectfully of residents. Staff had a good understanding of what a safe, quality service was and the factors that constrained the delivery of such a service. Inspectors observed easy interaction between residents and staff.

**Judgment:**
Substantially Compliant

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**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

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<td>Centre ID:</td>
<td>OSV-0003428</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>07 August 2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>01 October 2018</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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The arrangements for meeting social care needs in the designated centre were not appropriate to each resident’s assessed needs and did not promote their general well-being and welfare.

**1. Action Required:**

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
The pre-retirement group that is operated in one of the houses in the designated centre will be kept under review and any actions required will be put in place to ensure that the needs of each individual is met as assessed.
The registered provider will carry out more frequent unannounced inspections where there will be a focus on the social care needs of the residents. All residents goals will be reviewed taking into account changes in any of the resident’s circumstances and to ensure that individual needs are met.
The Person in Charge will be supported by a senior manager to carry out the Self-Assessment Tool that the HSE have developed based on the HIQA Assessment and Judgement Framework.

**Proposed Timescale:** 28/01/2019
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some goals seen were last updated in November 2017 Where challenges had arisen to pursuing other goals they were not reviewed. The person in charge confirmed that 4 annual reviews were overdue and that some reviews while completed were not yet integrated into the personal plan.

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

**Please state the actions you have taken or are planning to take:**
PCP meetings are scheduled for 3 of the 4 residents, awaiting confirmation date for the 4th resident. The PIC is reviewing all personal plans and part of the review is to look at goals and ensure they are up to date. Individual’s goals will be on the agenda of all staff meetings going forward. A PCP audit will be completed by November 30th 2018 and any actions identified will be completed by keyworkers with the support of the Person in Charge.

**Proposed Timescale:** 30/11/2018

**Outcome 06: Safe and suitable premises**
**Theme:** Effective Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory**
requirement in the following respect:
The general design, layout and presentation of one section of one house was poor and not suited to residents' needs. One resident's bedroom was accessed directly from the utility room.
Another bedroom in this house was also routinely accessed through the kitchen and the utility room. Insufficient space was afforded in this bedroom, the only source of natural light was a ceiling based skylight. Personal storage was provided but there was no space available for a wardrobe. There was no natural ventilation unless the main door or the door to the en-suite (which had a window) was left open. The en-suite was not suited to the resident's needs.

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

Please state the actions you have taken or are planning to take:
Upgrading work will be carried out on all the premises to meet the numbers and needs of the residents as per the compliance plan submitted on 28th August 2018.

Proposed Timescale: 31/12/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were evident areas of damp, defective paintwork, cracks, poor or damaged plasterwork and joinery, and broken floor tiles in one house. There was evident deterioration following a roof leak.

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

Please state the actions you have taken or are planning to take:
Upgrading work will be carried out on all the premises to ensure that they are in a good state of repair externally and internally.

Proposed Timescale: 31/12/2018

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While some fire safety works had been carried out since the last inspection a number of
works remained outstanding. Works which were not completed were infrastructural works to contain fire, to protect escape routes and works to ensure that inner rooms were not used as bedrooms.

5. 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:
All works required to ensure fire safety in the residences will be undertaken as per the compliance plan submitted on the 28th August 2018.

Proposed Timescale: 31/12/2018

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:
In the absence of a specific behaviour management plan for the behaviours of concern, it was not demonstrated that restricted access was the least restrictive procedure that could be applied to ensure resident safety and well-being.

6. 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:
Meetings have taken place with the Psychologist and a support plan has been developed and is now in place. Actions from the meeting are being implemented, and will be further enhanced as a result of a residents PCP meeting scheduled for 10/10/18. The restrictive practice will be submitted to the committee and will be reviewed by 31/10/18.

Proposed Timescale: 31/10/2018

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Identified failings such as the unsuitability of parts of the premises, staffing limitations, the failure to complete fire safety works and the failure to review arrangements that
were not suited to all residents needs all impacted negatively on the quality and safety of the service provided to residents.

The capacity and sustainability of the working arrangements of the person in charge required review.

Internal reviews identified and reiterated known deficits such as the unsuitability of parts of the premises and inadequate staffing resources but did not result in a robust effective plan to address the issues raised. The review did not demonstrate that all actions were appropriately allocated for completion in line with individual responsibility and accountability.

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:**  
All works in relation to the buildings and fire safety will be completed as per the compliance plan submitted and approved by HIQA on 28th August 2018. The designated centre comprises of 4 houses, these will be divided into 2 separate designated centres with the appointment of an additional Person in Charge. Additional staff has been put in place to address the staffing issues.

**Proposed Timescale:** 31/12/2018

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Staffing arrangements required review to meet the changing needs of all residents. Inspectors found that this was repeat failing which had become more pronounced since the last inspection due to residents changing and increasing needs.

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:**  
Additional staffing has been put in place to address the changing and increasing need of the residents. The number of residents in one house has been reduced as per the compliance plan.
Proposed Timescale: 24/08/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Overall staff training needs were provided for. It was noted however that some staff members were overdue refresher training in some specific areas which were considered mandatory in the centre.

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:
Training in the area of fire, safeguarding, manual handling and first aid, all which are mandatory, has been scheduled and staff have been notified of the training.

Proposed Timescale: 31/12/2018