Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Highwater Lodge
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	23 August 2018
Centre ID:	OSV-0005407
Fieldwork ID:	MON-0024670

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Highwater Lodge is a dwelling for four people, male or female, over the age of 18 years, who receive a service from Stepping Stones Ltd. The aim of the service is to provide a residential setting that is homely, and promotes the privacy, dignity and safety of those who access the service. The centre operates all year round and staffing is provided day and night to meet support the needs of the residents.
The designated centre is a large detached, modern house in a rural setting near a small town. There are spacious and nicely laid out gardens, and various both private and communal living areas.

The following information outlines some additional data on this centre.

Current registration end date:	30/05/2019
Number of residents on the date of inspection:	2

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
23 August 2018	09:30hrs to 17:00hrs	Julie Pryce	Lead

Views of people who use the service

The inspector spent time with one of the residents who appeared to be comfortable and at home. They were happy to show the inspector their bedroom which was furnished and decorated in accordance with their taste and hobbies.

It was clear that the staff and person in charge supported residents to communicate their wishes both at home and outside the service, and that their views were both listened to and responded to.

Capacity and capability

There were systems in place to ensure that the service provided to residents was regularly monitored and this resulted in a good quality service being provided to residents. There was a clearly defined management structure in place with clear lines of accountability. The person in charge was full time in the centre, and the person participating in management who was the Director of Quality, was a regular presence and had introduced various systems of oversight. Overall, there were effective governance arrangements in place and this was reflected in a high level of compliance.

The person in charge was appropriately skilled and qualified, and demonstrated evidence of leadership with the support of the person participating in management. Changes had been introduced since the previous inspection including changes in shift patterns, improved format of team meetings, staff supervision and appropriate follow up to any performance management issues. There was also evidence that the person in charge advocated on behalf of residents and this had resulted in one of the residents successfully maintaining a day activity of their preference.

Monitoring systems included a suite of audits, and regular meetings at all levels of service delivery. Audits had been conducted in various areas including medication management and document control. Actions required following these audits were monitored, and those reviewed by the inspector had been completed. This had resulted in improvements in practices relating to document storage, and in goal setting in personal plans. A series of meetings were held, from team meetings to senior management meetings. Team meetings included shared learning, and clear records were maintained of the meetings. Any agreed actions were monitored at the subsequent meeting.

Six monthly unannounced visits had been conducted on behalf of the provider, and an annual review had been prepared. In addition the person participating in

management had developed a quality enhancement plan, from which was generated a monthly report to management. Actions identified in this quality plan were sorted by a traffic light system in terms of urgency, and were monitored until complete. Improvements were made as a result of these systems, for example a new document to support staff competency was in the process of being introduced.

The provider was listening to residents' feedback and acting on it. There was a clear complaints procedure, and evidence that any complaints were reviewed in detail, and that all efforts were made to resolve any issues. On one occasion this resulted in a risk assessment being reviewed and a change in practice in transport arrangements being introduced, to the satisfaction of the resident.

The centre was adequately resourced to provide the required care and support in accordance with the needs of residents. There were appropriate staffing arrangements in place and the numbers of staff and the skills mix ensured that the needs of residents were met, including social care needs. Staff were available to support each resident in different individual activities.

Staff were appropriately supervised, and a regular formal supervision conducted by the person in charge included learning as well as supervision. Consistency of staff and continuity of care was maintained by the use of a core team, and a familiar relief panel where needed. Staff engaged by the inspector displayed and indepth knowledge of all the care needs of residents, and were knowledgeable about safeguarding and fire safety.

Regulation 14: Persons in charge

The person in charge demonstrated knowledge, qualifications and skills appropriate to the role.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff to support the social and healthcare needs of residents. Staff were knowledgeable and respectful of residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of appropriate training.

Judgment: Compliant

Regulation 23: Governance and management

There were robust systems in place to effectively monitor the quality and safety of the service offered.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place, and any complaints were acted on.

Judgment: Compliant

Quality and safety

Overall the provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and were supported to make choices.

Each resident had a personal plan in place which were detailed and regularly reviewed. There were sections in the plans relating to both healthcare and social care, and improvements had recently been made in setting meaningful goals with residents following an audit of the plans.

Residents were supported in daily activities and in various recreational activities. It was clear that there was a strong relationship between the residents, who cared for each others' welfare. They had enjoyed a summer holiday together, and also enjoyed activities such as meals out together. Their different personal interests were also supported, and each had daytime activities in accordance with their needs and preferences.

Healthcare was well managed, and both recent and on-going healthcare issues were responded to appropriately and in a timely manner, and there was evidence that the person in charge advocated on behalf of residents with other services to ensure the best possible health outcomes.

Where residents had behaviours of concern, there were behaviour support documents in place. However, the guidance in the documents was unclear, and sometimes too vague to give staff any direction. In addition there was insufficient recording of the responses to behaviour and the effectiveness of these responses to effectively review the plan.

There were safe practices in relation to the ordering and storage of medications. All staff had been trained in the safe administration of medications, and in the administration of rescue medications. There was weekly stock count, and stock checked by the inspector was correct. There was safe practice in relation to taking medications out on outings and returning them.

Regular prescriptions contained all the information required, however there was insufficient guidance for staff in relation to some 'as required' (p.r.n.) medications, which could result in subjective and inconsistent decision making as to when they should be administered.

Medication errors were well managed, by reflective practice following an error, and also by recording and review of any errors by management, so that any patterns could be identified.

A risk register was maintained in which all identified risks, both local and individual, are recorded. The information included a brief description and a risk rating. Control measures are briefly outlined, and the person responsible is identified. Each entry refers to a full risk assessment document where all required control measures were documented. Any accidents and incidents were recorded and reported, and presented to management for oversight at the monthly management meeting.

There was appropriate fire safety equipment throughout the centre, including extinguishers, fire blankets, emergency lighting and self closing fire doors throughout. Each resident had a personal evacuation plan which included any strategies which might be required to encourage residents to evacuate in an emergency. These strategies had been shown to be effective in regular fire drills.

There were structures and processes in place in relation to the safeguarding of residents. All staff have had appropriate training, and there is also shared learning and discussion about safeguarding at staff meetings. Staff displayed knowledge of safeguarding issues, and their responsibility in the safeguarding of residents.

The centre was visibly clean throughout, and there was appropriate cleaning equipment and hand hygiene facilities. A recent infection control issue had been well managed, and there was clear guidance to staff.

Regulation 13: General welfare and development

Residents had a meaningful day in accordance with their needs and preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

There were robust risk management procedures in place.

Judgment: Compliant

Regulation 27: Protection against infection

Any infection control issues were well managed,

Judgment: Compliant

Regulation 28: Fire precautions

Robust fire safety strategies were in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Staff had received training in medication management, and medication stock was managed safely. However there was insufficient guidance for staff as to when to administer 'as required' (p.r.n.) medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which was regularly reviewed.

Judgment: Compliant

Regulation 6: Health care

All healthcare needs were met promptly and appropriately

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans did not provide sufficient guidance to staff as to how to respond to or alleviate behaviours of concern

Judgment: Not compliant

Regulation 8: Protection

Residents were protected from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were upheld, and no rights restrictions were identified.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Highwater Lodge OSV-0005407

Inspection ID: MON-0024670

Date of inspection: 23/08/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Each PRN medication management plan will be reviewed and updated by the PIC/PPIM. Revised guidance will be documented on each PRN medication plan by the PIC/PPIM to ensure consistent decision making as to when administer PRN medication. The PIC will introduce the revised PRN medication plans to the staff team. A medication audit will be conducted in the centre by the PPIM in quarter 4 of 2018 to monitor medication practices. Any additional improvements required in medication management post audit will be monitored by the PIC through the centre's Quality Improvement Plan under regulation 29. Timeline: 30/10/18	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The behaviour specialist has updated the behaviour support plan with clear guidance to ensure consistent approaches for identified behaviours are present for staff members.	

The PIC/behaviour specialist will conduct a review session with the staff team to monitor the effectiveness of the new behaviour support plan and to ensure staff members have an up to date knowledge and skills appropriate to their role to respond to behaviours of concern.

The PIC/Behaviour Specialist will meet fortnightly to review behaviour incidents and agree any additional changes to the behaviour support plan.

The PIC/PPIM/Behaviour Specialist will meet monthly to review all incidents/near misses which have occurred in the centre and adjust controls in place to manage behaviour support and risk management.

Timeline: 30/11/18

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/10/18
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is	Not Compliant	Orange	30/11/18

	made to identify and alleviate the cause of the resident's challenging behaviour.			